Magazine template.qxd 11/29/01 9:22 AM Page 1

inside

02 THINK +
Recently announced monthly health benefits fall short of expectations.

03 NEWSREEL
HIV/AIDS-related news snippets from around the world, including approval of Trizivir in Canada and how HIV may increase STD rates in hepatitis C.

05 BUDDY BITES
The Advocacy Department is restructured, redesigned, and ready for action.

06 SAFER INJECTION SITES
The HIV epidemic in Vancouver's Downtown Eastside escalates as opposing groups argue over harm reduction options.

08 PHARMANET INDISCRETIONS
More pharmacists were caught looking into patient description records without authorization.

12 NORTH VANCOUVER ISLAND
A profile of the region and some of the services offered by the North Island AIDS Coalition Society.

features

09 "MAGNETIC" RELATIONSHIPS
Mixed HIV status couples take the good with the bad, and the positive with the negative.

21 PHARMACARE CUTS
The BC government is considering changes to the Pharmacare system that could have serious ramifications for some PWAs.

treatment information

13 IMMUNOLOGY
How T-cells attack the HIV virus.

15 NUTRITION
Guidelines for exercise and HIV, and why omega-3 fats are good for you.

19 HEPATITIS C
New treatment guidelines for people co-infected with HIV and hepatitis C.

24 OPPORTUNISTIC INFECTIONS
AIDS-related lymphoma in the era of HAART, and a primer on oral lesions associated with HIV infections.

27 TREATMENT ADVOCACY
Dispelling some myths about the quality of healthcare that prisoners with HIV/AIDS receive.

28 RESEARCH
Part II of how to separate the wheat from the chaff in research reports.

30 COMPLEMENTARY THERAPIES
Forget about the overly sweet stuff you get at cinema concessions. Licorice root is actually an effective curative for various ailments.

32 PAGINA ESPANOL
Habla usted español? Then this page is for you.

34 POSITIVELY HAPPENING
Your comprehensive guide to HIV/AIDS resources and support groups in BC.

40 LAST BLAST
Snapshots from AIDS WALK 2001

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

From a silk purse into a sow's ear

by Glen Hillson

In a televised cabinet meeting on October 3, 2001, the BC Government announced a program to provide monthly health allowances to PWAs (as well as people with other diseases and disabilities) on income assistance. It looked like our six-year struggle had finally paid off.

Tragically, the other shoe has now dropped with a very loud thud. The additional $225 (including a $40 diet allowance that many already receive) is far less than the $411 recommended by the Schedule C Advisory Committee. It is also less than the average tribunal award of $430 or the $300 program agreed to by the previous government. Still, at first it still seemed like a big step in the right direction. After all, the earliest tribunal awards were much lower than $225. When we first asked the government to introduce a health allowance program, our dollar expectations were far more modest. The incredible success of our advocates in securing $400-plus allowances fuelled high expectations.

Although $225 was something of a letdown, when viewed in a larger context it seemed like a sizeable accomplishment. When first elected, any government typically cuts expenses early in its mandate, then loosens the purse strings leading up to the next election. The current government has already made deep spending cuts and earnestly promises more. Thus, the introduction of a new program to help the sick and the impoverished at a projected cost of nearly $8 million a year seemed almost astonishing.

The picture has now become much clearer. At the same time as the program was created, a great deal was also taken away. It would appear that the Ministry may be creating an obstacle course that could make it even harder than before to qualify for a health allowance.

For example, under the old legislation, DB II recipients were able to apply for any health good or service for a life-threatening condition. Those provisions have been repealed and only the three items covered by the allowance (water, nutritional supplements and vitamins) will now be allowed. A long list of essential health needs that were validated by tribunal decisions are now completely out of reach. Crisis grants are no longer applicable for health goods. The Ministry can—and likely often will—appoint another medical practitioner to review doctor opinions and deny applications on that basis.

People who were awarded a larger monthly allowance previously will only get to keep it until the Human Resources Minister decides otherwise. Your doctor must explain on the application form that not only will the health goods prevent imminent danger to your life, but it will also alleviate your symptoms. What was originally a relatively quick simple form for physicians to complete is now onerous and time consuming and sets the bar for eligibility very high.

It will take more time to fully understand the ramifications of all of the changes. The new provisions will have to be tested—some through appeal. What seemed at first like cause for modest celebration is becoming less appealing with each new revelation. ⊕

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

Magazine template.qxd 11/29/01 9:22 AM Page 3

NEWSREEL

News from home and around the world

BCPWA launches new website

In late October, the BCPWA Society launched its new website to coincide with the Society's Annual General Meeting. The website is a resource for members, other HIV-positive individuals, AIDS service organizations, health care professionals, and interested members of the community.

Designer Chris Clay, of Digital Bloom in Victoria, made the site easier to navigate and incorporated the Society's mission, to empower persons living with HIV disease and AIDS through mutual support and collective action, throughout. Visit www.bcpwa.org.

Trizivir receives notice of compliance

Health Canada approved Trizivir for sale in Canada. It is the first time that three HIV drugs have been packaged in a single pill. Trizivir contains AZT, 3TC, and Abacavir, all of which are nucleoside analogues. Like its component drugs, it will be manufactured and sold by GlaxoSmithKline-ShireBiochem.

Pharmacare takes away drugs

The BC government announced in late October that they will delete from the Pharmacare formulary some drugs often used by PWAs. Among the products no longer covered are anabolic steroids and testosterone, several nasal corticosteroids, other related seasonal allergy drugs, and topical antifungal skin preparations. Access to these products may be provided when "medically necessitated" under Pharmacare special authority provisions.

Montreal researcher receives Order of Canada

Dr. Mark Wainberg, an internationally-renowned scientist in the field of HIV/AIDS, has been appointed as an Officer of the Order of Canada.

Dr. Wainberg, Scientific Director at the Lady Davis Institute for Medical Research at Montreal's Jewish General Hospital, was among the first people to identify the HIV properties of AIDS and the concept of HIV drug resistance. He is also Professor and Director of the McGill AIDS Centre and a former President of the International AIDS Society.

HIV may increase STD rate in hepatitis C

HIV infection could play a role in making the hepatitis C virus (HCV) a sexually transmissible disease.

It is one of the possible interactions that could be taking place between the two viruses, suggest scientists at Johns Hopkins University in the September 2001 issue of the journal Clinical and Diagnostic Laboratory Immunology.

In an overview of known research on the interaction between HIV and HCV in individuals infected with both viruses, the authors estimated that as many as 1 in 4 HIV patients is co-infected with HCV.

While HCV infection appears to have little effect on HIV progression and treatment, HIV infection does affect HCV. Co-infected individuals appear to have higher levels of HCV in their blood, progress to liver damage more quickly and require different treatment regimens than individuals infected with HCV alone. The authors note that coinfection with HIV appears to increase the rate of sexual transmission of HCV.

New formulation of Videx approved

A new enteric-coated version of one of the earliest HIV drugs could represent a significant addition to the current range of treatment options. When Videx (ddI) was first introduced about ten years ago, only AZT preceded it. It was previously formulated in a sachet, a large chewable tablet, and a liquid. Although Videx is an effective inhibitor of HIV replication, many people found the earlier formulations unpleasant to ingest. The new version comes in a single capsule taken once daily on an empty stomach and is more easily tolerated.

Activists and researchers criticize slow drug reviews

Patient groups joined forces in a news conference in Montreal on October 17, 2001 to call attention to the need for faster drug reviews in Canada. Louise Binder, Chair of the Canadian Treatment Action Council cited evidence that

NEWSREEL

News from home and around the world

Canada is much slower to review new drug submissions than other countries. Dr. Julio Montaner, Co-Director of the Canadian HIV/AIDS Clinical Trials Network, said the failure to ensure that safe drugs are made available to patients in a timely manner is ultimately contemptuous of the public.

Health Canada flaunts Canadian patent laws

Health Canada's purchase of a million generic tablets of Cipro is in violation of recent legislation that increased the life of drug patents from 17 to 20 years.

In October, Health Canada placed the order with Canadian generic manufacturer Apotec, stemming from rising fears of anthrax bioterrorism attacks. Government officials initially claimed that Bayer, the German company that holds the Cipro patent, was unable to meet demand. However, Bayer later disclosed that they had plenty of Cipro available and no one from Health Canada had approached them.

Under an international agreement, governments may import or manufacture cheaper generic versions of patented drugs in the event of a national emergency. Canada and the U.S. have opposed the use of generic HIV drugs in Africa and other countries where the AIDS epidemic is killing millions of people.

Expanded access to tenofovir

Tenofovir (Viread) is now available in Canada through an expanded access program. Tenofovir is a nucleotide reverse transcriptase inhibitor and is active against NRTI-resistant strains of HIV. Manufacturer Gilead Sciences has established eligibility criteria for enrollment in the program to make the drug available to patients in greatest need. For more information on tenofovir contact the BCPWA Society's Treatment Information Program at 604-893-2243.

Another drug company merger

Continuing the recent trend of mergers and buyouts in the pharmaceutical industry, Bristol Myers Squibb (BMS) bought DuPont Pharma. The sale will increase the presence of BMS in the HIV/AIDS therapeutic area with the addition of Sustiva (efavirenz) to its portfolio of antiretroviral drugs. Sustiva is a non-nucleoside reverse transcriptase inhibitor (NNRTI). BMS currently manufactures and sells ddI (Videx) and d4T (Zerit). BMS also has plans to introduce its first protease inhibitor, atazanavir, in the next 1-2 years.

Flea market raises funds for essential items

Polli & Esther's Closet recently held a successful flea market at the West End Community Centre. Volunteers put in many hours of work planning, sorting, hauling, and selling the donated items. The money raised will go toward purchasing necessity items such as underwear and socks for PWAs. This unique peer-run free store, situated in the Pacific AIDS Resource Centre, is open on Wednesdays and Thursdays. ⊕

Jackie Haywood, the BCPWA Society's Director of Support, surrounded by volunteers at the Polli & Esther's Closet flea market.

Magazine template.qxd 11/29/01 9:22 AM Page 5

Buddy Bites

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

The new and improved Advocacy Department

If you visited the Pacific AIDS Resource Centre in recent months, you will have noticed renovations underway at the BCPWA Society offices and in the Members' Lounge on the second floor. Remodelling our space is just one of the major changes to the Advocacy Department. The expansion of the Buddy Program will also improve advocacy services to BCPWA Society members.

The Advocacy Department offices have been physically enlarged to accommodate the Buddy Program in the same space as the rest of the Advocacy Department. Individual advocates' offices were moved to the rear area to make way for a service counter for the Buddy Program.

Many training sessions are accompanying these physical changes. The training has focused on the different Actionkits that the Advocacy Department introduced in June. This initiative furthers the BCPWA Society's mission to "empower persons living with HIV disease and AIDS through mutual support and collective action." Each Actionkit provides step-by-step information for BCPWA Society members to resolve their own problems or for Buddies to help members resolve problems. Subject areas include debt forgiveness and student loans. Many others topics, such as bankruptcy, are in progress. All deal with specific difficulties that our members often face.

Buddy Program training has also focused on service delivery and diversity training. We now have a mentoring program where a staff person directly observes actions of volunteers.

All of these initiatives are dramatically reducing waiting lists to see an individual advocate. Moreover, members are able to access assistance more quickly with trained volunteers from our own community. Staff members closely monitor all volunteer work. Individual advocates continue to personally address any particularly difficult cases.

The Buddy Program looks forward to continuing to serve our members in this new and expanded format. We expect to issue a call for additional volunteers in January, with training to occur in March. ⊕

BCPWA Internet Café opens November 19, 2001!

- surf the net for treatment information & the BCHIV News List
- set up your own email account
- resumé writing
- video conferencing

Hours: 11AM–4PM
Trained volunteers to assist you
Location: Upstairs at 1107 Seymour St
Open to all BCPWA members.

Status quo is not an option

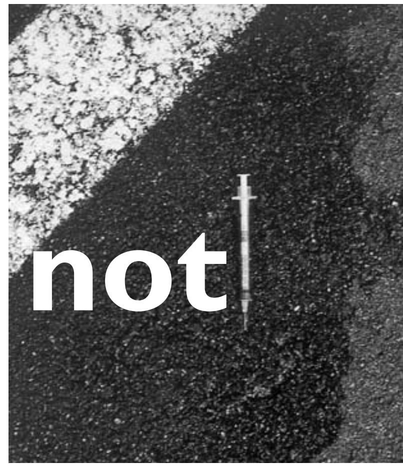


photo britt permien

The debate continues over introducing safer injecting rooms in Vancouver's Downtown Eastside

by Evan Wood

Since the mid-1990s, Vancouver's Downtown Eastside has experienced an explosive and continuous HIV epidemic among injection drug users (IDU). The epidemic has been particularly confounding for health researchers because the city has in place a well-established needle exchange program, an intervention that has been shown to prevent HIV infections among IDUs. Although a needle exchange flies in the face of the "say no to drugs" dogma, it is at the heart of harm reduction, a philosophy aimed at curbing crime rates and containing the spread of disease by enabling drug users to inject safely until they can be helped off drugs.

In 1996, researchers documented the emerging Vancouver HIV epidemic in a paper entitled "Needle Exchange is Not Enough." They argued for additional harm reduction interventions such as safer injecting rooms (SIRs). Safer injection rooms are legally sanctioned and supervised facilities where addicts can inject pre-obtained illicit drugs and where they are provided access to healthcare and other services, in addition to sterile injecting equipment. Although safer injection rooms have not been evaluated in North America, over 45 now operate in approximately a dozen European cites. A legal SIR recently opened in Australia.

Unfortunately, little was done in response to "Needle Exchange is not Enough." No sweeping policy changes were introduced. Instead, law enforcement was stepped up. That year the annual rate of new HIV infections among Vancouver injection drug users peaked at 18 percent, a level of spread that remains among the highest ever documented in the developed world.

The inaction of health policy-makers led to a subsequent study entitled "Deadly Public Policy." The authors demonstrated that the withdrawal of social services might have lit the spark that ignited the Vancouver epidemic that we are still dealing with.

More than 6,000 individuals were forced into run-down Downtown Eastside hotels because of cuts in federal government support for low-income housing. Addicted individuals were refused access to social housing and detox and mental health facilities were eliminated as budget reductions were imposed, further concentrating at-risk individuals into the neighbourhood. Driven deep into the low-income hotels by the war on drugs, living in fear of police, and having no access to drug treatment, injection drug users shared needles. The HIV epidemic raged on, much as it does today.

Several years later, debate continues to rage over the potential of safer injecting rooms as an intervention to combat the city's drug use epidemic. As has been the case since the emergence of the HIV epidemic, many of the people fighting for change are persons with HIV. These people and other advocates, including Vancouver Mayor Philip Owen, believe SIRs will bring users into care, clean up the outdoor drug scene, and help mitigate the HIV and overdose crises.

In 1996, the annual rate ***of new HIV infections among Vancouver injection drug users peaked at 18 percent, a level of spread that is among the highest ever documented in the developed world.***

However, community groups have expressed fear that the European experience with safer injecting rooms may not be replicated in Canada. The result is a stalemate with little hope of a safer injecting room trial commencing in the near future.

Safer injection rooms have three primary aims. First, they aim to alleviate the public disorder problems associated with public injecting and improper needle disposal by bringing injection drug users inside and off the street. Second, by having medical services at hand, they aim to prevent fatal overdoses that often happen when people inject alone. Never has there been a fatal overdose in a safer injecting room since they were first established in the mid-1980s. Finally, SIRs aim to limit blood-borne disease epidemics by providing sterile needles and supervising users to prevent needle sharing. Much of the harm

Magazine template.qxd 11/29/01 9:22 AM Page 7

reducing impact of SIRs is also attributable to the educational messages IDUs receive while at the safe injection site.

To raise awareness about the potential of safer injecting rooms, Vancouver researchers have explored several factors of the Downtown Eastside HIV epidemic that could potentially be changed if safer injecting facilities were established here. This research was conducted as part of the Vancouver injecting drug users study (VIDUS). The project has recruited over 1,400 addicts into a continual survey of injecting behaviour and the spread of HIV. The findings make a strong case for safer injection rooms:

- 28 percent of addicts shared a needle
- 75 percent of addicts reported injecting alone at least once
- 10 percent of addicts experienced a non-fatal overdose
- 14 percent of addicts reported injecting in a public space
- 25 percent of addicts reported needing help injecting
- 18 percent of addicts found it hard to access sterile needles

Sadly, those who needed help injecting were almost twice as likely to report sharing a needle in the last six months. Even more alarming, those who found sterile needles difficult to access were more than three times more likely to report sharing a needle. Clearly, the drug problem can no longer be ignored.

Can a safer injection facility help change these behaviours? The only way to know is to try. Although the concerns of community groups must be heard, harm reduction advocates are not proposing immediate and widespread opening of SIRs. Instead, they hope to initiate a rigorous scientific trial of safer injecting rooms to evaluate them within the framework of a pilot study. Such a trial would provide important public health information if safer injecting rooms help. Alternatively, the evaluation would ensure that the experiment is stopped if, for some reason, the SIR was harm producing in any way. With the current level of drug crime, exploding disease rates, a groaning healthcare system, and avoidable human misery, we cannot afford to delay the intervention any longer. ⊕

Advocates believe safer injecting *rooms will bring users into care, clean up the outdoor drug scene, and help mitigate the HIV and overdose crises in Vancouver.*

photo rachel rosen

Evan Wood is a student in the Department of Healthcare and Epidemiology at the University of British Columbia.

Government announces essential health benefits for people with HIV/AIDS and other disabilities

On October 3, the BC Ministry of Human Resources released the following fact sheet on the Monthly Nutritional Supplement.

Effective October 2001, the ministry will provide a monthly nutritional supplement of up to $225 to Disability Benefits recipients who face chronic progressive health deterioration with life-threatening symptoms.

The supplement consists of one or more of the following:

- $165 for additional nutritional diet.
- $20 for bottled water (for cases of immune suppression only).
- $40 for vitamins and minerals.

Eligibility is based on:

Receipt of Disability Benefits support and shelter allowance; and Information from a medical practitioner about:

- The medical condition causing the chronic progressive health deterioration;
- Evidence of specific wasting symptoms (including "malnutrition, underweight status, significant weight change, loss of muscle mass, bone density loss, neurological degeneration, significant organ deterioration or moderate to severe immune suppression) and;
- The necessity of the supplemental items to alleviate symptoms that, left untreated, would pose an imminent danger to life.

This monthly nutritional supplement replaces the need for people to apply for extra health benefits under section 2(1)(l) of Schedule C. This section will be repealed.

People with health-related monthly cash allowances previously-awarded through the BC Benefits appeals system will continue to receive them. If they currently receive less than the maximum $225 available through the new allowance, they may apply for the higher amount.

From now on seriously-ill disability recipients will not have to go through the appeal system. The new supplement provides a more efficient and less cumbersome way to meet their additional nutritional health needs.

Application forms will be available from ministry of Employment and Benefits Centres.

About 4,500 Disability Benefits recipients are expected to be eligible. ⊕

Magazine template.qxd 11/29/01 9:22 AM Page 8

Pharmanet database an open book?

More pharmacists caught peeking

by Glen Hillson

Recent media reports that more pharmacists have been caught snooping into patient prescription records without authority have added to PWAs' anxiety about their privacy. According to Pharmanet bulletins, five druggists have been caught and disciplined. A sixth complaint is pending. They were caught when consumers asked to review who had accessed their files, as opposed to being discovered by Pharmanet's internal audits. The National Post reported similar abuses of the rules in August 1998.

Pharmanet security is a particular concern in the AIDS community because the BC College of Pharmacists is pushing for changes to how pharmacists dispense antiretroviral drugs for treatment of HIV disease. Currently, the BC Centre for Excellence in HIV/AIDS is responsible for overseeing the distribution of antiretroviral drugs in BC. Although Pharmacare fully funds the cost of HIV drugs, Pharmanet does not record the drugs on the database of individual patient profiles. According to Pharmacare and the College of Pharmacists, this practice does not comply with BC legislation. Discussions between various stakeholders have continued for some time and a formal community consultation is planned for the coming months.

Pharmanet security is a *particular concern in the AIDS community, because the BC College of Pharmacists is pushing for changes to how pharmacists dispense antiretroviral drugs for treatment of HIV disease.*

Many PWAs, especially those who live in smaller communities or whose HIV status is not widely known, have expressed strong opposition to the inclusion of HIV drugs on their Pharmanet profiles. It would mean that any time they fill a prescription, the pharmacist would see from their record that they have been prescribed HIV drugs. Some people have even gone as far as to say they would forgo treatment if necessary preserve their privacy.

The other side of the coin is that the Pharmanet system is a valuable tool for protecting the safety of patients. Every time pharmacists fill prescriptions they are able to check the patient's records and could potentially identify unfavourable interactions between drugs that the patient is taking. For many PWAs who are less concerned about whether their pharmacist knows they are HIV-positive, this cross-checking is a very appealing safeguard. Some drug interactions can be lethal.

Pharmacists are only authorized to access records for the purpose of dispensing a prescription, counselling a patient, evaluating drug usage, or resolving coverage payment claims. Any other access, as occurred with the five disciplined pharmacists, constitutes a violation.

Ironically, in recent discussions with officials, representatives of the AIDS community have been assured that the security problems discovered back in 1998 are almost completely resolved, and no real cause for concern exists. The most recent discoveries expose the fallacy of that assertion. In fact, when interviewed about the most recent incidents, BC Health Services Minister Colin Hansen disclosed that only 75% of the recommendations put forward in 1998 have been implemented so far. Media reports gave no indication of which recommendations have yet to be put into practice.

The five pharmacists caught received fines for their actions. They were not suspended and did not have their licenses revoked.

The BCPWA Society has recommended that HIV drugs be included on Pharmanet only for patients who have given informed written consent. This procedure is similar to that currently used for participants in clinical research trials. ⊕

Glen Hillson is Chair of the BCPWA Society.

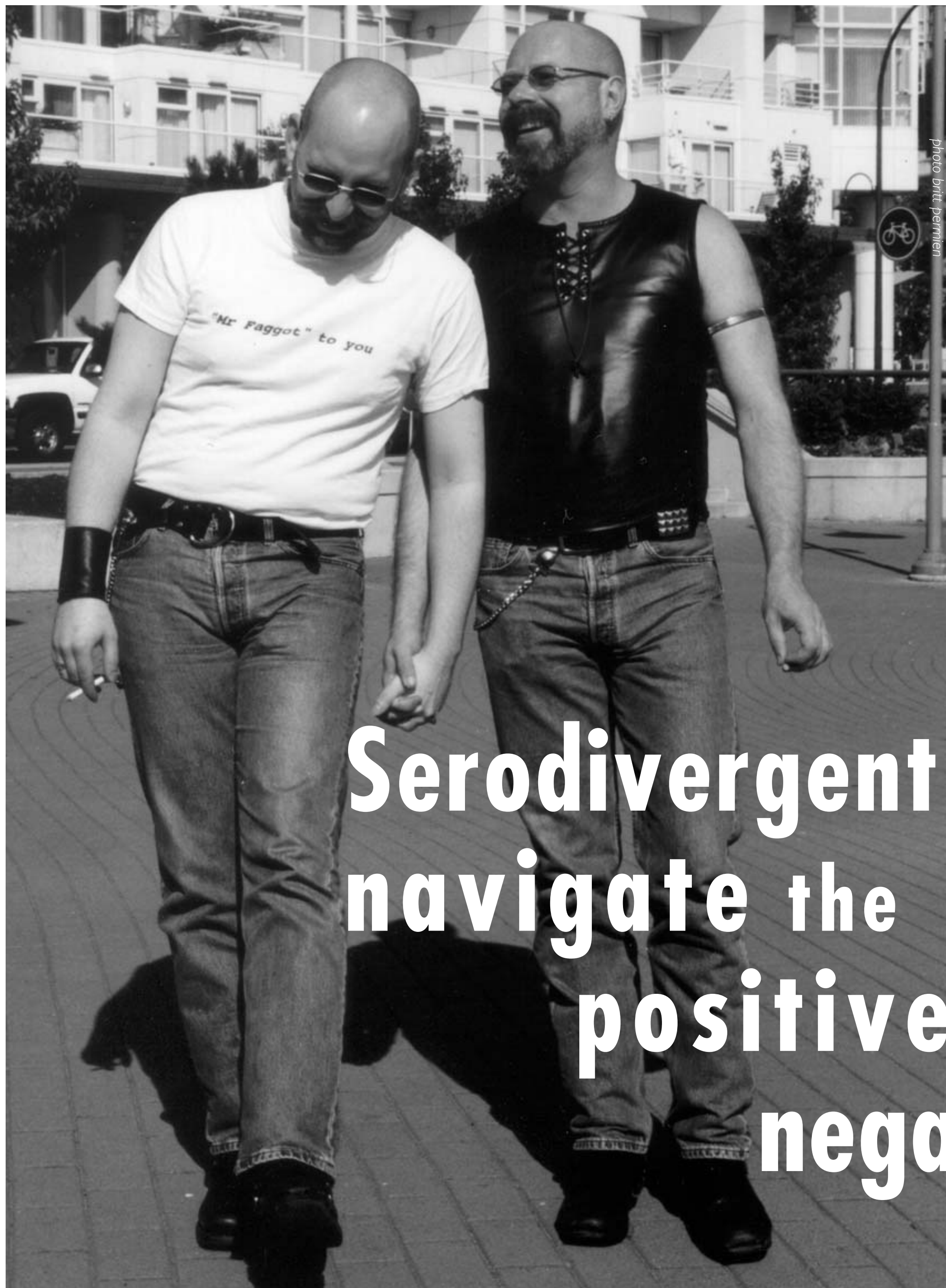


photo britt permien

Serodivergent couples navigate the positive and negative

by Jeff Rotin

Wayne Campbell and Michael O'Shaughnessy are sitting across from each other at the Davie Grind café in Vancouver's West End looking like bookends. Both are fair skinned and balding with close-cropped hair. Sporting his-and-his moustaches, beards, and hoop earrings, they are almost identically dressed in blue jeans, leather biker jackets, and heavy black boots. One significant difference is not visible: Campbell is HIV-positive and O'Shaughnessy is HIV-negative.

Mixed HIV status relationships are more commonplace than they were several years ago. With the advent of highly active antiretroviral therapy (HAART), a positive diagnosis is no longer an automatic death sentence. People with HIV/AIDS are generally leading fuller lives than they were pre-HAART, allowing them to pursue careers and long-term relationships.

How much the mixed HIV status impacts a relationship is difficult to gauge, due to a dearth of research on the subject. "Some people may feel that one partner being positive doesn't make all that much difference, but often they are deluding themselves," says John Ballew, an Atlanta-based psychologist and couples counsellor. He says much depends on whether or not the HIV-positive partner is in good health.

The notion of discord in the term serodiscordant, used by researchers to describe mixed HIV status relationships, hints at the obstacles these couples may encounter. For that reason, many people prefer the expression serodivergent, or magnetic, which suggests this attraction of opposites.

According to Ballew, the toughest challenge for serodivergent couples is communication. In his private practice, he finds that both partners may be reluctant to tackle important issues such as finances, health care, and living wills. They may also avoid such topics as retirement, aging, or careers that emphasize their different HIV status. He stresses the need for couples to share their fears and concerns. "The positive person doesn't want to sound like he's always talking about HIV. Sometimes he wants to protect the negative partner. The biggest danger is that neither talks about it."

John Finlay and Bryan McKinnon get a lot of moral support from their chosen family. Here they celebrate Thanksgiving together. Clockwise from upper left: Aedan, Karen, Dean, Madeline, Bryan, Merlin, John, and Phoebe, plus Rocky the dog.

Serodivergent couples may be reluctant *to tackle important issues such as finances, health care, and living wills. They may also avoid such topics as retirement, aging, or careers that emphasize their differences in HIV status.*

Communication is at the core of Campbell and O'Shaughnessy's relationship. Chatting over coffee at the Davie Grind, they explain how they had long, frank talks when they met in 1998 as volunteers at the Dr. Peter Centre, even before they began dating last year. They believe this has helped them achieve a deeper emotional bond.

Although O'Shaughnessy works in the HIV/AIDS field at the BC Centre for Excellence, Campbell never takes it for granted that O'Shaughnessy will understand what it is like to live with HIV. "I have to talk and make sure that I explain things clearly, that there is understanding," says Campbell. "And I have to listen, too."

O'Shaughnessy says he needs to be part of decision making around Campbell's health, since it affects his life, too. They strive for an equitable, give-and-take relationship. "We keep a tally: you have a bad day, I have a bad day," he says. "You can't have one person who's constantly down."

Ballew notes that it can be hard for serodivergent couples to strike that balance if the HIV-positive partner is unable to work or in poor health. A partner with HIV may feel like "damaged goods," or that he or she is not assuming enough responsibility in the relationship. "If they feel like they're lucky to have anybody that will put up with them," he says, "or that they're the recipient of charity, then that will show up in the dynamics of the relationship."

Fear of HIV transmission may be another dynamic of the relationship. The California Partners Study, conducted by the Center for AIDS Prevention Studies at the University of California, tracked 175 heterosexual serodiscordant couples from 1985 to 1995. The study found that many HIV-positive partners worried about infecting their HIV-negative partners; many described a process of "sexual abdication" immediately after testing positive.

"We were very conscious of the first time we had sex after John's diagnosis," says Bryan McKinnon. His partner John Finlay was simultaneously diagnosed with HIV and cancer in 1997, three years into their relationship. Their first attempt at sex after learning Finlay was HIV-positive was awkward and perfunctory—they just wanted to overcome the fear. It was a way of reaffirming their commitment to each other.

McKinnon, Operations Director at Hollyhock Leadership Institute, admits that in the early months he sometimes had nightmares about seroconverting. "I would wake up at four in the morning and panic that I was HIV-positive." He never discussed his fears with Finlay. "I wonder how many other negative

Magazine template.qxd 11/29/01 9:22 AM Page 11

partners think about that and do it quietly," he adds.

That no longer concerns them. McKinnon has not been tested in several years—which may not be that uncommon among HIV-negative partners in serodivergent relationships. McKinnon and Finlay feel the chances of transmission are low because they are monogamous and they continue to practice the same safe sex that they did before the diagnosis. That means using condoms for anal sex, oral sex without condoms, and no exchange of bodily fluids. However, condom fatigue poses a problem in many relationships, and it is magnified among serodivergent couples due to the inherent risks.

While there are resources *for people living with HIV/AIDS, from AIDS service organizations to support groups and health programs, there appear to be few, if any, direct resources for a negative partner in a serodivergent relationship.*

Finlay's health problems have placed restrictions on their lifestyle. He was reaching his top earning potential as a professional fundraiser when he was diagnosed and had to stop working. "All my friends have bought houses and cars and are consultants making $500 a day," he says. " I miss that."

Lifestyle restrictions can be tough when you are a young gay couple embarking on a new relationship. Shane Tucker, 29, and Noel McIntyre, a 21-year-old student, have been together for four months. Tucker, a peer counsellor at YouthCO in Vancouver, is co-infected with HIV and hepatitis C and has to monitor his physical exertion. When the couple rode their bikes from the West End to the University of British Columbia campus and back, it sapped Tucker's energy for the next week. "Noel wanted to play Frisbee and stuff, and I just couldn't do it," says Tucker, adding that it caused some friction. "I didn't tell him that I was wiped out."

Despite—or perhaps because of—his youth, McIntyre seems non-plussed by his partner's HIV-positive status. "I don't even think of him as having HIV," he insists. He volunteers at YouthCO, is studying to be a counsellor for PWAs, and feels he has a good grasp of HIV issues.

While there are resources for people living with HIV/AIDS, from AIDS service organizations to support groups and health programs, there appear to be few, if any, direct resources for a negative partner in a serodivergent relationship. Similarly, if a couple needs counselling they may find it difficult to find a therapist with expertise in mixed HIV status relationships.

The best strategy for serodivergent couples may be to live for the present, which, in light of the current world situation, is sound advice for everyone. Karen and David Colterjohn are embracing that philosophy. Karen tested HIV-positive in December 1992 while working in Japan. Right now Karen is on a "drug holiday" from her HIV medications, her CD4 count has skyrocketed to 600, and she loves her new job at the Humane Society. The Colterjohns are savouring these good times.

"We've gone through the hardest already. It feels like a vacation for us," says Karen.

Sitting at their dining room table in their small downtown Vancouver apartment on a lazy Saturday morning, they laugh as they recount their incredible saga. David was Karen's best friend in Japan, and their relationship began the night before she received her test results. They experienced the highs of new love and the lows of Karen's diagnosis in a foreign country where they feared disclosure and HIV information and resources were scarce.

In some respects, Karen's actual health often became secondary to other concerns, such as her fight with her family over finances. Their biggest challenge was a long and public immigration fight to bring Karen, a U.S. citizen, to David's native Canada after she was declared medically inadmissible. She only recently gained landed immigrant status.

Shane Tucker and Noel McIntyre (wearing glasses): The first time they had sex, the fear of Tucker transmitting HIV to him was "the furthest thing from my mind," says McIntyre with a grin.

They admit a certain unwillingness to consider the possibility of Karen's health declining. "That's still something I'm in denial about," says David, a journalist and freelance writer. "The notion that I might be around another 20 years after Karen dies. I can't imagine getting by on my own."

The fear of outliving one's partner may be a common thread in mixed HIV status relationships. It is something that O'Shaughnessy and Campbell have discussed in their many talks. "Basically he has to make it another forty years or I'll kill him," O'Shaughnessy says, laughing. "It's mainly me that has the issue with it because it's new to me. I've had some real anxiety moments about it."

Campbell refuses to let it dominate his thoughts. "I can't live with the threat of my dying ruling out everything else in my relationship, otherwise I'll just be touring funeral homes and picking out my casket. I'd rather be planning my next trip. I'm not dying, I'm living, and that's what I'm doing in this relationship." ⊕

Jeff Rotin is the Managing Editor of Living + Magazine.

North Vancouver Island

Doctor shortage compounds difficulties for PWAs

by Phillip Haines

Like other rural communities in BC, North Vancouver Island offers the benefits of beautiful landscapes, a slower pace, and lower rents, but it also poses a number of challenges to PWAs. The doctor shortage in BC has hit this region particularly hard: it was recently announced that nine doctors are leaving the Comox Valley. This exodus will leave a terrible medical void.

Compounding this doctor shortage is the difficulty in finding HIV-savvy doctors, since the HIV experts are mainly located in Vancouver. The Ministry of Human Resources assists PWAs to attend medical appointments outside of the region.

Aboriginal HIV-positive persons living on reserves face additional hurdles. They do not qualify for provincial assistance programs, such as Schedule C benefits, and must seek assistance from the federal government. Assisting HIV-positive aboriginal people is one of the biggest challenges for the North Island AIDS Coalition Society (NIAC).

Operating since July 1993, NIAC offers individual advocacy, support services, and treatment information. It also conducts prevention education programs within the school system and for front-line organizations and employees of various government ministries.

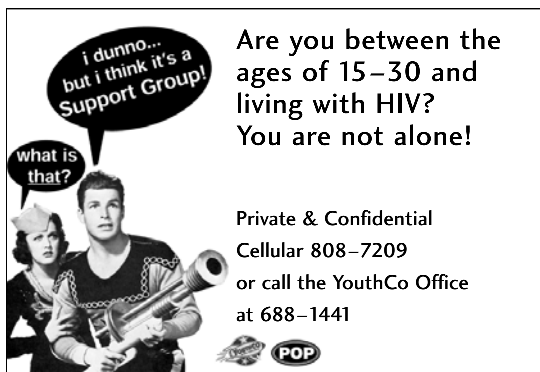
NIAC's geographic area extends from Fanny Bay north to Port Hardy, including the Gulf Islands and the BC Central Coast (Bella Bella). NIAC has three community resource centres. The main centre is located in the Comox Valley in Courtenay, and smaller centres operate in Campbell River and Port Hardy. NIAC also delivers five needle exchange programs in Courtenay, Campbell River, Port Hardy, Port McNeill, and Alert Bay.

NIAC also assists many persons in the region living with hepatitis C to complete disability applications. However, thus far NIAC has done this work without funding, and it may be forced to refer people elsewhere. The question is where—no other local organization can do this work or seems willing to take it on.

The North Island AIDS Coalition Society is open from 9am–4pm Monday to Thursday. Needle exchange programs operate in the evenings and on Saturday, depending on the location. For more information on NIAC programs, visit their website at www.island.net/~niac or email them at niac9@home.com. ⊕

Phillip Haines is the Executive Director of the North Island AIDS Coalition Society.

photo Lynn Copeland



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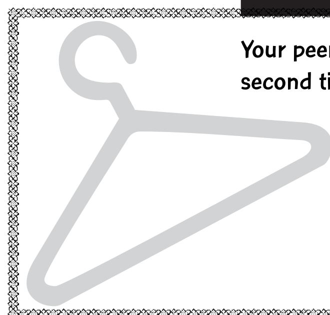

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The Treatment Information Program endeavors to provide all research and information to members without judgement or prejudice. The project does not recommend, advocate, or endorse the use of any particular treatment or therapy provided as information. The Board, staff, and volunteers of the BCPWA Society do not accept the risk of, nor the responsibliity for, damages, costs, or consequences of any kind which may arise or result from the use of information disseminated through this project. Persons using the information provided do so by their own decisions and hold the Society's Board, staff, and volunteers harmless. Accepting information from this project is deemed to be accepting the terms of this disclaimer.

CD8s in HIV: attack of the killer Ts

by Ken Rosenthal and Paula Braitstein

During a regular blood work-up, your blood is tested for a variety of components and functions, including red blood cells, organ function, CD4s, and CD8s. CD8 cells have always been counted and have generally been interpreted in relation to the CD4 count. A person with a healthy immune system has twice as many CD4s as CD8s; this ratio tends to be reversed when the immune system is compromised. This relation between CD4s and CD8s is called the CD4:CD8 ratio.

What CD8s actually do and how to interpret their numbers is not properly understood. However, as scientists learn more about the immune system, the role these cells play in HIV disease is becoming clearer.

What are CD8 cells?

Like just about everything in HIV disease, CD8s have several different names: CD8, CD8+ cytotoxic T lymphocytes (CTL), killer T-cells, and plain old killer cells.

CD8 cells are the "hit people" of the immune system. Their main job is to search and destroy. They have learned to recognize and kill only virus-infected cells, hence the name killer T-cell. They do their killing when the virus is in the act of reproducing in an infected cell. Thus, the CD8 cell response is one of the important tools that the immune system has at its disposal to protect the body from disease.

Importantly, CD8s only kill the virally infected cells and not cells that aren't infected—unlike antibiotics, which kill all bacteria, not just the dangerous ones. In some cases, this T-cell response can benefit the infected individual, while in other cases it can be harmful and lead to diseases of the immune system, such as autoimmune disease.

Whether a killer T-cell response is beneficial or harmful to a person depends, in part, on the nature of the virus. Some viruses are able to directly kill the cells in which they replicate (all viruses need a cell in which to replicate). Infection with these kinds of viruses triggers a killer T-cell response that then becomes a race between the virus and the immune system. If the killer T-cell response is fast and efficient, it is able to

eliminate virus-infected host cells before the virus can spread too far and cause damage. In this case, the killer T-cell response helps protect the person.

Alternatively, many viruses, such as hepatitis B, do not actually kill the cells they infect. If this kind of virus is able to infect many cells, or infects cells that cannot be replaced once they are killed by the CD8s, the killer T-cell response can cause severe immune-mediated disease. Thus, if viruses infect cells of the immune system itself, the killer T-cell response can lead to severe immunosuppression.

compromise begins. This CD8 response happens long before even antibodies become capable of inactivating HIV. After this early or acute phase, an inverse relationship develops between CD8s and HIV viral load. If the level of CD8s is high, the HIV viral load is low, and if there are low levels of CD8s, HIV viral load is higher.

Anyone who has taken antiretrovirals or is considering taking them will know that the virus can easily develop resistance to the drugs. HIV is considered a tricky virus, in part because it is able to mutate easily and develop this drug resistance, as well as escape notice by the immune system. So while the killer T-cells are attacking HIV, HIV is busy giving itself a makeover so that the killer T-cells won't be able to recognize it any longer.

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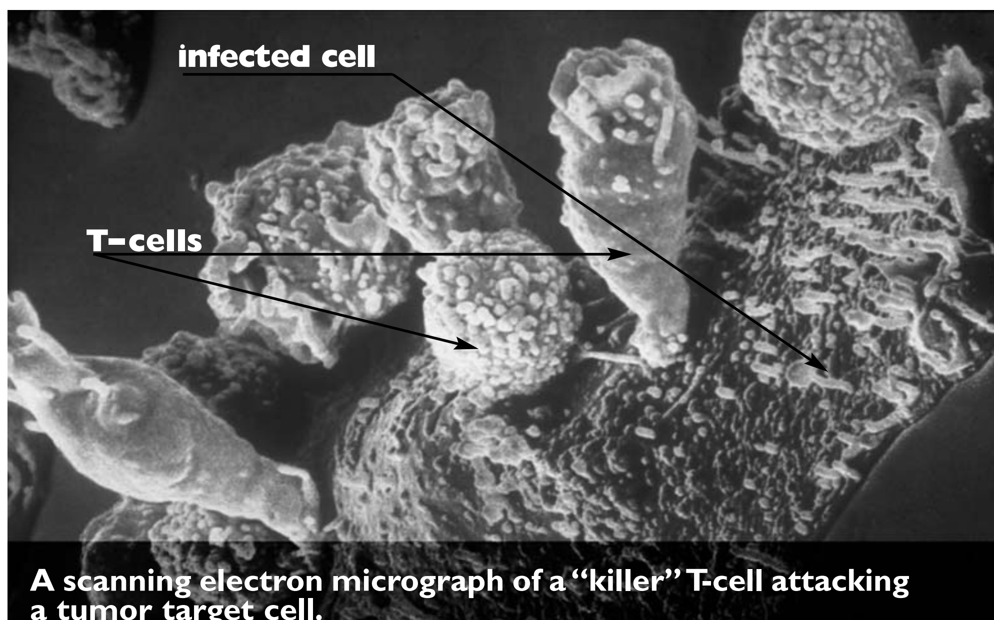


A scanning electron micrograph of a "killer" T-cell attacking a tumor target cell.

Importance of CD8s in HIV infection

HIV causes strong killer T-cell responses in people living with HIV/AIDS. After someone is initially infected with HIV, the killer T-cell response is very important in controlling the infection. During this early or acute phase of HIV infection, the number of CD8s rises in direct proportion to the amount of HIV rising in the blood. When the CD8 response reaches its peak, the virus level falls to what we now call the viral setpoint, which is the viral load after a few months of being infected but before severe immune

Failure of CD8s: Escape from recognition

Despite a strong killer T-cell response in HIV infection, CD8s are unfortunately unable to control the virus completely, and ultimately the virus wins.

HIV has evolved a number of ways to elude the immune system and survive. HIV is able to remain dormant in infected cells, meaning that the cell is infected, the virus is there, but the immune system cannot detect it. These latently infected cells are therefore invisible to killer T-cells. HIV-infected cells can also hide out in the central nervous system or other sites in the body where T-cells normally are not permitted.

Conclusions

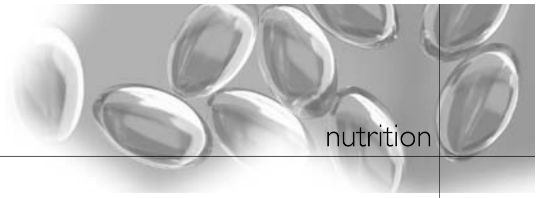
Of all the hits a killer T could be assigned, knocking off HIV is one of the toughest. HIV moves fast and has evolved many ways of hiding out and escaping from CD8 detection. The killer T-cell response to HIV can be both beneficial and harmful to someone who is infected with HIV. Although the killers may exert temporary control over the spread of HIV, they do so at the cost of destroying cells of the immune system, contributing inadvertently to immunosuppression and, ultimately, their own demise.

It is clear that we need a better understanding of the complex interactions between the killer T-cells and HIV. This knowledge has important implications for our understanding of AIDS and the development of vaccines against HIV. In the meantime, CD4s and viral load remain the only real predictive laboratory values available to evaluate disease progression. Though CD8s are clearly important and have an important relationship with the virus, exactly what the numbers mean in the context of managing your disease remains unknown. ⊕

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). For questions, comments, or additional information, please contact rosenthl@mcmaster.ca.

Paula Braitstein is Director of Treatment Information for the BCPWA Society.

Magazine template.qxd 11/29/01 9:22 AM Page 15



Fit for life

Guidelines for exercise and HIV presented at the AIDS Nutrition Service Alliance Conference

by Diana Peabody, RD

The AIDS Nutrition Service Alliance (ANSA) Conference was held in Philadelphia in September 2001. This annual conference addresses food and nutrition issues faced by people living with HIV and looks at ways that services and nutrition professionals can best meet their needs. The conference is attended by organizations that provide food through food banks, congregate meals (people coming together for a meal), or home delivery and by registered dietitians working in the field of HIV/AIDS. This year a number of the clinical nutrition presentations focused on BIA and body composition.

Recent studies have shown ***that exercise can also reduce abdominal fat and improve high triglyceride, blood sugar, mood, and quality of life.***

Mary Jane Detroyer, a registered dietitian and certified personal trainer, gave an interesting and timely presentation on exercise. We have long known that exercise is important to maintain lean body mass, muscle strength, and bone mineral density. However, more recent studies have shown that exercise can also reduce abdominal fat and improve metabolic complications (high triglyceride and blood sugar levels), as well as improve mood and quality of life. Detroyer presented the following key points and exercise guidelines for HIV-positive people.

- Address low testosterone. Low testosterone will make it difficult to build muscle mass. Discuss your testosterone levels with your doctor.
- Get your Bioelectrical Impedance Analysis (BIA)done regularly. It is motivating to keep track of your body cell mass (muscle) and fat stores.
- If your lean body mass is low, your ability to function and perform your normal daily activities will decrease. You may not have the strength or stamina to do all the things you want to do each day.
- If you are trying to gain lean body mass, you have to do progressive resistance training, which means lifting weights that keep getting harder over time. If you are inexperienced with weight-lifting, get advice from a qualified instructor.
- Start slow. What starting slow means will vary from person to person, but for some of you this means *really* slow. If you are not sure, get a referral to a physiotherapist.
- Slowly work towards the FITT principle: Frequency of 3–5 times per week; Intensity from 40–80% maximal effort; Timing of 30–60 minutes per time; Type of exercise depends on needs.
- If you are overweight and have a high blood sugar level, a very slight weight loss of 10% may lower your blood sugar level.
- Aerobic exercise is the most effective for losing weight and lowering triglyceride or blood sugar levels. However, if you are already very thin or have lost a lot of fat, aerobic exercise could make these things worse. Aerobic exercise gets the heart beating faster for a sustained period of time (at least 20 minutes).
- Smoking decreases exercise tolerance. To get the most out of your exercise routine, don't smoke at least 30 minutes before exercising. Of course, it is best to quit smoking altogether.
- If you are planning to exercise outdoors, dress appropriately for the weather. If you have diarrhea, make sure you know where the bathrooms are.
- If you go to a gym, it may be a good idea to avoid the sauna and whirlpool because these areas can be breeding grounds for germs.
- Always make sure you are well hydrated.
- Women going to a fitness centre for the first time should be aware that many exercise machines are not made for women. To avoid injury, check with the trainers at the fitness centre for instructions.
- If you have neuropathy, swimming and seated weight-lifting may work for you.
- If you have been sick recently, you may need to cut back on your usual routine.
- Always discuss your exercise plans with your doctor.

Getting started on an exercise program and finding the right one for you can be difficult, especially if you are out of shape or have been sick or are very tired. Remember not to overdo it at first and pace yourself according to your health and unique needs. The important thing is to get regular exercise so you can stay strong and healthy.⊕

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

Magazine template.qxd 11/29/01 9:22 AM Page 16

Guilt-free fats

Omega-3 fatty acids play many important roles in the body

by Ágnes P. Kalmár

There has been a lot of talk recently about omega-3 fatty acid (n-3). But what's so special about it? About 30 years ago, scientists noticed that Inuit people had lower rates of cardiovascular disease than the average North American, yet their diet was very high in fat. Inuit diet consists mainly of fish and marine mammals, which provide a rich source of omega-3 fatty acids. After much research, they found that n-3 fatty acids play many essential roles in the body.

Omega-3 fats are essential for growth and development and may play an important role in the prevention and treatment of cardiovascular disease (heart disease), hypertension (high blood pressure), arthritis, cancer, and even depression. They are also essential for infant brain development and normal brain function in adults. Low levels of n-3 fats may play a role in cognitive decline resulting from aging. Researchers have found that people suffering from depression have low levels of n-3 fats.

Learning ability may improve with adequate n-3 fat intake. In addition, n-3 fats can thin the blood and, therefore, lower blood pressure. However, you have to be careful not to take omega-3 fats in addition to blood-thinning or heart medications since they have additive effects. You may not be able to stop bleeding if your blood is too thin.

People with rheumatoid arthritis may also benefit from n-3 fats. Omega-3 fatty acids have anti-inflammatory effects and people with rheumatoid arthritis may find some relief in joint stiffness and pain. Some researchers speculate that n-3 fats may play a role in many other conditions since our body needs n-3 fats on a daily basis and long-term low intake disrupts the body's balance.

Omega-3 fats are ***essential for growth and development, and may play an important role in the prevention and treatment of heart disease, high blood pressure, arthritis, cancer, and depression.***

Balancing omega-3 and omega-6 fatty acids

Another essential fat is omega-6 fatty acid (n-6). We need to get enough of both n-3 and n-6 fats for our bodies to function optimally. Eating too much n-6 fatty acid and not enough of the n-3 fats disrupts the body's balance.

Omega-3 fats are mainly found in salmon, herring, and other fatty fish, as well as in flax seeds and soy products. By contrast, n-6 fats are found in most margarines, most oils, foods prepared with those oils, grains, and meat from grain-fed animals, such as beef. It is not surprising, then, that most people consume a lot of n-6 fats but do not consume enough n-3 fats to meet their daily requirements. The average North American diet today has a ratio of 20:1 of n-6 fatty acids to n-3 fatty acids, yet the Canadian Dietary Recommendations suggest a 6:1 ratio of n-6 fatty acids to n-3 fatty acids.

N-3 fats and HIV

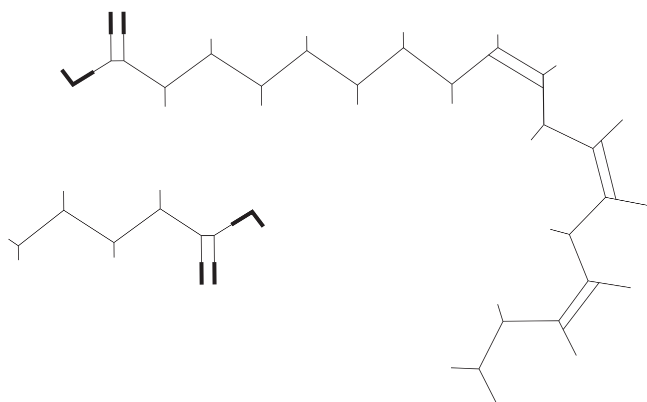
Many people with HIV who have been treated with antiretroviral therapy (HAART) have developed high triglyceride (TG) levels. High triglyceride levels are one of the risk factors for developing cardiovascular disease, so it is very important to keep them at normal levels. At this point, it is still not known why people with HIV suddenly develop such high TG levels. It could be a side effect of the antiretrovirals, a result of the HIV itself, a combination of the two, or other factors.

Protect yourself from developing cardiovascular disease. You can lower TG levels by decreasing dietary fats and sugars, taking medications to lower triglyceride levels, and possibly by eating more foods high in n-3 fats. Researchers have consistently found that n-3 fatty acids in large doses can lower TG levels by 20–35%. While the results are promising, no published studies on n-3 fatty acids have specifically looked at people with HIV.

Getting your daily requirements

Everyone should consume foods rich in n-3 fats to meet their daily requirements. (Refer to the table for good sources of n-3 and n-6 fats).

Magazine template.qxd 11/29/01 9:22 AM Page 17



The Canadian guidelines recommend 1.0–1.6g of n-3 fats for adults and 7–10g of n-6 fats daily. N-6 fats are found in many foods eaten on a regular basis, but n-3 fats are found mainly in fish, soy, and flax.

Concentrated sources of n-3 fats, in the form of fish oil supplements, are available in health food stores. Risks are associated with taking fish oil supplements because manufacturers do not have to follow strict guidelines.

Some supplements may contain high doses of vitamin A and D, which naturally occur in fish oil. Taking high doses of vitamin A and D over time may cause toxicity, especially to the liver. So make sure that the supplement does not contain these vitamins. By contrast, some fish oil supplements contain vitamin E, which is good because it helps prevent the oxidation of the easily broken-down n-3 fats.

Doctors at St. Paul's HIV/AIDS treatment centre recommend taking 3–6g of salmon oil daily to help reduce your TG levels. Taking more than 6g/day of fish oil is risky because the n-3 fats will thin your blood to such a point that if you cut yourself or experience internal bleeding, it will be difficult to stop the bleeding.

Talk to your dietitian or doctor before taking any fish oil supplements because drug interactions could occur.

Flax oil supplements are also a good source of n-3 fats, but the n-3 fats in flax oil are less readily available than from fish oil. Flax oil has not been shown to be as effective as fish oil in reducing TG levels, but it can be part of a healthy diet. ⊕

Table 1. Food sources of omega fatty acids

Foods high in n-3 fats	Serving size	n-3 fats (g)	n-6 fats (g)
Flax seed oil	1 tbsp.	6.6	1.6
Flax seed ground	2 tbsp.	3.2	0.8
Pink salmon (canned with bone)	3.5 oz (100g)	1.7	0.13
Herring	3.5 oz (100g)	1.38	0.21
Pink salmon fillet	3.5 oz (100g)	1.32	0.16
Halibut fillet	3.5 oz (100g)	1.22	0.23
Carp fillet	3.5 oz (100g)	0.79	0.85
Omega Pro Liquid Eggs	100g	0.5	0.05
Omega 3 eggs (in shell)	1 large	0.38	0.69
Snapper	3.5 oz (100g)	0.32	0.07
Tuna canned in water	3.5 oz (100g)	0.27	0.04
Berries	1 cup	0.2	0.2
Peas	1/2 cup	0.2	0.2
Green leafy vegetables (broccoli kale, Chinese greens, salad greens)	1 cup raw 1/2 cup cooked	0.1	0.03
Wheat germ	2 tbsp.	0.1	0.8
Foods high in n-6 fats	**Serving size**	**n-3 fats (g)**	**n-6 fats (g)**
Corn oil	1 tbsp.	0.1	7.9
Tofu, firm	1/2 cup	0.7	5.0
Tofu, medium	1/2 cup	0.4	2.9
Soy milk	1 cup	0.4	2.9
Chicken	3.5 oz (100g)	0.6	2.6
Vegetable oil	1 tbsp.	0.13	1.79
Olive oil	1 tbsp.	0.13	1.79
Oat germ	2 tbsp.	0.2	1.6
Pork	3.5 oz (100g)	0.04	1.1
Hard margarine	1 tbsp.	0.06	1.0
Beef	3.5 oz (100g)	0.2	0.6
Foods high in both n-3 and n-6 fats	**Serving size**	**n-3 fats (g)**	**n-6 fats (g)**
Sardines (in their own oil)	3.5 oz (100g)	1.47	3.52
Walnut oil	1 tbsp.	1.4	7.6
Canola oil	1 tbsp.	1.3	3.2
Soybeans cooked	1 cup	1.1	7.8
Walnuts (English)	2 tbsp.	1.0	5.4
Soy oil	1 tbsp.	1.0	7.0

Ágnes P. Kalmár, B. Sc., is a Dietetic Intern at the Royal Columbian Hospital and a member of Vancouver Dietitians in AIDS Care.

Magazine template.qxd 11/29/01 9:22 AM Page 18

Newly diagnosed taking charge

by R. Paul Kerston

If you are newly diagnosed with HIV, you need to consider your physical, mental, and emotional well-being. Taking charge of your health is an important first step.

If you are not associated with a health-care professional who is particularly knowledgeable about HIV disease, it is wise to look around. Although HIV is not a recognized medical specialty, there are physicians who have done considerable work in the HIV field. The Treatment Information Program (TIP) at the BCPWA Society can provide a list of these doctors.

Find a healthcare professional that you feel comfortable with and trust. You need a relationship that fosters information-sharing and mutual decision-making.

A general health checkup is a good idea. Some immunizations (hepatitis A and B, among others) could be in order.

You'll need to make decisions about when to commence treatment and about the various treatment options. The message is no longer "Hit early; hit hard!" The philosophy now is to "hit" later in order to preserve the body's own defense system, as well as to avoid difficulties associated with long-term use of HIV medications.

This means getting some tests done. One basic test is the viral load test, which measures how much HIV virus can be detected in the blood. A higher number means more of the virus is present and circulating. Another test conducted in conjunction with viral load measures T-4 cells, which are part of our natural immune system. These T-4 cells are under direct attack by the HIV. As the viral load climbs, this measurement can drop. The correlation between viral load and T-4 counts determines your state of health and the start of treatment. Two or three tests conducted at least a month apart are needed to determine a trend. A single measurement will not do. The increase or decrease in viral load must equal a certain percentage (or "log") before it is considered a valid change.

Look around for a *healthcare professional who is particularly knowledgeable about HIV disease. There are physicians who have done considerable work in the HIV field.*

Under the former guidelines, treatment was recommended when the T-4 cells were under 500mm3 and the viral load was over 5,000 copies/ml. Now considered too aggressive, these guidelines were revised to a T-4 cell count of under 350mm3 and a viral load over 50,000 copies/ml.

Lifestyle questions must be taken into account when choosing specific drugs because of the sheer number of pills and the side effects of various medications. Complementary therapies can enhance quality of life and assist in immune system repair. You can usually learn about these outside of your patient-physician relationship, but always advise your doctor of all alternative remedies you are taking.

Healthy living and harm reduction are other areas to consider. Is your housing safe and secure for now and for the near future? If nothing else, adequate long-term housing helps reduce stress. Safety and cleanliness are paramount for HIV healthcare. You should have your diet and intake of essential nutrients assessed. Past issues of Living + Magazine have dealt with many specifics, including protein and enhanced vitamin needs. Further information is also available in the TIP office and the Pacific AIDS Resource Centre (PARC) Library.

Above all else, take a moment to inform yourself before leaping into anything. You need to be confident about important decisions you take in the treatment of HIV infection. ⊕

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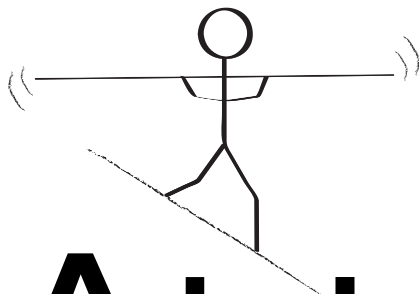
Vancouver, BC V6B 5S8
Tel: 604-893-2243 or
1-800-994-2437 ext. 243
Email: treatment@parc.org

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

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

Magazine template.qxd 11/29/01 9:22 AM Page 19



A balancing act

Canadian treatment guidelines for HIV and hep C co-infection reveal the difficulty of treating both diseases simultaneously

by Amanda Armer-Petrie

The Canadian guidelines for the treatment of HIV and hepatitis C co-infection were recently published in the Canadian Journal of Infectious Diseases (2001;12A:3A-21A) by a National Working Group of medical experts commissioned by Health Canada.

Because HIV and hepatitis C virus (HCV) share some of the same transmission routes, co-infection with these two viruses is a common occurrence, especially if infection is caused through blood transfusion or injection drug use. To make matters worse, the immunodeficiency caused by HIV seems to accelerate HCV. Treating both infections simultaneously can be problematic, especially if drug and alcohol addictions complicate treatment.

Possible co-infection should be considered with anyone diagnosed with either HIV or HCV since both viruses have the same means of transmission. Initial assessments usually take place in the primary care setting. If you are diagnosed with both HIV and HCV, the next step is a referral to a centre with access to experts in HIV/HCV and, if necessary, addiction management. Several groups and community organizations provide support and information for those diagnosed with co-infection. Continual medical care is the responsibility of the primary care physicians and specially trained nurses, but expert physicians should always be accessible to make fundamental decisions and deal with any complications.

Once diagnosed, certain fundamental issues must be addressed for optimal treatment of both diseases. First, if there is a substance abuse problem, it is necessary to assess the possible dangers of continuing substance use while on medication. Assessment for other liver viral infections, in particular hepatitis A or B, is also necessary.

With the overlapping toxicities associated with the treatment of HIV and HCV, both treatments do not typically begin concurrently. In order to treat both diseases effectively, stability must be achieved on one treatment before beginning the next. In some cases, it is better to treat HIV first, whereas in others HCV treatment is required initially. The order depends largely on the respective stages of each disease.

Thus far, no evidence suggests that more frequent monitoring is beneficial to those with co-infection; however, liver function must be monitored closely.

If the treatment is suitable and permission is given, then treatment can start. The side effects are worse in the first two months so it is important to have support, be stable, and stay as stress-free as possible. Flexibility is crucial during this time. It may be necessary to make frequent trips to physicians for assessment since many potential side effects of combination therapy could occur. Treatment can cause flu-like symptoms and affect moods, causing irritability and depression. Problems can occur with diabetics and those with thyroid problems, as well as in those with any other unrelated illnesses. If treatment is unsuccessful, a liver transplant may be considered provided that the HIV infection is stable.

Treatment of HIV infection follows the guidelines recommended for PWAs not infected with HCV, beginning with immune status (T-cell count), viral load, and a willingness to stick to combination antiretroviral therapy. If addiction issues are present, combination therapies directly observed at street clinics, needle exchange centres, or methadone treatment centres may be an option. ⊕

Very little data is available on the use of HIV and hepatitis C drugs at the same time. Management of HCV/HIV co-infection is not easy. However, for people who are co-infected, an excellent support network, including trained medical staff and groups experienced in the physical and emotional problems related to co-infection, is necessary to help them lead as healthy a life as possible.

Amanda Armer-Petrie is a researcher with the BCPWA's Society's Treatment Information Program.

Cuts to BC's Pharmacare:

Lower income PWAS will be hardest hit if government proceeds with plans

by Glen Hillson and Wayne Campbell

The relatively easy access to prescription drugs that PWAs in British Columbia have enjoyed for the past decade may soon evaporate. Recent announcements by both the federal and provincial governments could place life-saving drugs out of reach for many. And it seems likely that the hardest hit by changes will be those who have already been reduced to poverty by their illness.

On August 16, 2001, the Vancouver Sun reported that the BC government is considering several changes to the Pharmacare system that are intended to save the government money. In the article, BC Health Services Minister Colin Hansen said, "Clearly we have a very generous Pharmacare system and yet we don't have the economy that can support the most generous program in Canada." Measures under consideration include decreasing the portion of drug costs currently covered by Pharmacare, as well as removing coverage altogether for some of the more expensive drugs. Decreasing coverage for seniors is another possibility.

A mere two days before the Sun article appeared, the Globe and Mail reported that Federal Health Minister, Allan Rock told delegates at the Annual General Meeting of the Canadian Medical Association that drug costs in Canada are "unsustainable." Rock said he would soon be recommending that the federal drug licensing system consider the cost effectiveness of new drugs before licensing them for sale.

Under the present regulatory framework, the federal government considers only the safety and effectiveness of drugs when deciding whether to approve them. Health Canada does not currently have a mandate to consider cost implications when licensing drugs. Rock's announcement even drew fire from the profit-minded policy analysts at BC's Fraser Institute who said that "every Canadian should be distressed at the prospect of Rock's proposal" and "costs are none of Health Canada's business."

Global access issues

Many factors impact the availability of drug treatments, including research, development, approval, and price. Funding overrides all aspects of drug availability. A combination of public and private support has funded research to better understand HIV and to develop drugs.

Most of the costs of developing the HIV drugs now on the market were paid for by pharmaceutical company investments. It usually takes many years and a large amount of money to develop a single new drug. Before a drug can be sold, it must undergo rigorous clinical trials to prove it is both safe and effective. Once the trials are complete, the company must then apply to licensing bodies in all of the countries where they hope to sell their product.

"Higher user fees mean *lower-income people may go without necessary drugs, possibly resulting in higher hospital costs later," says Dan Cohn, Assistant Professor of Political Science at SFU.*

For the past several years, one of the most important issues for AIDS treatment activists in Canada has been excessively long review times for new drug submissions. Typically, new HIV drugs are available sooner in the United States and Europe than they are in Canada. These delays are almost exclusively the result of a lack of financial resources allocated to Health Canada's Therapeutic Products Directorate, the federal agency tasked to regulate prescription drugs.

Drugs with the highest price tags are often the most difficult to access. Once a drug company has approval to sell a drug, it may or may not apply for a patent. In Canada, if a patent is granted, the Patent Medicines Prices Review Board (PMPRB) may regulate the price of the drug. However, without a patent the

the wrong prescription

SHOPPERS DRUG MART
Phone: (604) 681-3411
G06
Store # 201
OFFICIAL PHARMACARE RECEIPT
Rx# 4546789 Refills: 2 Patient Pays: $ .00
Smith John
Abc Street, Phone: (604) 123-6666
VANCOUVER BC
PHN 00012345678901
Dr. Jones MD Lic: 00000
Date: 25-Sep-01 30 Days
URSO(URSODIOL) 250MG TAB Mfg: AXC
URSODIOL 250 MG
120 TAB DIN 02238984 Tx# 687809
Cost: $158.40 Fee: $7.60 TOTAL: $166.00
Pnet Pays: $166.00 PC: PC
Alt Pays: N/A
Pharmacist's Signature:

photo by John Kazachenko

Caryn Duncan of the Vancouver Women's Health Collective spoke at the BC Health Coalitions rally in defence of Pharmacare.

company can set its price unilaterally and disregard advice from the PMPRB, as happened with the sale of Sustiva, manufactured and sold by DuPont Pharma. Funding for higher priced drugs is often more tightly controlled by provincial drug formularies and private insurance companies. People on low incomes who must pay for any portion of their drug costs are less likely to buy drugs that are more expensive.

HIV drugs have only been available to about 5% of HIV-positive people in the world because of poverty and high prices. Although generic versions of HIV drugs could be produced and distributed affordably, the enforcement of patents by drug companies with the backing of prosperous nations such as the US and Canada has prevented that from happening. This summer, to make matters worse, the Canadian government quietly increased the life of drug patents from seventeen to twenty years. This move came after the World Trade Organization ruled against Canada on a complaint filed by the United States.

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Other factors also contribute to rising expenditures on prescription drugs. Dr. Michael Rachlis, who participates in an Ontario-based medical reform group, says, "The real issue is that there is a tremendous over-subscribing of all drugs." Direct advertising to consumers also places a burden on drug plans. Although the United States and New Zealand are the only countries where direct-to-consumer advertising of prescription drugs is permitted, the Canadian government has recently softened its rules that constrain drug advertising.

BC compared to the rest of Canada

The Canada Health Act governs healthcare in Canada. The delivery of that care—including providing prescription drugs—is the responsibility of individual provinces. How drugs are paid for varies between provinces. A portion is funded by tax dollars through provincial health plans, while individual consumers and employment and private health plans account for the remainder. The average percentage of prescription drugs costs borne by provincial governments in Canada is 43%, but the rate varies from as low as 26.7% in PEI to as high as 56.3% in BC.

However, looking at public expenditures only tells part of the story. When public and private spending are combined, BC spends less per capita on prescription drugs than any other province. The average annual cost of prescription drugs for a resident of BC is $285, compared to $322 in Alberta and a whopping $416 in Ontario. Health policy researcher Colleen Fuller says, "The ideas being floated aren't about *cutting* costs, they are merely about *shifting* costs."

Lower per capita drug costs in BC is primarily attributable to two factors. The first is that as a large volume purchaser, the BC government is able to buy drugs in bulk from manufactur-

Magazine template.qxd 11/29/01 9:22 AM Page 21

ers at lower prices. If one province can achieve such saving, why doesn't Canada introduce a crown corporation for national purchasing and wholesale of prescription drugs?

Reference-based pricing is another contributor to lower drug costs in BC. Several years ago the government started the Reference Drug Program, which mandated the use of the most cost-effective drug in any therapeutic category as first-line therapy. The system prevents drug companies from persuading physicians to use new expensive drugs when older, cheaper drugs may serve equally as well or better.

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HIV Drugs in BC

In the late 1980s, when AZT was first introduced for treatment of HIV, the provincial government balked at covering the cost. The anxiety and despair caused by invoices for large sums added to the already considerable suffering of PWAs. Fourteen anti-HIV drugs are now licensed for sale in Canada, provided free of charge by prescription.

About ten years ago, the BC government established the BC Centre for Excellence in HIV/AIDS (BCCFE) at St. Paul's Hospital. The Centre has established (and periodically revises) guidelines for the medical treatment of HIV/AIDS. The BCCFE is the gatekeeper for access to HIV drugs. Pharmacare provides the BCCFE with an annual budget for the purchase of HIV drugs. It then distributes the drugs throughout the province to patients who qualify under the medical guidelines and whose prescriptions the centre has approved.

Concerned interest groups at the Pharmacare rally.

photo by John Kozachenko

Many other drugs are frequently prescribed for HIV patients. Antibiotics, antifungals, and chemotherapy are just some examples of treatments for opportunistic infections and cancers experienced by PWAs. Prescription drugs are also often necessary for the management of a broad range of symptoms and side effects, including pain, depression, insomnia, diarrhea, and other intestinal problems. These prescriptions are handled through community pharmacies. The ease or difficulty of access depends on the particular drug as well as the circumstances of the individual.

Pharmacare covers certain drugs only under special authority based on applications from individual patients. Another method is to grant physicians with certain patient populations (such as HIV/AIDS) blanket authority for commonly prescribed drugs in that population. Antifungal agents, such as fluconazole and itraconazole, are covered by the special authority provisions, but some physicians who commonly treat HIV patients have been granted prescribing authority and are not required to do the paperwork for individual patients. Other examples of special authority drugs are

- methadone for heroin addiction
- loperamide (Imodium) for diarrhea
- zopiclone (Imovane), a sleeping medication
- Losec (omeprazole) for stomach ulcers
- Rebetron for hepatitis C
- Lamivudine (3TC) for hepatitis B

Other drugs are not funded at all, such as

- Serostim (human growth hormone) for wasting
- L-acetyl carnitine for peripheral neuropathy
- Smoking cessation medications (Nicoderm, Zyban)
- Erectile dysfunction medications (Viagra, Muse, prosteglandin)

All residents of BC are covered by Pharmacare. Although antiretrovirals are fully funded through the BCCFE, seven different plans cover other drugs under the system. Each plan provides different levels of coverage, depending upon the age, finances, and medical circumstances of the individual. Recipients of BC Disability Benefits through the Ministry of Human Resources receive 100% coverage for all prescriptions. Most other PWAs fall under the Universal Plan. Each family must pay 100% of the first $800 of prescriptions in a calendar year and after that Pharmacare pays 70%. If a family spends more than $2000 in calendar year, coverage is then increased to 100% for the remainder.

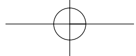
The proposed cuts have come under fire from several quarters.

"Higher user fees mean lower-income people may go without necessary drugs, possibly resulting in higher hospital costs later," says Dan Cohn, Assistant Professor of political science at SFU and associate with the Canadian Centre for Policy Alternatives. "If the government is facing fiscal constraints, why would it cut a program that in all likelihood saves it money?"

Seth Klein, Director of the centre's BC office adds, "People shouldn't have to pay for medically necessary treatment, period. Cutting Pharmacare puts the Liberal's tax cuts in true perspective. For many people, what they save in taxes they will now spend on drugs." ⊕

Glen Hillson is Chair of the BCPWA Society.
Wayne Campbell is a member of the BCPWA Society Board of Directors.

Magazine template.qxd 11/29/01 9:22 AM Page 23



Christmas 2001 at BCPWA

December 17&18:

5th Annual Yuletown 2001,

BCPWA lounge

December 14:

2001 BCPWA Annual Christmas Banquet and Show,

BC Place, 6 pm – 10 pm

Banquet Tickets: $5.00 per member, $25.00 per guest.
All tickets must be purchased in advance
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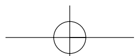
604.681.2122 ext. 323
Tickets on sale November 1, 2001



Magazine template.qxd 11/29/01 9:22 AM Page 24

Lymphoma and HIV

Cancers still a concern with immunosuppression

by R. Paul Kerston

Cases of AIDS-related lymphoma (ARL) have declined since 1995, but the disease still poses a dilemma to PWAs in the era of highly active antiretroviral treatment (HAART). Normally, the greatest worry from lymphoma is its spread throughout the body. However, for PWAs the biggest question is how to treat two diseases that ravage the immune system when the treatments for these diseases also deplete the body's defences.

Lymphoma is a type of cancer in which the cells of the lymphoid tissue multiply unchecked. The name "lymphoma" refers to the body's lymphatic system of protection against infection. Our lymphatic system, which is almost parallel to our circulatory system, includes nodes located at strategic points throughout the body, such as the armpits and groin. Local nodes orchestrate defensive attacks on invasions by foreign bodies through both the connected lymph system and our circulatory system. There are a variety of red cells (erythrocytes) and white cells (leukocytes) in the blood, as well as plasma, the fluid carrying the red and white blood cells.

One of the five different types of leukocytes is called lymphocytes, which includes B and T cells. In HIV disease, we measure T-4 and T-8 cell counts, which are also called CD-4 and CD-8 counts, respectively. Lymphocytes are very much affected by HIV disease. As HIV increases its hold on the body by invading and taking over (among others) T-cells, the viral load increases and T-4 and T-8 cells often decrease.

A genetic predisposition and environmental causes are believed to cause cancer. In lymphoma, a single lymphocyte acquires or accumulates several genetic mutations and becomes unable to reproduce normally. When this cell (and succeeding ones) do reproduce, they mutate and form tumors. The greatest danger from these tumors is the possibility of spread to other organs.

The two general types of lymphoma are Hodgkin's disease and non-Hodgkin's lymphoma (NHL). NHL refers to a collection of more than 24 kinds of cancer of the lymphatic system. Primarily affecting older individuals, it spreads beyond the lymphatic system and affects cells found mainly in the lymph nodes and spleen. Lymphoma affects HIV-negative people at a yearly rate of eight cases per 100,000 people. People with HIV are more likely to have lymphoma of more than one organ.

Symptoms for NHL include painless swelling in the lymph nodes of the neck or groin, as well as generalized itching, weight loss, fever, and night sweats. These signs are similar to symptoms observed in many diseases, including HIV disease.

Diagnosis for NHL involves determining which lymphoid cells are affected, so the first step is often removal of a sample of affected tissue for examination. Computerized tomography (CT scans) and magnetic resonance imaging (MRI) may also be needed. Chest x-rays can determine lung involvement. A bone marrow biopsy may also be required.

Normally, the greatest worry ***from lymphoma is its spread throughout the body. However, for PWAs the biggest question is how to treat two diseases that ravage the immune system when the treatments for these diseases also deplete the body's defences.***

Aggressive B-cell NHL is an AIDS-defining diagnosis that now accounts for 2–3% of newly diagnosed AIDS cases, according to the Center for Disease Control and Prevention (CDC) in the US. However, some feel this number is misleadingly low because cases of NHL that occur after another AIDS-defining infection are not reported to the CDC.

According to the article "AIDS-Related Lymphoma" in the Bulletin of Experimental Treatments for AIDS (January 1998; p. 22), "In 1994, the National Cancer Institute (NCI) estimated the probability of NHL developing among people with AIDS at 19.4% by 36 months after starting antiretroviral therapy. It is unclear how much that rate has decreased in the US since the era of HAART." Before 1995, the rate of NHL increased steadily among PWAs. The National Cancer Institute of Canada (Statistics 2000) lists the number of new cases of NHL at 6,000

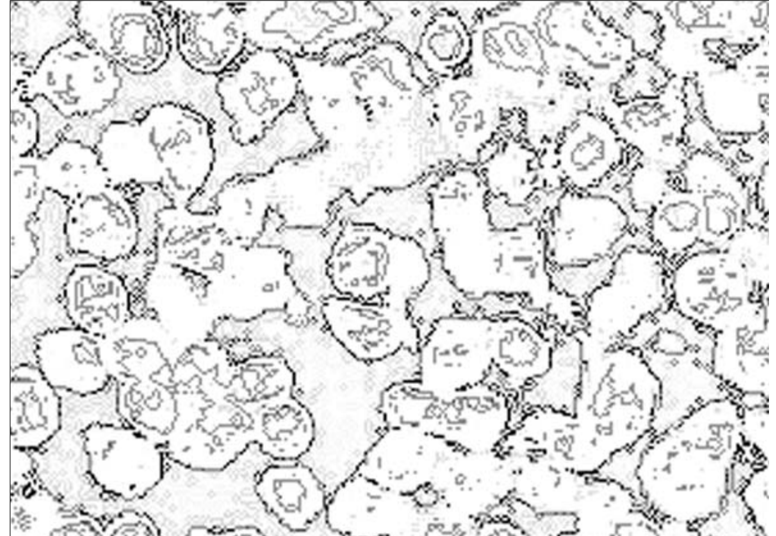
Magazine template.qxd 11/29/01 9:22 AM Page 25

(3,300 male, 2,700 female). This statistic does not distinguish between HIV-negative and HIV-positive individuals.

Two types of treatment are usually given to people with NHL—chemotherapy, which uses drugs that target the cancer cells, and targeted radiation therapy, which uses x-rays for the same purpose. Combinations of both therapies are also effective.

AIDS-related NHL poses interesting questions regarding the best chemotherapy. A standard treatment for NHL consists of four drugs: cyclophosphamide, an alkylating agent; doxorubicin, a topoisomerase inhibitor; vincristine, a tubulin-binding agent; and prednisone, a corticosteroid. To provide optimal care, specific drugs and their dosages can be varied, depending upon an individual's circumstances. *The Trials Search Guide to HIV Clinical Trials in California* lists eleven studies that are evaluating various treatments for NHL in people with HIV.

Hodgkin's disease has symptoms similar to NHL, and the diagnostic tools are the same. Some therapies include the same drugs as NHL treatments.



Researchers are exploring ***the possibility that another virus or viruses may work in tandem with HIV in the development of lymphomas.***

Researchers are exploring the possibility that another virus or viruses may work in tandem with HIV in the development of lymphomas. A current theory is that HIV may enable other viruses to lead to cancers. One such virus under consideration is Epstein-Barr, which has a proven connection with, among others, a form of lymphoma called Burkitt's lymphoma.

One serious form of ARL affects the brain. At the 37th Interscience Conference on Antimicrobial Agents and Chemotherapies (ICAAC) in Toronto, researchers reported that the rate of new non-Hodgkin's lymphomas affecting the central nervous system (CNS) is decreasing among individuals using HAART and is rare in persons with high T-4 cell counts. CNS lymphoma can be detected in the eye. Eleven percent of people with CNS lymphoma had an inflammation of the iris and surrounding parts of the front of the eye months to years prior to diagnosis. Therefore, regular eye appointments are important to detect early warning signs.

Lymphoma treatment also depletes lymphocytes. Dr. Alexandra M. Levine has acknowledged that chemotherapy and radiation therapies are associated with declines in both T-4 and T-8 cell counts, suggesting that in these circumstances, viral load tests may more accurately reflect the efficacy of HAART therapy.

A retrospective case control study of 29 patients at the University of Toronto suggests that long-term, high-dose acyclovir may help prevent NHL. This drug is used for some herpes viruses, including zoster (shingles), an opportunistic infection associated with HIV. However, the largest gap in current NHL research likely exists in antiviral research, particularly regarding the Epstein-Barr virus that appears to be clearly associated with various cancers.

In a related development, at last year's XIII International AIDS Conference in Durban, Mark Bower et al described the effect of HAART on outcomes for patients with AIDS-related lymphoma. One of their conclusions was that HAART, possibly in connection with other therapies, is associated with a change in some of the characteristics of ARL. However, you shouldn't rush to start HAART because it has its own difficulties. More research is clearly in order.⊕

Complete references are available from Living + magazine upon request.

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

Magazine template.qxd 11/29/01 9:22 AM Page 26

Oral exam

Keeping an eye out for oral lesions

by Amanda Armer-Petrie

Maintaining a healthy, pain-free mouth is a fundamental issue for people living with HIV/AIDS. Early detection is the key to successful treatment. PWAs and their healthcare providers must vigilantly monitor any changes that occur within the mouth. It is imperative to have regular dental visits and learn self-care strategies.

Five types of oral lesions are commonly associated with HIV infections:

Fungal lesions

Candidiasis is the most common fungal infection, affecting about 90% of all AIDS patients. Pseudomembranous candidiasis (oral thrush) manifests itself as white patches on the tongue or palate that are easily removed, whereas erythematous lesions are deep red or maroon sores. Both respond well to simple treatment and, in certain circumstances, over-the-counter treatment is available. Angular cheilitis, found as small fissures and white plaques at the corners of the mouth, also responds well to over-the-counter medicine; however, hyperplastic lesions are chronic and can be difficult to treat, requiring longer term treatment.

Bacterial lesions

Bacterial lesions attack the soft tissue and bone of the mouth. Symptoms include sore, weeping gums that bleed spontaneously, gum line erosion, loose teeth, and bad breath. Because deterioration is quick, fast diagnosis with fast effective treatment is the key to success. Linear gingival erythema (LGE or HIV gingivitis) is a painful condition that causes a distinct fiery red band along the margin of the gum at least 2mm wide, without ulceration. Treatment involves professional removal of the plaques and daily rinsing.

Necrotizing conditions are types of bacterial lesions that cause tissue damage to various parts of the mouth: the gums (ulcerative gingivitis), the bone around the teeth (ulcerative periodontitis), and the inner lining of the mouth (ulcerative stomatitis). If left untreated, damage can occur to the underlying tissue leading to maxillofacial surgery. Patients are prone to relapse and must make regular dental visits.

Candidiasis, or thrush, ***is the most common fungal infection, affecting about 90% of all AIDS patients.***

Viral lesions

Viral lesions can cause aesthetic problems as they often occur on the lips. Human papillomavirus manifests itself as painless cauliflower-type warts that require removal to ensure all viral particles are excised. Even then, you must watch the area of the viral growth for signs of malignant transformation.

Herpetic eruptions are small cysts or blisters along the lips and on the inside lining of the mouth. They are usually treated orally. Infection can spread easily by touching the lips and then other parts of the body. Hairy leukoplakia (HL) are hair-like projections on the side of the tongue and cannot be manually removed, requiring drug (acyclovir) therapy.

One form of the herpes virus causes cold sores on or near the lips. Outbreaks are more likely to occur when the immune system is under stress. Acyclovir is an oral medication used to decrease both the frequency and duration of outbreaks of herpes.

Neoplastic lesions

Oral Kaposi's sarcoma (KS) is the most common abnormal growth (neoplasm) found in persons with HIV/AIDS. Although these lesions are uncomfortable, PWAs often miss them. They usually appear on the ridged surface on the roof of the mouth as deep red or purple sores, they do not pale with compression, and they can appear singly or in a cluster. Several methods of treatment, including chemotherapy and surgical removal of larger lesions, are available. It is crucial to recognize this type of lesion.

Ulcerative lesions

Antineoplastic agents, which prevent the development of neoplasms, can sometimes be responsible for the inflammation of the mucous tissue in the mouth, or stomatitis. This condition can cause problems for any existing sores in the mouth and lengthen the healing process. One symptom of stomatitis is painful inflamed ulcers found in all areas of the mouth, in some cases so painful that the patient has difficulty eating. ⊕

Amanda Armer-Petrie is a researcher with the BCPWA Society's Treatment Information Program.

Magazine template.qxd 11/29/01 9:22 AM Page 27

Stripped of their rights

Prisoners with HIV/AIDS are getting substandard health care

by Michael Linhart

Many people believe that when people are sent to prison for committing crimes, they lose their rights. Nothing could be further from the truth. The Supreme Court of Canada has concluded that prisoners do not lose their rights simply because they have been convicted of crimes. This ruling eventually became part of the Corrections and Conditional Release Act (CCRA). The CCRA specifically states "that offenders retain the rights and privileges of all members of society, except those rights and privileges that are necessarily removed or restricted as a consequence of the sentence."

Another popular myth is that prisoners receive top-quality healthcare. In fact, prison doctors have a limited understanding of serious illnesses such as HIV/AIDS and hepatitis C. Institutional physicians often have small rural practices and cannot possibly stay abreast of the ever-changing trends in treatment information. Consequently, prisoners receive insufficient care and treatment, below the level of care that the general populace receives.

Prison doctors have a *limited understanding of HIV/AIDS.They often have small rural practices and are unable to stay abreast of changing trends in treatment information.*

Prisoners are unable to access a variety of nutritional options or purchase vitamins beyond a simple one-a-day generic vitamin. Since 1989, the Correctional Service of Canada has had a policy that the one-a-day multi-vitamin available for purchase through the inmate canteen is sufficient. This policy is applied to all prisoners regardless of their health status. Access to additional vitamins is at the sole discretion of the institutional physician. However, these doctors are often not aware of the latest treatment trends and do not see vitamins as necessary for the average HIV prisoner.

Another common myth is that the prisoners just sit around doing nothing. Every prisoner must participate in programs, such as life skills training or drug treatment, designed to foster self-improvement and reduce criminal behaviours. Otherwise, they are expected to work in some capacity.

Some prisoners have actually designed a program to teach other prisoners how to take care of people who are ill. Prisoners at Mountain Institution in Agassiz, BC, have developed such a program. Each year, several groups of prisoners are taught how to provide palliative care to dying prisoners. The recipients may have HIV or hepatitis C or just be elderly.

Prisoners also do things for the community outside the prison walls. Each year, Mountain Institution holds an AIDS Walk inside the institution. The money raised goes to the BCPWA Society Prison Outreach Program for direct services to HIV-positive prisoners. In addition to a 10-kilometre walk, they play sports and games during this fund-raising event.

The facts about prisons are really quite simple: Prisoners do things to occupy their time above and beyond the expectations of the prison system. They do not receive standards of care comparable to those found in the community, despite the claims of prison bureaucrats and policy-makers. ⊕

Michael Linhart is Prison Outreach Program Coordinator for the BCPWA Society.

Ringing the Bullshit Bell part II

How to assess the validity of a scientific paper

by Paula Braitstein

This article is the second 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.

When assessing scientific research, pay attention to the numbers. How many people started the trial? How many actually finished? What reasons did people have for dropping out (e.g. drug side effects)? For how long did researchers follow-up on those people that dropped out?

Look at the p-value. The p-value is a statistical test of the significance of the results that determines the probability that the results could be due to chance alone. It is based on calculations using statistical tests and measured against a pre-determined level. The pre-determined level is usually 0.05 (i.e. 5% or 5 in 100 times, the result you get is purely due to chance). Sometimes it can even be 0.01 (1% or 1 in 100). A significant p-value does not necessarily mean that a result is important. A statistically significant result could be clinically insignificant or even irrelevant. Alternatively, you can have a statistically non-significant result that has major clinical implications.

Many factors can influence the validity of a p-value. Is the sample size large enough to be able to detect a difference, if a difference is present? How many times have they looked at the data? You have to make the p-value smaller if you look at the data multiple times—something not often done. For example, are they presenting 48-week data after presenting at other conferences data from 36, 24, 12, 8, and 6 weeks? If so, they should explicitly say they have adjusted the p-value to account for multiple comparisons.

An odds ratio (OR) or relative risk (RR) measure is often used to quantitatively describe whether and by how much a result is statistically significant. An odds ratio is the odds of something happening compared to the odds of it not happening. Relative risk isn't significantly different, but it is used more to describe the relative risk of developing a particular disease given a particular exposure. Both are presented in the same numerical way. If an OR or RR is 1.0, the odds of something happening are the same as the odds of it not happening. In other words, it's not significant. If the OR is 2.0, the odds of the event happening are twice as high.

Like all expressions of probability, variability is inherent in the calculation of the odds ratio. This variability is called the confidence interval, usually expressed as 95% or 99%, meaning that you can be 95% or 99% confident that the true value lies somewhere in that range. For example, if the OR is 2.0 with a 99% confidence interval of 1.4–3.2, then a 99% certainty exists that the true result lies somewhere between 1.4 and 3.2 and is, therefore, statistically significant. By contrast, if the OR is 4.6, but the confidence interval is 0.9–8.7, the interval includes the value of 1.0. That means there is the chance that the result is in fact 1.0, rendering it insignificant.

Look at how researchers ***analyzed the data. If they say the analysis was observed or "as treated," it means they only analyzed people who actually made it to the end of the trial.***

Another important factor to consider regarding confidence intervals is how big the range is. If the confidence intervals are small, that's good because it means there's less variability as to where the true value will fall. However, if the confidence intervals are large, it generally means there's a problem with the data, such as small sample size or inappropriate statistical test. Always be suspicious if the confidence intervals aren't presented.

Also, look at how researchers analyzed the data. If they say the

Magazine template.qxd 11/29/01 9:22 AM Page 29

analysis was observed or "as treated," it means they only analyzed people who actually made it to the end of the trial. For example, a trial might have started with 500 people, but only 100 were left at the end because the rest had dropped out, possibly due to side effects. If they say "intent-to-treat," or ITT, they mean they analyzed everyone who started the trial, no matter what happened to them, including those who dropped out. Usually they count people who drop out for whatever reason as a failure of the drug. This more conservative approach is also the most appropriate way to analyze clinical trial data. All data should be presented ITT. Sometimes one variable, such as viral load, might be presented ITT, but another, such as CD4 count, might be "as treated."

Endpoints can be deceptive depending on how they are presented. An endpoint is also called an "outcome" in clinical research. Sometimes it's a laboratory or surrogate marker, such as change in viral load, and sometimes it's a clinical outcome, such as an AIDS-defining opportunistic infection. Pay attention to how endpoints are measured. What definitions are used for various outcomes? When they say 50% reached a viral load below the limit of detection, do they mean below 500 copies/ml, below 100, or below 50?

If researchers state that the participants had a CD4 increase of 50%, that may sound great, especially if you see the blue bar is twice as high as the red one on a graph. However, if the study population has an average CD4 count of 10, a 50% increase would mean that their CD4s increased by 5 to 15. That's not considered a significant result. Still, the p-value might actually be significant. In the words of Martin Delaney, "pictures can tell a thousand lies as well as a thousand words." ⊕

Paula Braitstein is the Director of Treatment Information at the BCPWA Society.

Table 1. Summary of Factors Influencing the Quality and Outcomes of Randomized Clinical Trials

Randomized Clinical Trial Design	Presentation/Publication Style
Patient Selection: - Are patients drug naive or experienced? - Are they generally in good or poor health? - Is their disease stage early or advanced? - From where and on what basis were they selected? - Were all patients drawn from the same source?	***Publication/Presentation Bias:*** - Was the trial published or presented only because it had a favourable outcome, or was it not published because it did not have a favourable outcome?
Placebo: - Was a placebo used rather than the gold standard? - Was the use of a placebo justified?	***Incomplete presentation of results:*** - Are all aspects of the trial being presented? - Has the data been "salami-sliced"? - Have different aspects of this data been published or presented separately elsewhere? (e.g., clinical outcomes in one place, surrogate outcomes in another, toxicity in another)
Me Too!: - Was it a "me too!" study? Was this explicit?	***Intent To Treat vs. On Treatment:*** - Are only patients who finished the treatment being presented?
Allocation of treatment: - Was treatment allocation in fact randomized? - Was method of randomization stated?	***Disclosure of Dropouts and Withdrawals:*** - Have the reasons for patient drop-outs and withdrawals been discussed? - Were there equal proportions in each of the treatment arms?
Statistics: - Were the statistical tests used pre-determined and appropriate?	***Results vs. Objectives:*** - Did the results meet the original objectives of the study?
Blinding: - Were the patients and/or providers blinded? ***Fixed doses:*** - Was the appropriate dose used in both the experimental and standard arms? - Were doses with higher toxicities and/or lower efficacy employed? - Is the dose justified?	***Conclusions:*** - Do the conclusions in fact match the results of the trial? ***Peer Review:*** - Was the data published in a peer-reviewed journal? - Was the data presented in an independent, peer-driven setting?
P-values: - Was the significance level adjusted in advance for multiple outcomes?	***Power and Sample Size:*** - Were power and sample size calculations made explicit and calculated accurately?
Significance Level: - Was the significance level 0.05 or less?	***Significance Level:*** - Was the pre-determined significance level stated? - Did it remain constant?

More than just candy

Licorice offers a host of medicinal benefits

by Tom Mountford

For thousands of years in China, Egypt, and Greece, licorice was prized for its many medicinal uses. People used it for respiratory infections, coughs, and sore throats. It was a soothing coating agent in the digestive and urinary tracts. More recently, as components of the root are identified, the known benefits are increasing.

The main constituent of licorice root is glycyrrhizin (G), an anti-inflammatory agent that inhibits the breakdown of cortisol produced by the body. It has antiviral, antibiotic, and antimicrobial properties. Licorice root contains both flavonoids—potent antioxidants that protect liver cells—and the closely related chalcones, which help heal digestive tract cells.

Standard licorice containing G can help relieve asthma and treat respiratory infections (bronchitis, pneumonia). It is an expectorant with demonstrated antiviral activity. Major components have been shown to induce interferon production. Interferon binds to cell surfaces and stimulates the synthesis of proteins that prevent viral infection. Italian researchers demonstrated that extracellular destruction of virus particles, prevention of intracellular virus activation, and impairment of viral components to assemble are all attributable to licorice root.

Licorice and its extracts ***are safe for normal, moderate use, but long-term or excessive use can produce headache, lethargy, sodium and water retention, and high blood pressure.***

In HIV research, G inhibited HIV reverse transcriptase in the test tube, in addition to inducing interferon production. Studies on injections of G isolated from licorice show it could have a beneficial effect on AIDS. Preliminary evidence on orally administered licorice found moderate use is safe and effective for long-term treatment of HIV disease. Anyone using it long-term should have their physician monitor their blood pressure.

US investigators have reported study results verifying that licorice root properties work against staph and mycobacterium species that cause MAC (mycobacterium avium complex) and tuberculosis infections, opportunistic infections that can take a great toll on persons with HIV/AIDS. Candida albicans is also believed to be affected by licorice.

High blood pressure and water retention can be serious side effects of G for some people. In such cases chewable deglycyrrhizinated licorice (DGL) tablets are available. They must mix with saliva to promote the release of salivary compounds that stimulate the growth and regeneration of intestinal cells. Their effect on heartburn has not been proven.

Rather than inhibiting the release of acid, as in current medications, DGL stimulates the normal defence mechanisms that prevent ulcer formation. DGL improves both the quality and quantity of the protective substances that line the stomach and intestinal tract; increases the life span of the intestinal cell; and improves blood supply to the intestinal lining. Building up the mucous coating of the stomach lining makes it more resistant to the irritating effect of acid. It will also reduce the gastric bleeding caused by aspirin. DGL is safe, inexpensive, and lacks the side effects of drugs used for ulcers, but DGL will not inhibit HIV.

Another component of licorice, phytochemicals called coumarins, are blood thinners and may prevent blood clots. Coumarins are believed to deactivate certain carcinogens before they can alter a healthy cell into one susceptible to cancerous growth. Used for flavouring food (and providing odour), the triterpenoid components of licorice may protect against cancer as well by deactivating steroidal hormones that promote cancer growth, slowing down rapidly dividing cells. Glycyrrhetinic acid (GA), also used mainly as a flavouring agent, is being investigated in cancer research in Japan after reducing tumors in mice.

Active and chronic viral hepatitis is frequently treated with injections of GA in Japan. Many studies have proven this treatment effective; however, the side effects are potentially severe.

Magazine template.qxd 11/29/01 9:23 AM Page 31

Oral administration has not been rigorously studied.

Many people apply licorice extracts topically (cream or gel form) to herpes sores (shingles) 3–4 times a day. The healing and soothing benefits remain in DGL; however, GA has actually inhibited the herpes virus in the test tube.

For eczema, contact and allergic dermatitis, and psoriasis, the application of an ointment with pure GA reduces associated itching and inflammation. In a clinical study on eczema, improvement was as effective as hydrocortisone without negative side effects. The anti-inflammatory action of GA is largely a result of its ability to inhibit the formation and secretion of inflammatory compounds.

Other uses of licorice are varied. In the 1950s licorice was used to treat the classic "adrenal insufficiency" disorder—Addison's Disease, which was much like Chronic Fatigue Syndrome, causing weakness, fatigue, and low blood pressure. Both disorders present evidence for impaired activation of the hypothalmic-pituitary-adrenal axis leading to low levels of cortico-steroids in the blood, resulting in the abnormal secretion of minerals, low blood pressure, and low blood volume. Licorice can be used to balance estrogen levels in during premenstrual syndrome and menopause. For cardiovascular health, several compounds isolated from licorice roots have been shown effective against LDL cholesterol oxidation, which is associated with accelerated atherosclerosis.

Licorice root candy is even being marketed to retard tooth decay in Europe, in addition to its other potential benefits. Most candy sold in North America as licorice is actually flavoured with anise (look closely at the label).

Licorice and its extracts are safe for normal use in moderate amounts. Long-term use, as mentioned above, or ingestion of excessive amounts can produce headache, lethargy, sodium and water retention, excessive loss of potassium, and high blood pressure. Pregnant women, people with diabetes or glaucoma, or people taking heart or blood pressure medications should not use licorice. It should only be used if you have normal cortisol levels, which could be elevated by drugs or depression. ⊕

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

BIA Tests at BCPWA

The Treatment Information Department would like to thank Serono for generously donating a BIA (Bioelectrical Impedance Analysis) machine. Serono has been a supporter of the BCPWA Society's BIA program in the past and this machine will enable us to offer the program again.

The Treatment Information Department hopes to offer the BIA program again in the new year.

Questions or concerns about your treatment or health?

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

BCPWA Treatment Information Program

LOCAL 604.893.2243
LONG DISTANCE 1.800.994.2437

Magazine template.qxd 11/29/01 9:23 AM Page 32

PÁGINA ESPAÑOL

La Ira Conferencia de la Sociedad Internacional del Sida, sobre la patogénesis y tratamientos del VIH, tubo sede en Buenos Aires, Argentina, en Julio del 2001.

by Ramón Hernández

Esta es la primera conferencia que realmente une dos importantes componentes de la investigación sobre el VIH, ciencias básicas y clinicas. El proposito de esta conferencia fue de poner un programa completamente basado en ciencias para que los cientificos puedan moverse de un aspecto del problema al otro en una senda transnaciónal y asi evitar que dichas áreas compitan entre si. "La Ciencia Inpulsara el Futuro" fue el tema principal de esta conferencia.

El objetivo final para los investigadores, medicos encargados de las atenciónes de la salud compremetidos en la lucha contra el VIH/SIDA, es definir una solución final para esta pandemia, ya sea mediante una vacuna eficaz o mediante la erradicación del VIH de una persona infectada. Esto puede lograrse solamente a través de "labor Conjunta" de investigadores de base y medicos clinicos.

Entre los muchos documentos cientificos presentados an esta conferencia, los resultados de diferentes investigaciones clinicas, confirman o dan claves para tomar una routa diferente para comprender esas investigaciónes.

Interupción estructurada de los tratamientos (IET)

La inerrupción extruturada de los tratamientos esta siendo evaluada en tres ecenaios diferentes en la arena de las terapias contra el VIH. Cada aplicación esta asociada con una racional distinta, riesgos unicos y beneficios.

En pacientes que responden bien a las terapias antivirales, una IET quizas estimule una multitude de respuestas inmunetarias y finalmente contribuya al control de la replicación del VIH, esta racional tiene más sentido en el caso de una infección aguda de VIH. cuando los antivirales fueron comenzados antes de la depistación de VIH. Es muy prometosa la observación de la información reportada aumento mitigado de VIH RNA observados despues de IET repetidas en infeccion aguda del VIH.`

En pacientes que no responden a las terapias antiretrovirales con muchos virus resistentes a las drogas. IETquizas permitan hacer una repoblación de virus que son sensitivos a estas drogas. Resultados a un regimen antiviral de rescate cuando es precedido por una Interupcion Estructurado de los Tratamientos (IET), subsequentemente quizas sea superior a las practicas corrientes de regimenes modificados sin IET. Esta hipótesis ha sido provada en investigación clinica. IET quizas ponga pacientes con niveles muy bajos,en la cantidad de celulas CD4 , en un riesgo muy grande de complicaciónes muy serias. Por esta razón, IET debe considerarse en el punto de vista experimental.

IET han sido tambien evaluadas como medio para reducir la carga de muchas pildoras y asi como las toxisidades causadas por estas drogas.En areas con recursos muy limitados estas estrategias ofrecen la posibilidad de un acceso más grande a los antivirales.El tiémpo y la duracións optimal de IET en estos pacientes no se sabe, horarios flexibles para re iniciación de la terapias ya sea por cause del CD4 o VIH RNA que entan en los unbrales o los dos representan una extrategia. Horarios "fijos" designando la duración de IET representa un aproche de alternativo. Los mayores riesgos de la IET para estos pacientes incluyen la resistencia a las drogas, la re población de los depositos del VIH que gradualmente fueron reducidos por los tratamientos, la calidad de vida, ya sea de manera muy sutil o de las funciones mentales.

> **Investigaciónes clinicas** ***no ha podido determiner hasta este moménto en forma definitiva que La IET es benefica para dodos los que estan tomando drugas contra el VIH .***

Conclución

Investigaciónes cientificas no han podido determinar en forma definitiva que la IET es benefica para cada persona que esta tomando tratamientos contra el VIH. A esta fecha la IET todavia esta considerada, como esperimental y no se recomienda ni se garantisa que es una opción ideal, cada caso es unico y otros factores importantes deben ser considerados antes de tomar la decisión de participar en una IET. Mucha precausión debe ser la regla.

Ramón Hernández is a Treatment Counsellor with the BCPWA Society.

Volunteering at BCPWA

Profile of a volunteer: DAVID MARCH

"David's contribution to the AIDS Walk and BCPWA is enduring because he has tirelessly educated the greater community on the issues people with HIV/AIDS face."

Naomi Brunemeyer

Volunteer History
Public relations sponsor to BCPWA's annual AIDS Walk since 1997. Also volunteered for AIDS Vancouver's "Buddy Program" in 1993-94 and AIDS Walk '94 and '96. (I slept through '95!)

Started at BCPWA
Started as a volunteer in 1997.

Why pick BCPWA?
At first, it was a fashionable cause for a trendy gay guy. Then, when I found out my brother was HIV-positive, it finally hit home that my family was threatened, and I had to have a way to fight back.

Why have you stayed?
I've stayed because of my brother's case, and because of the friends I've made over the years at BCPWA through my involvement in the AIDS Walk.

Rating BCPWA
A-positive! It's more goal-focused than other charities.

Strongest point of BCPWA
By and large, the people there know what they're doing.

Favourite memory
Hanging out in the AIDS Walk media tent with Pierre (to avoid the rain) and listening to two drag queens talk about their lives.

Future vision for BCPWA
A quiet place where they once fought a good fight and eventually won a big war!

2001 is the International Year of the Volunteer!

Gain and share your skills for a valuable cause

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!

for further information and an application form **contact**:
volunteer coordination at 893.2298
cybeller@parc.org
or Human Resources at 1107 Seymour Street

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

Magazine template.qxd 11/29/01 9:23 AM Page 34

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 November 27.

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, 1pm–4pm. 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 PM except cheque issue week. 441 East Hastings Street. For more information call 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, BC, 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.

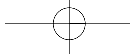
COMPLEMENTARY HEALTH FUND (CHF): For full members entitled to benefits. Call the CHF Project Team 893.2245 for eligibility, policies, procedures, etc.

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, 1459 Barclay Street for more information. Email: ffl@radiant.net.

WRITE TO US: Pos-Hap, Living + Magazine 1107 Seymour St. Vancouver, BC V6B 5S8
Call us 893.2255 • Fax us 893.2251 • email us pozhap@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.

GASTOWN MEDICAL CLINIC: specializing in treatment of addiction and HIV. Located at 30 Blood Alley Square. Phone: 669.9181.

GILWEST CLINIC: Comprehensive health care for persons with HIV/AIDS. Also methadone maintenance program. Richmond Hospital, 7000 Westminster Hwy., Richmond. To book an app't., call 233.3100. For more info, call 233.3150.

HEPHIVE: Hepatitis & HIV Education Project. Jointly run by BCPWA and Vancouver Native Health, the project supports people who are co-infected with Hepatitis and HIV+ to make informed treatment decisions. Call (604) 254.9949 ext 232, or toll free 1.800.994.2537. Vancouver Native Health Clinic, 449 East Hastings, upstairs.

OAKTREE CLINIC: Provides care at a single site to HIV infected women, children, and youth. For information and referrals call 875.2212 or fax: 875.3063.

PELVIC INFLAMMATORY DISEASE SOCIETY (PID): Pelvic inflammatory disease is an infection of a woman's reproductive organs. The PID Society provides free telephone and written information: 604.684.5704 or PID Society, PO Box 33804, Station D, Vancouver BC. V6J 4L6.

PINE FREE CLINIC: Provides free and confidential medical care for youth and anyone without medical insurance. HIV/STD testing available. 1985 West 4th Avenue, Vancouver, BC V0J 1M7. Phone: 736.2391.

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 East 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.

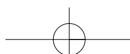
HAIR STYLING: Professional hair styling available at BCPWA. Call information desk for schedule, 681.2122 ext 323.

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

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 Al.

Saturday

Keep Coming Back Narcotics Anonymous: All welcome! 12-step program. 7:30 to 9:30 pm. Gay and Lesbian Community Centre, room 1-G, 1170 Bute Street, Vancouver. Call 660.7949.

LOWER MAINLAND

Monday

SUPPORT GROUP: For HIV positive persons as well as friends and family. Every 2nd and 4th Monday of the month, 7 to 9 pm. White Rock/South Surrey area. For information call 531.6226.

LULU ISLAND AIDS/HEPATITIS NETWORK: Weekly support group in Brighouse Park, Richmond (No. 3rd & Granville Ave.) Guest speakers, monthly dinners, videos, snacks and beverages available. Run by positive people, confidentiality assured. Everyone welcome. For information call Phil at 276.9273 or John at 274.8122.

Tuesday

THE HEART OF RICHMOND AIDS SOCIETY: Weekly support group for those affected by HIV/AIDS. 7-9 pm at Richmond Youth Services Agency, 8191 St. Albans Rd. For information call Carl at 244.3794.

SUPPORT GROUPS & PROGRAMS

CARE TEAM PROGRAM: Small teams of trained volunteers can supplement the services of professional home care or friends & family for people experiencing HIV/AIDS related illnesses. Please call AIDS Vancouver Support Services at 681.2122 ext. 270 for more information.

HIV-T SUPPORT GROUP: (affiliated with the Canadian Hemophilia Society). Our group is open for anyone who is either hemophiliac or blood transfused and living with HIV/AIDS. Should you need more information, please call (604) 866.8186 (voice mail) or Robert: 1.800.668.2686.

HOME AND HOSPITAL VISITATION PROGRAM: People living with HIV/AIDS who are in hospital or have recently been released can request visits or phone contact from trained, caring volunteer visitors. Call AIDS Vancouver Support Services at 681.2122 ext. 270.

P.O.P. PRISON OUTREACH PROGRAM: is dedicated to providing ongoing support for HIV+ inmates and to meeting the needs of our members in the correctional system. Direct line phone number for Inmates with HIV/AIDS. 604.527.8605. Wednesday through Sundays from 4 p.m. to 10 p.m. Collect calls will be accepted and forwarded, in confidence, to the POP/Peer Counsellor on shift. For more information call the Prison Liaison voice mail at 681.2122 ext. 204.

PEER AND SUPPORT COUNSELLING: BCPWA Peer and Support Counsellors are available Monday to Friday from 10 to 4 in the support office. Counsellors see people on a drop-in or appointment basis. Call 893.2234 or come by 1107 Seymour Street.

PROFESSIONAL COUNSELLING AND THERAPY PROGRAM: Professional counsellors and therapists are available to provide 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, educa-

tion, retreats, social opportunities, referrals, and skills-building opportunities. Cell phone: 808.7209. Office: 688-1441. E-mail: information@youthco.org. Website: www.youthco.com

AIDS GROUPS & PROGRAMS

AIDS AND DISABILITY ACTION PROGRAM AND RESOURCE CENTRE: Provides and produces educational workshops and materials for disabled persons. B. C. Coalition of People with Disabilities. #204 - 456 West Broadway, Vancouver, BC V5Y 1R3. Phone: 875.0188. Fax: 875.9227. TDD: 875.8835. E-mail: adap@bccpd.bc.ca. Website: www.bccpd.bc.ca/wdi.

AIDS CONSULTATION AND EDUCATION SERVICES: 219 Main Street, Vancouver, B. C., V6A 2S7. Phone: 669.2205.

AIDS VANCOUVER: PARC, 1107 Seymour Street, Vancouver, BC V6B 5S8. Phone: 681.2122. Fax: 893.2211. 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: 607-207 W. Hastings., Vancouver, BC, V6A 3Y9. Phone: 604.696-0100. 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.

MENNONITE CENTRAL COMMITTEE: HIV/AIDS Education and Support Program. For more information contact Nicole Giesbrecht at 604.850.5539.

Magazine template.qxd 11/29/01 9:23 AM Page 38

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 & PROGRAMS

CAMPBELL RIVER SUPPORT GROUPS: Art therapy and yoga/meditation sessions. Phone: 1.250.335.1171. Collect calls accepted.

COMOX VALLEY SUPPORT GROUP: Comox Valley. Also see North Island AIDS Coalition. Phone: 250.338.7400

AIDS GROUPS & PROGRAMS

AIDS VANCOUVER ISLAND (AVI): Offers a variety of services for those affected by HIV/AIDS,including support, education and street outreach. Office located at the Victoria HIV/AIDS Centre, 304-733 Johnson St., Victoria, BC V8W 3C7. Phone: 1.250.384.2366 or toll free at 1.800.665.2437. Fax: 1.250.380.9411.

AIDS VANCOUVER ISLAND – REGIONAL & REMOTE, NANAIMO: Offers a variety of services for those affected by HIV/AIDS. #201 - 55 Victoria Road, Nanaimo, BC V9R 5N9. Phone: 1.250.753.2437. Fax: 1.250.753.4595. Collect calls accepted.

MID ISLAND AIDS SOCIETY: For PWA/HIVs, partners, family, friends, and the community. Education, resource materials, & monthly newsletter available. Call 1.250.248.1171. P. O. Box 686, Parksville, BC V9P 2G7.

NORTH ISLAND AIDS COALITION (NIAC): All of our offices offer Individual Advocacy, Support and Education, and Harm Reduction Programs. E-mail: niac@island.net. Website: www.island.net/~niac. Courtney office: NIAC, 355-6th St., Courtenay, BC V9N 1M2. Phone: 250.338.7400 or toll-free 1.877.311.7400. Fax: 250.334.8224. Campbell River: NIAC, 684B Island Highway, Campbell River, BC V9W 2C3. Phone: 250.830.0787 or toll-free 1.877.650.8787. Fax: 250.830.0784. Port Hardy Office: NIAC, 8635 Granville Street, Ground Floor, Port Hardy, BC V0N 2P0; mailing address: PO Box 52, Port Hardy, BC V0N 2P0. Phone and fax: 250.902.2238. Cell phone: 949.0432.

VICTORIA AIDS RESPITE CARE SOCIETY: 2002 Fernwood Rd., Victoria, BC V8T 2Y9. Phone: 1.250.388.6220. Fax: 1.250.388.7011. E-mail: varcs@islandnet.com. Website: http://www.islandnet.com/~varcs/homepage.htm.

VICTORIA PERSONS WITH AIDS SOCIETY: Peer support, comprehensive treatment information, food bank, newsletter. Located at: 541 Herald Street, Victoria, B.C. V8W 1S5. Phone: 1.250.382.7927. Fax: 1.250.382.3232. E-mail: support@vpwas.com. Homepage: www.vpwas.com

THOMPSON-OKANAGAN

HEALTH

OUTREACH HEALTH SERVICES: Full STD/HIV testing and counselling; health care, pregnancy, and contraception counselling; needle exchange. Suite 102, 1610 Bertram Street, Kelowna, BC. Phone: 250.868.2230. Fax: 250.868.2841.

VERNON - NORTH OKANAGAN-YOUTH AND FAMILY SERVICES OUTREACH HEALTH AND NEEDLE EXCHANGE: Information and support available to individuals affected by HIV and AIDS. 2900 - 32nd Street, Vernon, BC V1T 2L5. Phone: 1.250.545.3572. Fax: 1.250.545.1510.

AIDS GROUPS & PROGRAMS

AIDS RESOURCE CENTRE - OKANAGAN & REGION: Information, referral, advocacy, peer support, social & supportgroups,education and resource library. Phone: 1.800.616.2437 or Fax: 1.250.868.8662, or write to #202 - 1626 Richter Street, Kelowna, BC V1Y 2M3. E-mail: kares@silk.net. Pentiction Office: 800.616.2437, Princeton Office: 800.616.2437.

AIDS SOCIETY OF KAMLOOPS (ASK): PO Box 1064, Kamloops, BC V2C 6H2. Phone: 1.250.372.7585. Fax: 1.250.372.1147.

PENTICTON AIDS SUPPORT GROUP: For PWAs, family and friends. Contact Sandi Detjen at 1.250.490.0909 or Dale McKinnon at 1.250.492.4000.

CARIBOO-INTERIOR

AIDS GROUPS & PROGRAMS

CARIBOO AIDS INFORMATION AND SUPPORT SOCIETY (CAIS): Williams Lake and Hundred Mile House area. c/o The NOOPA Youth Ctre. P.O. Box 6084, Williams Lake, BC V2G 3W2. Prevention Worker for Youth also available. Phone: 250.392.5730. Fax: 250.392.5743. Needle Exchange in Williams Lake. Phone: 250.398.4600.

CIRCLE OF LIFE: Held at the White Feather Family Centre every second Tuesday from 4:30-5:30. For

information call Gail Orr at 397.2717.

QUESNEL SUPPORT GROUP: For PWA/HIV and their families. For information call Jill at 1.250.992.4366.

NORTHERN B.C

AIDS GROUPS & PROGRAMS

AIDS PRINCE GEORGE: Support groups, education seminars, resource materials. #1 - 1563 - 2nd Avenue, Prince George, BC V2L 3B8. Phone: 1.250.562.1172. Fax: 1.250.562.3317.

PRINCE GEORGE AIDS PREVENTION NEEDLE EXCHANGE: Providing outreach and nursing service. 1095 – 3rd. Avenue, Prince George, BC V2L 1P9. Phone: 1.250.564.1727. Fax: 1-250.5655.6674.

PRINCE GEORGE: NORTHERN INTERIOR HEALTH UNIT: STD clinic; HIV testing (pre and post counselling), and follow-up program. 1444 Edmonton Street, Prince George, BC. V2M 6W5. Phone: 250.565.7311. Fax: 250.565.6674.

KOOTENAYS

AIDS GROUPS & PROGRAMS

ANKORS: Office at 101 Baker Street, Nelson, BC V1L 4H1. Phone: 250.505.5506 or 250.505.5509 or toll free: 1.800.421.2437. Fax: 250.505.5507. Website: http://ankors.bc.ca. West Kootenay/Boundary Regional Office 250.505.5506, info@ankors.bc.ca; East Kootenay Regional Office 250.426.3383, ankors@cyberlink.bc.ca.; Cranbrook Office: #205-14th. Avenue, North Cranbrook, BC V1C 3W3.

NORTH COAST

AIDS GROUPS & PROGRAMS

AIDS PRINCE RUPERT: Provides support, group meetings, needle exchange, HIV testing (including pre/post counselling), and education. Located at 2-222 3rd Ave. West, V8J 1L1. Please call for information 1.250.627.8823 or fax 1.250.627.5823.

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 man, living with HIV+ serving a seven year sentence. I would like to correspond with people to learn about the latest health trends or for friendship. Robert Trice, PO Box 1200, Agassiz, BC, V0M 1A0

qualifications: HIV +, willing to learn, willing to work in a dynamic team environment, no previous treatment knowledge necessary

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

the TIP Team!

Treatment Information Counsellors wanted!

BCPWA Human Resources 893-2247

Leonard George, Former Chief of the Tseil-Waututh Nation, gives a morning blessing.

The Denman Fitness dance team leads the crowd through a pre–Walk stretch.

BC CTV anchors Pamela Martin (l) and Coleen Christie (r) flank BCPW's Director of Development Melissa Davis.

AIDS Walk 2001 in Stanley Park

The Honourable Hedy Fry, MP Vancouver Centre and BCPWA Chair Glen Hillson.

Emcee Bill Monroe entertains the crowd.

Lorne Mayencourt, MLA Vancouver Burrard and the Honourable Gordon Campbell, BC Premier.

Peter Adamo, BC Lottery Corporation (l) helps artist Joe Average auction of one of his paintings.

BCPWA Executive Director Ross Harvey and Libby Davies, MP Vancouver East.

Hairstylists from the Lounge Hair Studio help raise money for the AIDS Walk.