inside

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 3,500 HIV+ members.

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BRITISH COLUMBIA
Ministry of Health and Ministry Responsible for Seniors

Living + Magazine
1107 Seymour St.
Vancouver BC
V6B 5S8
TEL (604) 893-2255
FAX (604) 893-2251
EMAIL living@parc.org
BCPWA ONLINE www.bcpwa.org

think+

opinion and editorial

Women are ignored in research

by Shari Margolese

It's time to get serious about including more HIV-positive women in drug trials. Since my diagnosis in 1993, I have been inundated with data and headlines such as "HIV on the rise in women" and "Women make up 20% of new infections." While we have been deciding what to do about this "emerging group," the number of women with HIV has risen to the point where they represent 50% of all HIV infections in the world. That's 18 million women. I'd say that we have emerged! Yet, only a handful of us is included in HIV treatment research. Consequently, little woman-specific information is available to help HIV-positive women make important treatment decisions.

Canadian women are coping with this inequity in treatment access and information with self-dosing experimentation and potentially sub-optimal treatments. We are taking unsupervised drug holidays or stopping drugs altogether. When potent AIDS cocktails hospitalized me in the late '90s, I reverted to a dual therapy treatment regimen to regain my quality of life.

Recently, I was speaking with a positive woman who has been on a cumbersome HAART program for several years. She said her treatment was intolerable and that most of the time she only took half of the drugs prescribed! The diarrhea and nausea kept her from caring for her children and from working, so she started self-dosing. If she feels good, she takes all her meds. If she doesn't feel good, she doesn't. Fear of being chastised or cut off her medication altogether keeps her from telling her doctor.

If she and I had treatment regimens that considered our physiological and practical needs, perhaps we might have better luck tolerating and adhering to therapy. Is this science? No, but it should be.

There ARE many barriers to women accessing trials. These include faults in the trials themselves, such as unrealistic minimum weight requirements and the restrictions placed on women of childbearing age. There are restrictions due to geographic proximity. While many HIV-positive Canadian men live near big cities with access to large medical facilities, many positive women live in the suburbs or rural areas. Many more live in countries where drugs are not available. This is only the tip of the iceberg.

It's hard to say what can be done to include more women in HIV drug trials and other research. Activists voice their concerns. Researchers send out bulletins asking for more women, even bribing us with childcare and transportation. I regularly hear, "Oh, we tried to get women" or "Women don't want to enroll in trials." Well, I don't buy it! If 50% of the world's HIV-positive people are women, then 50% of the trial subjects must also be women!

What will it take to ensure that women are equally represented in trials? Perhaps nothing short of legislating inclusion. Perhaps a combination of changes to the process is needed. Perhaps it would make a difference if they lived in countries that could afford the treatments.

If we are to have access to safe, effective, and practical treatments, it is time to stop trying to get women into trials and start getting them into trials. ⊕

Shari Margolese is the national woman's representative on the Canadian Treatment Action Council (CTAC).

NEWSREEL

News from home and around the world

Advocacy alert

The BC Ministry of Health is routinely rejecting special authority requests for testosterone with little reason, which is affecting the quality of life of many people living with HIV/AIDS. Testosterone is prescribed for PWAs to fend off wasting.

Pharmacare delisted testosterone and put it under Special Authority Process. Doctors can make a special request for testosterone on behalf of a patient if they feel it is necessary for the health of the patient.

The BCPWA Society is working with the Ministry of Health to resolve this issue.

Ottawa researchers find new way to attack HIV

Ottawa researchers have found a way to attack HIV where it hides from other drugs and reduce it to undetectable levels, according to a report published in the journal Virology.

The finding, by researchers at the Ottawa Hospital Research Institute, offers some of the strongest hope that it may be possible to remove all HIV from a person's body. Research is still in the early stages.

When HIV infects the body, it attacks the immune system, killing T-cells. Some of the infected cells don't die right away and instead remain dormant for years, creating a reservoir for the virus.

As a result, HIV remains hidden in cells, even though patients appear otherwise free of disease. Researchers have found that when HIV-infected patients stop taking their drug "cocktails," the virus returns.

The research team reports that a naturally occurring protein can reduce the level of HIV to undetectable levels in those dormant cells. However, they caution against raising false hopes for a cure.

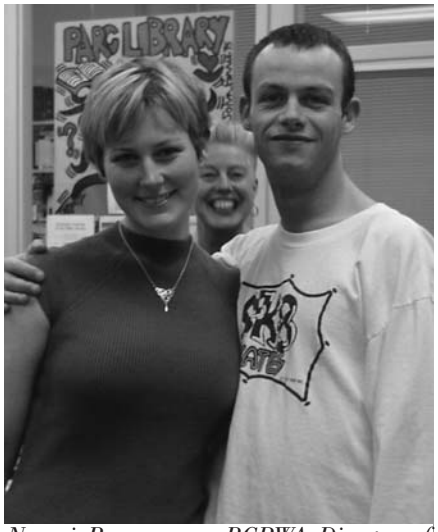
Source: Canadian Press

Regionalization back on the agenda?

For the third time in eight years, the provincial government is significantly reshaping health care delivery in BC, which may renew the possibility of regionalization of services for PWAs.

In December, BC Minister of Health Planning Sindi Hawkins announced the collapsing of 52 regional health authorities into five, resulting in the immediate termination of 600 health board members. The restructuring is expected to lead to hundreds of layoffs.

This may be the first step in the regionalization of services provided for people living with HIV/AIDS. Earlier in the year, then Health Minister Corky Evans announced he would not force regionalization upon AIDS organizations that did not want it.



Naomi Brunemeyer, BCPWA Director of Communications, and volunteer Chad Conley at a reception for delegates of the Pacific AIDS Network (PAN) annual forum. AIDS Vancouver and the BCPWA Society hosted the reception at the Pacific AIDS Resource Centre.

Ecstasy lowers CD4 counts

Researchers in the European Union have been studying the impact of ecstasy on the immune systems of mice and people and have found some troubling data.

Seventeen healthy male subjects received 100 mg ecstasy once or twice over a period of 24 hours. Blood samples were collected before, during and after the study.

The researchers found that a single dose of ecstasy (100 mg) taken by mouth caused a 30% decrease in CD4 cells within hours. Within a day after taking this dose, CD4 cell levels returned to normal.

Among subjects who received two doses of the drug, four hours apart, the decline in CD4 cells was even more serious, reaching a level 40% below normal. Although T-cell levels rose a day later, they did not return to normal.

Another important finding is that ecstasy clearly reduced the ability of T-cells as well as other immune system cells to fight infections.

This information was provided by the Canadian AIDS Treatment Information Exchange (CATIE). For more information, contact CATIE at 1-800-263-1638.

Old drug offers new hope

A drug that has been in use for over a decade to treat prostate cancer may prove to be a critical breakthrough in helping to fight off diseases in people living with HIV/AIDS. The effect of leutinizing hormone releasing hormone (LHRH) is being evaluated in a series of Melbourne-based pilot studies for its potential to rebuild the immune system by stimulating the thymus gland.

Researchers in Melbourne are hoping LHRH will increase the levels of T-cells produced by the thymus.

Source: Victoria Positive Women in Australia, www.home.aone.net.au/pos.women

NEWSREEL

News from home and around the world

Addicts to get heroin under research project

A federal government agency will give doctors money to provide heroin to about 125 drug addicts in Vancouver, Toronto, and Montreal under a national research project searching for an effective way to cut crime and control the cost of caring for injection-drug users.

The drug could be offered by next summer to people who have been addicted more than a year. Addicts in the program must have tried at least twice to get off heroin by using the substitute drug methadone. Under the Narcotics Control Act, heroin can be prescribed by doctors to patients in hospital.

The project has not received final approval. Full funding for the clinical trials has not been confirmed.

One-third of the drug users in this study are HIV–positive and more than 90 per cent are infected with hepatitis C.

Source: The Globe and Mail

Pharmacare reviewing drug reference program

On November 23, BC Minister of Health Planning Sindi Hawkins announced the formation of an independent consultation panel to seek cost-effective alternatives to Pharmacare's reference drug program (RDP). The panel will solicit input from stakeholders, including physicians and pharmacists.

Under the RDP, Pharmacare creates groupings of drugs that treat the same condition and sets its coverage level for each group at the price of the most cost-effective drug. Pharmacare coverage of a more expensive drug within the group can be approved based on medical reasons presented by the patient's doctor.

North American AIDS Treatment Action Forum (NATAF) delegates at a cocktail reception (l. to r.): Lance Toma and Claire Wingfield from San Francisco's Asian & Pacific Islander Wellness Center, Charles Clifton from Test Positive Aware Network in Chicago, and Adimika Meadows from the Seattle Treatment Education Program. Over 450 delegates participated in NATAF 2001 in Vancouver from December 2 to 5. The conference focused on treatment education, treatment action and skills building. The BCPWA Society was one of the host organizations.

AIDS WALK at Mountain Institution

The Chain Link Society, a peer-run organization dedicated to supporting and educating prisoners in Pacific Region correctional institutions, held another successful AIDS WALK at Mountain Institution in Agassiz, BC. The money raised was donated to the BCPWA Society's AIDS WALK.

Founded in 1997, the Chain Link Society's primary function is to educate the inmate population about the myths and realities of HIV/AIDS and other life affecting conditions, and to reinforce healthy lifestyle practices within the prison environment. They operate the National HIV/AIDS Peer Education and Counselling Program. In conjunction with the Con AIDS Network Project, an inmate-based program, they produce over 200 pamphlets on topics ranging from proper diet to alternative treatment therapies. ⊕

Buddy Bites



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

Does welfare take money off your cheque every month?

How to get your monthly payments lowered

Are you paying back welfare for a damage deposit or unpaid hydro bills? No money left to pay for health care or other needed supplies? These welfare payments are called "Repayment Agreements" and are taken off your cheque every month until they are paid back. If you are going without basic needs or health care supplies, you can ask welfare to lower your payment or to have it cancelled.

BOX 1

Date

Name of Welfare Worker
Ministry of Human Resources
Name of Office

Dear Welfare Worker

I am writing to ask you to lower the amount of money taken off my check from $_____ to $_____ each month. I am completely disabled and I am living on welfare. The extra costs of with living with HIV/AIDS are always increasing. I do not have enough money on welfare to buy basic items. I go without things I need which help me with my health needs.

I require the money the Ministry takes off my check each month to buy

_____
_____
_____
_____
_____

As well, I need to buy other items from time to time. Because I live in poverty I have no other way to pay for them except with my welfare cheque.

If you are unable to lower the payments from my check as I have asked, then I ask for an Appeal Kit, so that I can appeal your decision.

Sincerely,

your name

BOX 2

Personal Budget Information

MONTHLY INCOME

Source: $

MONTHLY EXPENSES

	$
Food	
Rent	
Hydro	
Telephone/Long Distance	
Laundry	
Soap, shampoo	
Cleaning supplies	
Personal/hygiene	
Clothing	
Non Food items	
Quality of Life/Recreation	
Health care needs	
Pet	
Transportation	
Other	
EXPENSE TOTAL	

Money left over $

STEP 1:

Write a letter to your Welfare worker asking for the repayment to be lowered (See box 1)

STEP 2:

Fill in the budget form (See box 2)

Show in the budget form how much you can afford to pay each month. For example, if you can afford to pay $1.00/month, you must be able to show that you have $1.00 left over from all of your expenses to make that payment every month.

STEP 3:

Take the following papers to Welfare

- *Your letter asking for a lower payment.*
- *A completed budget form.*

STEP 4:

Ask Welfare to date-stamp and photocopy your papers for your records

STEP 5:

Call you Welfare worker later on the same day

Ask him/her: Did they get your letter? Will they lower the payments?

STEP 6:

If your worker says "Yes" and will lower the payments

You will need to go to your welfare office and sign a new repayment agreement with the lower amount.

Ask for a copy of the new repayment agreement for your records.

STEP 7:

If your worker says "No"

Ask for an appeal kit and contact an advocate.

A decade on the frontlines

Janet Conners talks about her role in the AIDS movement

by Naomi Brunemeyer

The personal journey of prominent AIDS activist Janet Conners mirrors the AIDS advocacy movement itself. Since she became infected with HIV in 1989, Conners has challenged stereotypes in her many roles as educator, caregiver, advocate, and mother. As the movement itself has evolved, so has her place within it. Her revelations about the entire AIDS community and, more specifically, women and HIV/AIDS, are just as insightful as her personal legacy to those infected and affected by HIV.

When first documented in the early 1980s, HIV was narrowly perceived as a disease transmitted through sex between men. That stigmatization contributed to the increased risks of transmission of the virus in other groups, including women. While Conners believes that some risk factors intensify the likelihood of women contracting HIV, she feels that you can't talk about AIDS without first talking about homophobia.

"One of the first things that was known about HIV was that it was a sexually transmitted disease," says Conners, who lives in Hatchet Lake, near Halifax, Nova Scotia. "There is not a disease that is sexually transmitted in the gay community, which is not transmitted sexually in the straight community. But we were coming up against discrimination, and I was someone's wife and a mother."

"ULTIMATELY, A WOMAN NEEDS TO BE HER OWN ADVOCATE. I CANNOT EMPOWER ANYONE ELSE. EACH PERSON MUST EMPOWER THEMSELVES."

Conners' late husband Randy contracted HIV through the blood system, and she later became infected through him. The medical community was providing only the information that they deemed her husband needed to know. Gay men were blamed for infecting the blood system because they donated 7% of all of Canada's blood.

"I think, on many levels, the medical community viewed us as innocent victims," Conners says. "They were half right. We most certainly were victims, and we allowed ourselves to stay victims for a long time."

For the first few years after their diagnoses, Conners and her husband dealt with HIV essentially on their own, with little support. They felt strongly discouraged from joining AIDS service organizations because they did not feel the ASOs were designed for them.

September 1991 was the most important time in her life, according to Conners. She attended an AIDS retreat in New Brunswick. It was there that she realized AIDS organizations belonged to all PWAs and that she had a place within the AIDS community. The following week, Conners joined the Nova Scotia Persons With AIDS Coalition, and by the end of the year, she was a board member.

While Conners' involvement in the AIDS community may have initially been triggered by her anger towards the injustice done to those who relied on the Canadian blood system, she began to see the AIDS community from a larger perspective. She appreciates the issues that leave women vulnerable to HIV infection, but she also understands how other complexities such as homophobia, racism, sexism, poverty, despair, and ignorance all contribute to the AIDS epidemic.

In the beginning of the AIDS movement, it was easier to focus on prevention. Connors herself found prevention work empowering. Now, twenty years into the AIDS epidemic, she feels the AIDS community should be seen holistically, though she agrees that prevention work tends to be most effective when it is targeted towards specific groups. The societal barriers faced by women that contribute to their increased risk of contracting the virus need to be addressed in prevention messages.

The increasing number of positive test results in heterosexual women shows that prevention messages may have failed. Many traditional HIV prevention models don't acknowledge the poten-

tial power imbalance in many heterosexual relationships, nor do they recognize that an affordable, reliable prevention method for women requires partner cooperation. Based on her experience conducting HIV prevention education in Canadian high schools, Conners feels that many women are not the instigators of sexual activity and therefore lack control.

Her involvement in the AIDS community has not been confined to prevention efforts. Conners feels it is imperative for PWAs to be involved in the operation and ownership of ASOs. She believes that the role of PWAs should be far greater than prevention education.

As PWAs and healthcare professionals witnessed the failure of promising new drug therapies for many persons with HIV/AIDS, Conners became increasingly involved in advocacy work surrounding treatment issues. She saw several priority areas where she believed PWAs should take a leadership role: high-level policy decisions, universal treatment, expanded research that includes complementary therapies, and global education and prevention initiatives.

While Conners believes women can occupy many roles within the community, she still feels a need for women to continue to be front-line treatment advocates. "Ultimately, a woman needs to be her own advocate," she says. "I talk about when I wasn't empowered to encourage women, but I cannot empower anyone else. Each person must empower themselves."

Conners thinks that the very reasons why women are at risk of contracting HIV can lead them to not advocating on their own behalf. She says that stereotypes of HIV-positive people can shame a woman into not seeking treatment. As well, in relationships where both partners are HIV-positive, many women tend to assume a caregiver role, which may take priority over their own treatment. At her own doctor appointments, Conners found herself dealing with her husband's condition instead of talking about her own health.

While research may be conducted on women and AIDS from a social or psychological perspective, scientific treatment research is sorely lacking.

Conners argues that a lack of understanding exists about how HIV works in a woman's body. "By looking at all the reasons why women contract HIV, it continues to force women into a victim's role. We are either recipients of the disease or the vectors of the disease."

Specific women-centred issues exist within the AIDS community—from prevention to addressing the needs of the already infected, but Conners still believes that the HIV-infected community needs to see itself as one community.

"First, we are persons living with HIV, and secondly, we are men, women, gay, straight, old, young, persons of colour, aboriginal, IDU, or whatever group an individual may claim," she concludes. "I believe that we are a community created by this disease and by the myriad of problems—injustices, health, discrimination, ignorance—associated with HIV. Within the community, I think that we need to see ourselves as a whole community, not as a bunch of groups of people with HIV." ⊕

Janet Conners (l) received a Meritorious Service Medal from Governor-General Adrienne Clarkson on June 25, 2001.

Naomi Brunemeyer is the Director of Communications and Marketing for the BCPWA Society

The new BCPWA Society Board of Directors elected for the year 2001/2002 on October 27, 2001.

left to right: David Dunn, Wayne Campbell, Paul Lewand, Joel NC Leung, Glen Hillson, Jeff Anderson, Janet Wilson (absent: Andrew Christmas, Richard MacNab, Malsah)

NOT JUST A GUY THING

Women with HIV face distinct social, emotional, and biological challenges

by Karina Pourreaux

Initially, HIV/AIDS was considered a gender-biased disease found in gay men. Time revealed that was not true. Slowly but surely, women became infected as well. As of December 2000, 8% of all AIDS cases in Canada were among women over 15 years old, with the majority of infected women being in the 30–39 age group. In 2000, women—primarily teenagers and young adults—accounted for 52% of positive HIV test reports. Recent HIV case estimates indicate that the number of women in Canada living with HIV/AIDS continues to grow, whereas the overall annual number of positive HIV tests reported since 1995 has decreased.

It has taken several years to realize how different it is for a woman to be living with HIV—socially, emotionally, and biologically. The clinical results of the Canadian Women's HIV Study (CWHS) provides a rich and unique source of information on women living with HIV in Canada and how their situation compares to men with HIV.

Gender differences

HIV is still found mainly in gay men (73% of AIDS cases to the end of 1999). The male HIV-positive population is estimated to be mainly white (82%), whereas aboriginal women constitute the largest group of infected women (47%). White HIV-positive women comprise only 18% of HIV-positive women.

As many as 42% of HIV-positive women may experience significant gynecological problems to the point that cervical cancer is now an AIDS-defining disease. Among men, genital problems linked to HIV include anal HPV infection and anal cancers.

The social impact of HIV also differs between men and women. An American study showed that during the first years of HIV infection, women have significantly lower amounts of virus in their blood than men. Yet, women develop AIDS just as swiftly as men do. Lower virus levels in women meant that soon after HIV infection, a smaller percentage of them would have been eligible to start antiretroviral (ARV) treatment when it was based on viral load results. The eligibility criteria for ARV treatment relied upon clinical recommendations available at the time of this study. These recommendations are reviewed regularly and have been updated recently so that viral load results are no longer used as the prime indication for starting ARV.

The Canadian Women's HIV Study

So far, 677 women have been recruited to the CWHS study. This cohort consists mainly of white women (58%) and black women (33%). Aboriginal women (4%) are underrepresented compared to the national data. The mean age of participants in the study is 34 years, ranging from 16 to 77.

The main sources of infection are through sex and through intravenous drug use. In Canada, the injection drug use category is of increasing concern: in 1999, it accounted for 32% of women with AIDS compared to 16% in 1990. In the CWHS, 48% of the participants who answered the question indicated they had used illicit drugs; of these women, 75% had injected cocaine, heroin, or speedball.

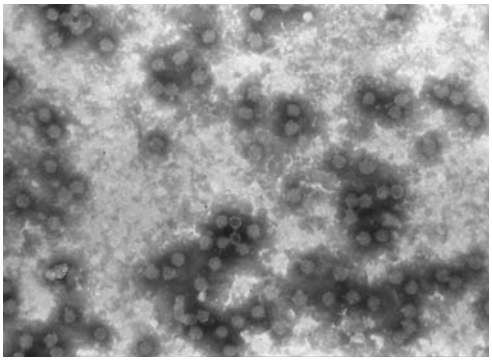
Pneumocistis carinii pneumonia (PCP) is the leading AIDS-defining disease in women participating in the CWHS.

Of the 673 women who answered a question about civil status, 42% were married or living common law, 29% were single and had never been married, 22% were separated or divorced, and 7% were widowed. The study did not reveal whether the death of a partner was related to AIDS. Seventy percent of respondents indicated that they smoked. Eighty-five percent of participants had been pregnant before their first study visit.

CERVICAL CANCER IS NOW AN AIDS-DEFINING DISEASE—AS MANY AS 42% OF HIV-POSITIVE WOMEN MAY EXPERIENCE SIGNIFICANT GYNECOLOGICAL PROBLEMS.

Human papilloma virus

The main objective of the CWHS is to see what link exists between human papilloma virus (HPV) and HIV. HPV is transmitted sexually and found in both men and women. Sixty-seven



Human Papilloma Virus

percent of the HIV-positive participants in the CWHS had HPV.

HPV is the lead cause for condylomas (warts in genital areas) and cancer of the cervix. Over 100 different types of HPV exist, and some are more dangerous than others. Some types cause condylomas, some types stay unnoticed, and others contribute to the development of cervical cancer.

The test for HPV detection is not part of a routine visit to your gynecologist. In most clinics that do offer HPV testing, patients must pay for the test. One of the only ways to get HPV results free of charge in Canada today is by taking part in the CWHS. If you know your HPV result, you are more likely to get adequate care according to the results. So far, no cures exist for HPV, although physicians can treat the symptoms, such as condylomas and lesions.

In 1999, the CWHS published an article on the risk factors associated with HPV. The article noted several factors that made it more likely for a woman to be among the two-thirds of CWHS participants who had tested positive for HIV. These were CD4 count below 200 cells/μL, being non-white, not always using a condom during sexual intercourse, or being under 30 years old. If you have any one of these criteria, you are more likely to have HPV. From 1993 to 1998, the CWHS recruited HIV-negative women in order to compare the results of both groups. In an analysis comparing HPV types leading to cancer (oncogenic types) and those not leading to cancer (non-oncogenic types), researchers found that HPV, and particularly oncogenic HPV, was more likely to persist in women with HIV.

Sexual behaviour

In an article published by the CWHS group in 1998 on sexual behaviour and pregnancy outcome, 71% of the participants answered they had had sex in the six months prior to their first study visit. Since then, this number has increased slightly to 74%. Among participants today, 89% had a steady partner at first study visit and 57% of them were always using condoms. Among those who had occasional partners, which was only 11% of those who answered the question about sex, a majority (66%) of them always used a condom during intercourse.

Women generally have a real concern that they not infect others. Analyses showed a clear link between an undetectable viral load and consistent condom use, and as such, it is believed that those who are adherent to their medication tend to practice safe sex. The statistics also revealed that women with a CD4 count greater than 200 were more likely to be sexually active. Women who had known their HIV status for less than 24 months or who were under 35 years old were also more likely to have sex. This finding is not surprising in light of the fact that general health and well-being influence sexual activity.

Pregnancy

As mentioned above, many women with HIV are adolescents or young adults, while women with AIDS are mostly between the ages of 30 and 39. These are childbearing years, and, therefore, the risk exists of passing the virus to the next generation during pregnancy, childbirth, or breastfeeding. HIV-positive men do not have to confront the choice of giving birth or pursuing a pregnancy when they have just learned of their or their partner's HIV status.

In Canada, more children are being born to positive mothers, but fewer of them are infected. The risk of mother-to-child transmission of HIV in Canada still exists, but this risk can be lowered if the mother's HIV status is known. When pregnant women know they are HIV-positive, the correct antiretroviral prevention can be offered to the mother and to the infant.

A study of AZT conducted by Forbes, Money, and Remple in British Columbia found a reduction in the HIV transmission rate from 28% in untreated mother-and-infant pairs to 13% in partially treated mother-and-infant pairs and to 0% in completely treated mother-and-infant pairs. In June 1994, the Ministry of Health in British Columbia recommended that HIV testing be offered as a routine prenatal component, with informed consent and pre- and post-test counselling. Consequently, in 1995 about 55% of pregnant women in British Columbia were tested for HIV. This proportion was estimated to be up to 80% in 1999 (60% through routine prenatal testing and 20% through physician or patient concern about higher risk). In all Canadian provinces, the decision to have an HIV test or not is the woman's.

In the CWHS, 85% of participants had been pregnant at least once upon entry into the study. The data suggests that when women learned about their positive HIV status, many chose not to have children in the future. If they found out about their HIV status during the first 20 weeks of pregnancy, women tended to get an abortion. When it was known that AZT could help reduce transmission of the virus to the baby by two-thirds, women still chose not to become pregnant. However, if they were already pregnant, more women chose to continue their pregnancy.

Lipodystrophy

Analysis of data from the CWHS showed that, among study participants on protease inhibitors, 32% had lipodystrophy and confirmed the findings from other studies showing that, most probably, metabolic abnormalities are a result of protease inhibitors.

Conclusion

Without research, many of the findings of the CWHS might not have been noticed and the differences between men and women living with HIV would probably not be as well known. Without gender-specific knowledge, women are less likely to be treated adequately. A close gynecological follow-up and safer sex practices are key elements in preventing HPV infection and its consequences. ⊕

Karina Pourreaux is the Study Co-ordinator for the Canadian Women's HIV Study in Montreal.

The Canadian Women's HIV Study

The Canadian Women's HIV Study is a collaborative cohort of HIV-positive women in Canada that serves research purposes. Women living with HIV are recruited through Canadian clinics that follow HIV-positive women. Participants are given an anonymous study code and are seen every six months, at which time they are asked questions about their health, illnesses, drinking and smoking habits, sexual behaviours, etc.

Also, a Pap test is done and another sample is taken for HPV screening. All these results and answers are compiled at the coordination centre and comprise an invaluable source of information for women, physicians, and policy makers. To find the closest participating clinic or for general information on women and HIV, go to www.cwhs.ca.

For women only

Organization serves the distinct needs of HIV-positive women

Over a decade ago, a small group of women in Vancouver began meeting in each other's homes to discuss issues facing HIV-positive women. Some were living with the virus, others were affected by it, but they could all see a growing need for women-specific support services in British Columbia. From this grassroots support group, Positive Women's Network (PWN) grew to its current membership of 500 HIV-positive women across BC. Though they are a diverse group, members share many common experiences: isolation, stigmatization, judgement, inappropriate curiosity, and shame. These issues remain as potent as they were in 1989.

As the only organization west of Toronto that serves women living with HIV, PWN is dedicated to improving their quality of life through support, community education, and research.

Among its initiatives, the organization actively advocates for increased research in the field of microbicides, which represents the possibility of a woman-controlled form of HIV prevention. Microbicides, a substance that kills numerous pathogens, can be used as a non-invasive gel. Traditional prevention practices often don't take into account the power dynamics that can exist in women's relationships and affect their use of condoms. Telling women to "just keep safe" is simplistic and not very useful, argue the people at PWN.

The inequity in women's relationships can limit their access to health care, support services, and treatment, resulting in late diagnosis and thus delayed medical intervention. PWN encourages open discourse and an analysis of the power dynamics in women's intimate relations.

Women living with HIV also have a difficult time getting good medical expertise. Physicians tend to lack knowledge of women's risks of contracting the virus. Many doctors still don't see a need for women to be tested for HIV, so women often learn of their HIV status during a prenatal workup. To compound matters, physicians are typically not familiar with the unique treatment needs of HIV-positive women.

To address this issue, PWN developed the Health Care Provider Education Project. In particular, they worked with rural AIDS service organizations, teaching them how to train physicians to provide better health care to women. They are now working on a toolkit for the project.

"I've been asked how I can sustain my enthusiasm and commitment to this work," says Marcie Summers, Executive Director of PWN, "given the reality of change occurring slowly and in such minuscule ways."

She finds a source of motivation in the incredible courage, tenacity, and vibrancy of the community of Canadian HIV-positive women. "Their determination to carry on their lives with dignity is nothing but inspiring. They are survivors. While HIV has changed their lives forever, having the privilege of working with these women, learning from them daily, has fundamentally changed mine." ⊕

POSITIVE WOMEN'S NETWORK SERVICES

DIRECT SUPPORT

Advocacy
Day retreats and outings
Drop-in centre
Food bank
Sharing circle
Home visits
Hospital visits
Hot lunch program
Information and referrals
One-to-one outreach
One-to-one support sessions
Support for family and care providers
Support groups
Telephone counselling

EDUCATIONAL SUPPORT

Health care provider education
The Positive Side newsletter
Public education and awareness
Referrals
Treatment information
Workshops

COMMUNITY-BASED RESEARCH

Women's Health Research Project

614 – 1033 Davie Street, Vancouver, BC V6E 1M7
Tel: 604.692.3000
Fax: 604.684.3126
Toll-free: 1.866.692.3001
Email: pwn@pwn.bc.ca

Staff members of Positive Women's Network

The buck doesn't stop here

Disability benefits don't necessarily end when you return to work

by Lisa Kallio and Gweneth Crook

Are you thinking about working or enrolling in training? Are you concerned about what will happen with your benefits if you do? Misinformation about what will happen to your benefits if you return to work or enroll in training is plentiful.

Fortunately for people with HIV/AIDS living in British Columbia, the federal and provincial governments and private insurers all have programs and resources to assist you. The following current information is designed to provide a basic outline about the impact on your disability benefits if you return to work.

RECENT CHANGES TO THE CANADIAN PENSION PLAN NOW ALLOW INDIVIDUALS RECEIVING CPP TO GO BACK TO WORK ON A PART-TIME BASIS.

Disability II

Disability II is a lifelong designation. If you choose to work, you will not lose your DBII designation and will continue to qualify for enhanced medical coverage as long as you live and work in BC. The Ministry of Human Resources will continue to pay for your MSP premiums, prescription costs, and dental benefits. If you find that you have to leave your job after trying a return to work, you can get back on BC Benefits quickly if you still meet the asset and income requirements.

You can also consider returning to work on a part-time basis. For the first $200 a month you earn, no penalty is applied to your DBII benefits. You only get to keep 25% of any additional earnings over $200. For example, if you earn $300 one month, you keep this money and the government deducts $75 from your disability cheque. (The first $200 is exempt, plus 25% of the remaining $100, for a total of $225). If your income is less than what you received when on DBII, you can get topped up from the ministry.

You can continue to collect your monthly DBII cheque if you attend school.

Canadian Pension Plan

The Canadian Pension Plan has recently made some changes to their benefits program. They now allow individuals receiving CPP to go back to work on a part-time basis. You are able to earn up to $300 a month and still collect your benefits. We contacted CPP staff, and they indicated that you do not need to report income to CPP until you are earning more than $3,600 annually.

If you are able to return to work on more of a full-time basis, you can collect CPP and your wage for the first three months of your work trial. If you stop working within the three months, your CPP benefit will continue. If you continue working, your CPP benefit will discontinue. If within the next five years you are unable to continue working for the same medical reasons (related to HIV), your reapplication will be fast-tracked. However, the new amount may be readjusted to reflect your latest earnings.

Private insurance plans

Each insurer and individual insurance plan is different with respect to benefits, part-time work policies, and vocational rehabilitation. We recommend you obtain a copy of your specific policy and determine what your options are. Your choices may include working part time and receiving a top-up to your benefit rate from the insurance company. Some policies may suspend benefits if you are working at all, so it is extremely important to understand your specific policy when making a decision.

We have not addressed benefits such as Schedule C and living subsidies in this article. We could not cover every eventuality, but we can help you gather the correct information.

We understand that returning to work can be an intimidating and frightening process. Before you make a decision, be sure that you have the correct information. We are available to answer any questions. Please do not hesitate to contact us at the BCPWA Society at (604) 893-2244. ⊕

Lisa Kallio (l) is a Vocational Rehabilitation Counsellor with Orion Health. Gweneth Crook (r) is an Employment Specialist with IAM Cares. They both work with individuals with HIV/AIDS who are considering a return to work or school.

treatment information

Does herpes accelerate HIV infection?

by Meaghan Byers

Researchers have studied the links between HIV and herpes for more than two decades. Early in the HIV epidemic, a persistent herpes infection was one of the first signs of HIV infection. By the late 1980s, scientists were postulating that somehow these two viruses interact at the cellular level in a way that results in a more efficient transmission of HIV and possibly even an increased rate of HIV replication. The scientific evidence to support this later hypothesis is still accumulating, but enough evidence already exists to cause concern for several reasons.

The herpes virus remains in the body after initial infection. It is incurable and can flare up causing recurrent active disease and symptoms when the body is under stress or the immune system is weakened. For a long time, it was common knowledge that HSV-2, spread through sexual contact, was the culprit behind genital herpes. HSV-1, a far more common form of herpes that is spread through saliva or nasal secretions, was believed to only cause cold sores. As much as 70% of the population has HSV-1, and for most people, the virus remains dormant. Now researchers know that you can get genital herpes from oral sex with a person who is having an episode of cold sores. Similarly, you can also get a cold sore from performing oral sex on a person who is having an outbreak of genital herpes.

Recent evidence suggests that more than 50% of genital infections among men are caused by HSV-2, while almost half of genital infections among women are caused by HSV-1. For those HIV-positive people who still have a healthy immune system, the frequency of outbreaks is no different than among HIV-negative people with either herpes virus. However, once the immune system becomes compromised by HIV infection, herpes outbreaks are often more painful, more frequent, and seldom clear up spontaneously.

Herpes and HIV

HSV-2 herpes is the most common sexually transmitted disease (STD) among people with HIV. In fact, in the last few decades, it has increased in prevalence by 30% among the general population. For those people who contracted HIV through sexual activity, the prevalence of HSV-2 is even higher, with 60% to 80% of people with HIV having it. For this reason, the possibility that HSV-2 can interact with HIV and potentially accelerate the progression of HIV is very disturbing.

That herpes outbreaks are more frequent and severe in HIV-positive people is

TREATMENT INFORMATION PROGRAM MANDATE & DISCLAIMER

In accordance with our mandate to provide support activities and facilities for members for the purpose of self-help and self-care, the BCPWA Society operates a Treatment Information Program to make available to members up-to-date research and information on treatments, therapies, tests, clinical trials, and medical models associated with AIDS and HIV-related conditions. The intent of this project is to make available to members information they can access as they choose to become knowledgeable partners with their physicians and medical care team in making decisions to promote their health.

The Treatment Information Program endeavors to provide all research and information to members without judgement or prejudice. The project does not recommend, advocate, or endorse the use of any particular treatment or therapy provided as information. The Board, staff, and volunteers of the BCPWA Society do not accept the risk of, nor the 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.

not a big surprise considering the nature of HIV. The body normally controls herpes outbreaks with the part of the immune system affected by HIV. When HIV weakens the immune system, the dormant herpes viruses are more likely to start causing trouble. When T-cell counts are below 50, recurrences are more severe and prolonged and the ulcers may even develop secondary infections. Infections become more frequent and more painful and the chance of spreading both viruses increases.

HSV-2 and the transmission of HIV

Convincing evidence demonstrates that HIV is transmitted to someone with herpes more efficiently during an outbreak of genital herpes, possibly as much as 3–5 times more efficiently. Two biological aspects of genital herpes support this hypothesis. First, genital ulcers cause a mucosal disruption, which may allow entry of HIV. Second, genital herpes lesions attract activated CD4 cells that act as target cells for HIV attachment.

Studies also suggest that transmission of HIV is more likely to occur from a person who has genital ulcers, although this route has been harder to study. When HIV and HSV-2 are both present in the body, each herpes sore is chock full of both HSV-2 and HIV particles. Scientists believe this viral boom occurs because the body creates billions of new T-cells when it responds to the herpes outbreak. These T-cells in turn release billions of HIV particles that are manufactured by the body every day. Research shows that HIV shedding from genital herpes lesions is frequent. Therefore, scientists believe that higher levels of HIV virus during a herpes outbreak may make HIV even more infectious during these times. For this reason, HSV-2 appears likely to facilitate transmission of HIV to uninfected sexual partners.

HSV-2 and the progression of HIV

To make matters even worse, evidence is accumulating to support the hypothesis that recurrent flare-ups of HSV-2 virus somehow cause an increase in HIV replication, possibly accelerating the progression of HIV. While the scientific studies conducted to date are inconclusive, researchers have good reasons to believe a causal link exists. Several in-vitro laboratory studies have indicated that certain regulatory HSV proteins can increase the rate of HIV replication. In addition, both HSV-2 and HIV can co-infect CD4 cells, suggesting that these viruses may interact frequently in vivo. Several clinical studies have shown that opportunistic infections, or other means of immune activation (such as pneumocystis carinii pneumonia, bacterial pneumonia, tuberculosis, or immunizations) can stimulate HIV replication and, at least transiently, increase viral load. Herpes seems to have a similar effect. Evidence shows that plasma HIV viral load increases in people who have recurrences of genital herpes.

Studies have shown that during acute outbreaks of herpes infection, the amount of HIV RNA increases substantially in the genital lesions. One study, involving analysis of swabs taken from lesions of twelve men co-infected with HSV and HIV, found the herpes sores were loaded with HIV particles as well as HSV. High amounts of HIV RNA were found in people with both high and low plasma HIV RNA levels, meaning that the amount of virus in the lesions was not related to the amount found elsewhere in the body. The amount of HIV RNA remained at high levels until the sores healed. These bursts of HIV virions that accompany genital lesions may also help to explain how a herpes outbreak increases the chance of transmission of HIV.

THERE IS CONVINCING EVIDENCE THAT HIV IS TRANSMITTED TO SOMEONE WITH HERPES MORE EFFICIENTLY DURING AN OUTBREAK OF GENITAL HERPES.

Implications

The results of such studies are extremely important for preventing the spread of both herpes and HIV and for protecting the health of people who are already co-infected. The incidence of herpes infections continues to increase and the highest prevalence of herpes is among persons with HIV. Detection and treatment of genital herpes appears to decrease the rates of HIV infection and offers survival benefits to those who are infected with both viruses.

Use of acyclovir, an antiviral medication used to treat herpes, is associated with increased survival in HIV-infected persons. Studies indicate that acyclovir may slow the progression of HIV disease by preventing reactivation of HSV. The suppression is also believed to offer the additional benefit of reducing T-cell activation. Highly active antiretroviral therapy (HAART) medications do not prevent recurring outbreaks of herpes, though outbreaks do appear to be less frequent and severe.

Consensus has not been reached on using antiviral medications to suppress HSV in HIV-positive patients. Routine use of HSV-specific antiviral therapy is not yet recommended as part of the medical regimen of co-infected people. However, it may prove to be warranted to suppress herpes among people with HIV, if evidence of the acceleration of HIV in the presence of herpes continues to accumulate. Given that the vast majority of HSV-2 infections in the US are both unrecognized and untreated, a lot of people not only have an increased risk of getting HIV, but, for those with HIV, herpes is a potentially deadly addition to the mix. ⊕

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

Staying a step ahead of Darwin

Overcoming drug resistance

by Paul Kerston

The advent of highly active antiretroviral treatment (HAART) regimes, or drug cocktails, has given many people with HIV/AIDS renewed hope and new leases on life. For those who had exhausted the relatively few drugs available before HAART, it has given them a greater sense of security. Still, treatment failure is always a concern, as is the possibility of viral load levels climbing and CD4 counts dropping because of drug resistance.

HIV drugs are divided into three classes: six protease inhibitors (PIs), six nucleoside reverse transcriptase inhibitors (NRTIs), and three non-nucleoside reverse transcriptase inhibitors (NNRTIs). All these drugs impede the lifecycle of the virus in its attempt to take over healthy cells for reproductive purposes. No virus can replicate itself without a host and HIV is no exception. In the course of daily replication, HIV produces thousands of mutant stains as a result of replication error. Normally these mutant viruses yield to the superior wild-type virus that makes up the dominant population. This happens because wild-type virus is the fittest, meaning its ability to replicate is superior to the mutant strains. However, in the presence of HIV drugs that suppress wild-type viruses but not necessarily all of the mutant strains, a mutant quasi-species may supplant wild-type HIV as the dominant strain present in an individual patient.

According to the BC Centre for Excellence's Dr. Richard Harrigan in his paper "Genotypic Tests for HIV Drug Resistance," an estimated ten billion virion (single viruses) are reproduced each day within a single human. Most of these virion are genetically identical copies of wild-type HIV. However, about ten million naturally occurring genetic errors happen every day, resulting in mutant strains of virus. In the absence of genetically selective drug pressure, these mutant strains yield to the fitter and therefore dominant wild-type HIV. However, when wild-type virus is prevented from replicating by drugs, resistant mutants can break through and replicate in the right circumstances.

Sometimes, a single mutation confers resistance, as in the case of 3TC and NNRTIs. For PIs and NRTIs, more than one mutation is required for high levels of resistance. The location on HIV genomes (the complete set of genes in the chromosome of each cell) of the many mutations that cause drug resistance has been studied. On average, one mutation at every position in the genome must occur hundreds of times per day.

Two types of tests are used to detect mutations and the resulting effectiveness of drugs against HIV. Genotypic testing involves looking for specific mutations in the genome which are thought to confer lower susceptibility to specific drugs. Phenotypic testing directly tests specific drugs in lab cultures. In his paper, Harrigan also states that "genotypic changes in the HIV-1 genome can determine the appearance of phenotypic resistance.… So the genotype can be considered an early warning."

WHEN WILD-TYPE VIRUS IS PREVENTED FROM REPLICATING BY DRUGS, RESISTANT MUTANTS CAN BREAK THROUGH AND REPLICATE IN THE RIGHT CIRCUMSTANCES.

Given the importance of potential treatment failures, one must question when genotyping is indicated. Currently, genotyping is done when viral load exceeds 1,000 copies/mL, partly because genotyping is not normally successful below that figure. Guidelines suggest the individual should still be on therapy when tested, but the reason for testing is the failure of those particular drugs. In future, if drug-resistant HIV is routinely being transmitted, testing could occur before initiating therapy. This is not current practice.

If you are a PWA, ask your physician if genotypic testing is suitable for you. While there may be some reluctance before initiating treatment, there should be none when switching therapies. The current maxim of hitting hard on the first round makes it imperative to seek optimal second- and third-line drugs when that need arises.⊕

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

Long–term survivors

Mutant viruses, diverse genes, and a bit of luck

by Ken Rosenthal and Paula Braitstein

photo Lynn Copeland

"Outwit, outplay, and outlast" may be the credo of the television show "Survivor", but when it comes to surviving HIV for the long haul, it's a different ball game. The course of HIV infection is highly variable from one infected individual to another, with some people rapidly progressing to AIDS and death and others surviving for more than a decade without any evidence of disease progression. A small proportion of infected individuals—estimates run from less than 5% to 10%—are characterized as long-term non-progressors (LTNP) or long-term survivors (LTS). Generally, these are HIV-infected individuals who, in the absence of treatment, have low or undetectable viral load levels, higher and relatively stable CD4 T-cell counts, and have no symptoms or are free from AIDS-defining illnesses for over 10 years.

WHEN IT COMES TO DEALING WITH DISEASE, BEING A MUTT IS BETTER THAN BEING A PUREBRED.

Identification of LTNPs has led to comparisons with persons with different rates of disease progression (especially rapid progressors) in order to better understand the various genetic, viral, and immunological factors associated with control of HIV infection. Knowing these factors could help doctors identify individuals at low risk of progression, for whom early therapy may be inappropriate, and will help in the development of HIV vaccines and treatments.

Immune and virologic features of LTNPs: concerns and characteristics

Unfortunately, researchers have no standardized definition for LTNPs. This variation makes it difficult to compare studies. Not surprisingly, the results of many studies of LTNPs are questionable because too few patients were examined or they were compared to inappropriate control groups. One of the strictest definitions for LTNPs came out of the Vancouver Lymphadenopathy AIDS study, which identified only 1% of 239 HIV-infected individuals as non-progressors.

Although the strictness of the definition may vary, generally LTNPs have plasma viral loads below detection and infectious virus is hard to extract from their blood cells. Despite these conditions, the virus is replicating in their lymph nodes, but the structure of the lymph nodes, known as the lymph node architecture, remains preserved and capable of being the immune system's headquarters. (In people who develop AIDS, their lymph node architecture becomes destroyed, preventing the immune system from fighting any longer.) The virus infecting LTNPs usually replicates slowly, is not able to bind cells together (also called non-syncytial-inducing or NSI), and uses chemokine receptor 5 (CCR5) as its co-receptor to infect cells.

Immunologically, long-term survivors usually have stable and higher numbers of CD4 T-cells (usually greater than 500/mm3) and maintain strong CD4 helper T-cell responses to HIV. CD8 T-cell counts also tend to be higher. The CD8 cells are capable of strong killer T-cell activity and are able to recognize a wide range of HIV antigens expressed on infected cells. CD8 T-cells from LTNPs are also able to prevent HIV replication within a cell without actually killing the host cells. (Please see the November/December 2001 issue of Living+ for a more complete description of the role of CD8 cells). Although it has been argued that many LTNPs have high amounts of neutralizing antibodies against HIV, these antibodies do not appear to play a significant role in slowing disease progression in these people.

Generally, LTNPs have a broad range of immune responses to HIV. However, it is hard to determine whether these strong HIV-specific immune responses are responsible for the slow progression or simply reflect a largely undamaged immune system.

Australia and mutant viruses

The Sydney Blood Bank Cohort is a group of long-term survivors who became infected through the Sydney Blood Bank in Australia. This group of eight individuals was infected after transfusion from a common donor whose HIV contained a dele-

tion in the nef gene, an important HIV gene. After more than sixteen years of infection, three of the living members of this group still have stable CD4 counts and undetectable viral loads. Recently, though, the original donor was diagnosed with AIDS and started antiretroviral therapy.

The findings in this group of individuals are similar to monkeys infected with mutant strains of simian immunodeficiency virus (SIV) that lacked the nef gene. These monkeys do not show signs of immunodeficiency, and they are protected against infection with normal HIV.

Although being infected with nef-deleted or genetically altered HIV may be associated with slow progression, a recent study found only 4% (3 of 70) of LTNPs infected with HIV contained deletions in the nef gene. Thus, infection with mutant HIV only accounts for a small proportion of LTNPs.

It's in the genes: mutts and mutant co-receptors

Most immune responses are genetically controlled. The most important human genes involved in the regulation of the human immune responses are called the Human Leukocyte Antigens (HLA). These genes and their products play a central role in determining exactly which antigens, such as bacteria and viruses, can be presented to the T-cells of our immune system. Therefore, it is not surprising that several studies have examined whether an association exists between HIV disease progression and the type of HLA. Indeed, certain HLA types, notably HLA-B35 and HLA-Cw04, were consistently associated with rapid progression to AIDS. In contrast, the presence of others, namely HLA-A3, HLA-B14, HLA-B17, and HLA-DR7, have been associated with low rates of HIV disease progression. In a study using a more strict definition of LTNPs, 85% (11 of 13) LTNPs were found to be HLA-B*5701 positive while only 9.5% of progressors (19 of 200) had this gene.

Genetic diversity gives a population survival advantage. At an individual level, the more diverse a person's HLA type, the more likely they are to survive an infection. In other words, when it comes to dealing with disease, being a mutt is better than being a purebred. When a person has a greater variety of HLA, their T-cells can recognize and make immune responses to a broader variety of antigens. A recent study showed that individuals who inherit the largest diversity of HLA types and who lack the HLAs associated with rapid HIV progression have significantly slower progression to AIDS.

LONG-TERM SURVIVORS USUALLY HAVE STABLE AND HIGHER NUMBERS OF CD4 T-CELLS AND MAINTAIN STRONG CD4 HELPER T-CELL RESPONSES TO HIV.

In addition to the role of HLA in long-term survival, attention has focused on human genes that enable HIV to enter human cells in the first place. One of the major "doorknobs", or co-receptors, that HIV uses to enter a cell is called chemokine receptor 5 (CCR5). A mutated form of CCR5 is found in Caucasians, but not in people of African or Asian descent. Interestingly, individuals who have this mutant gene for CCR5 (CCR5D32) show slower HIV disease progression and develop AIDS-defining illnesses much later. The lower number of doorknobs for HIV to bind to and infect cells likely accounts for this slower progression. A recent study from a French research group showed that by analyzing both doorknob genes (chemokine co-receptors) and HLA genes, they could accurately predict 70% of HIV-infected individuals as LTNPs and 81% as progressors. Their results show that the combined host genetic background of an individual strongly influences HIV disease progression.

Co-infection with hepatitis G virus

Individuals infected with HIV are often co-infected with other viruses. Co-infection with hepatitis B virus (HBV) or hepatitis C virus (HCV) increases mortality among HIV-infected people, and the course of HCV is faster in HIV-infected patients. Some unexpected reports have shown that people who are infected with both HIV and GB type virus C/hepatitis G virus (GBV-C/HGV) have slower progression of disease and longer survival compared to people who are not co-infected. How or why this happens is not yet understood.

Conclusions

The remarkable survival of a small percentage of untreated HIV-infected individuals continues to raise important questions. Immunologic, virologic, and genetic studies of LTNPs have begun to reveal the reasons why some individuals have slower rates of disease progression. Many of these reasons appear to be genetically determined, but there is still room for chance. Hopefully researchers will one day find the means to ensure all people with HIV are LTNPs, irrespective of their genetic background. ⊕

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

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.

If I take antiretroviral therapy during my pregnancy, will it have any side effects in my baby?

Expecting and Concerned

Dear Expecting and Concerned,

The antiretroviral drugs used to decrease mother-to-infant HIV transmission include combinations of drugs in pregnancy, zidovudine (AZT) during labour and delivery, and oral zidovudine to the infant for the first six weeks. This very difficult treatment course has had a major impact on the rates of HIV infection from mother to infant. Before the use of therapy in 1994, one in four infants born to mothers with HIV disease were infected. Using AZT alone in all phases of therapy, the rate dropped to one in twelve. Since 1997, the use of combinations of drugs (highly active antiretroviral therapy, or HAART, with three drugs) has lowered the rate to less than one in fifty.

All drugs have some side effects. Some are short-lived, lasting from days to weeks, but others may have longer term effects that last for months to years. Infants exposed to antiretroviral drugs during the pregnancy, at delivery, and during the first six weeks may show some short-term problems with lower counts of red cells (anemia) or white cells in the blood. These lower blood cell counts highlight the importance of conducting blood tests at birth and at two and four weeks of age so that therapy can be stopped if the infant is showing side effects. If treatment is stopped, the blood counts return to normal within weeks.

In 1994, a study began that compared children exposed to AZT in pregnancy with children not exposed to AZT. Six years later there was no difference in the growth, development, or immunity between the two groups. We continue to study all the infants exposed to antiretroviral therapy.

Since 1997, combinations of drugs are routinely used in pregnancy and thus far, very few significant long-term adverse effects have been observed. Two years ago, a report from France indicated that in a study of hundreds of children born to mothers who had therapy in pregnancy, seven children had evidence of mitochondrial toxicity (problems with the cells respiratory system) and two infants had died from brain problems. A study of 20,000 HIV mother-infant pairs in the US revealed that 223 infants died, but not from the same problems seen in the French study.

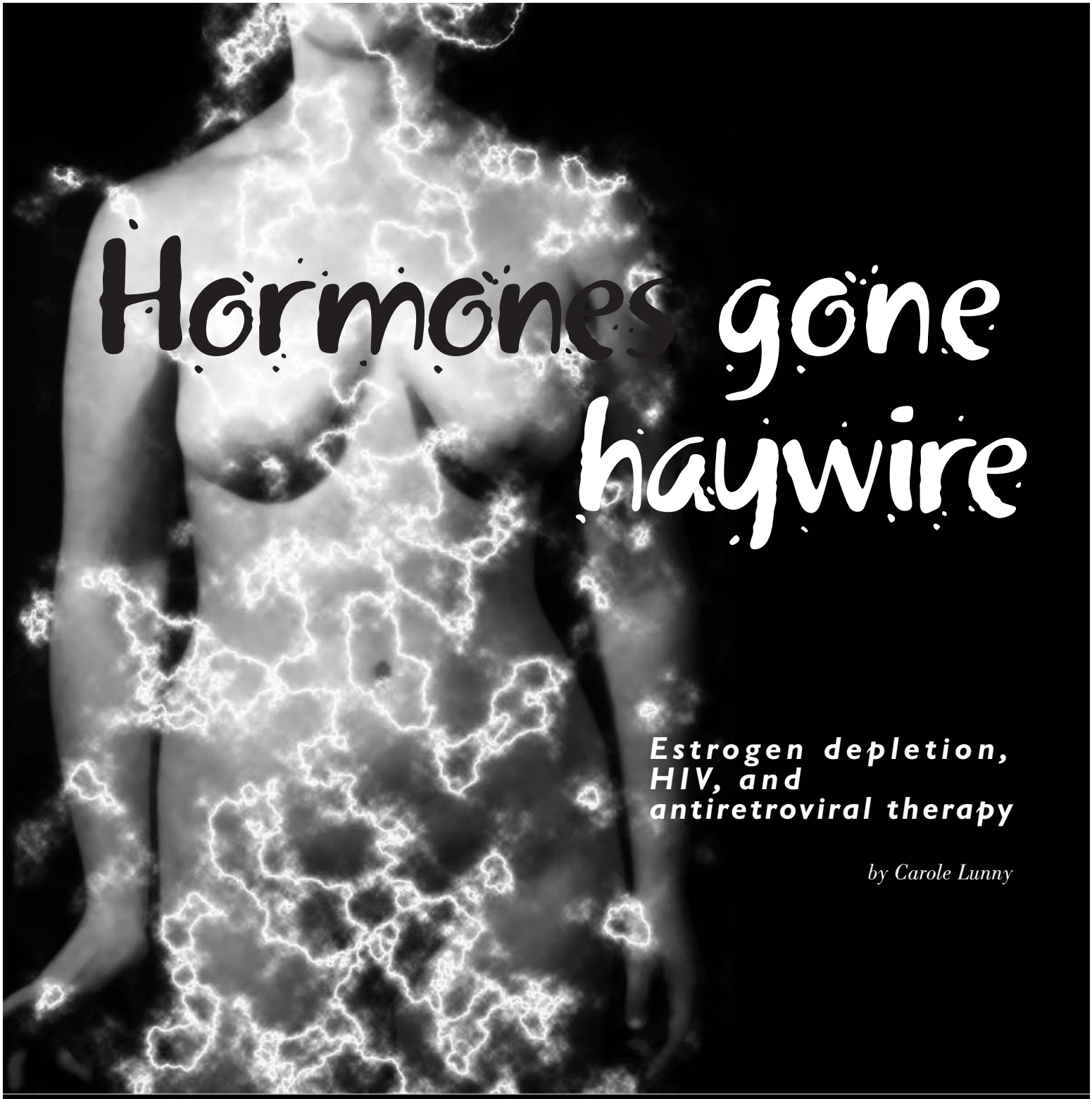
These cases demonstrate the importance of long-term studies to detect adverse effects that may develop later in life. To have meaningful data, the larger HIV centres in Canada, the US, and Europe need to actively work together to detect problems as early as possible. This co-operation is now happening, and aside from the few cases from France, no other long-term adverse effects have yet been identified.

In summary, antiretroviral therapy plays an essential part in treatment during pregnancy and drastically reduces the risk of HIV transmission from mothers to their infants. Some minor early side effects can occur, but these are temporary. Long-term adverse effects are very rare, but we need to collect data from all infants exposed to these medications in order to ensure that we can detect any problems as early as possible.⊕

Dr. Jack Forbes

Dr. Jack Forbes is a Paediatric Infectious Disease Specialist. He is Co-director of Oak Tree Clinic (Women and Family HIV Centre) at the Children's and Women's Health Centre of British Columbia.

Send your questions to:
Ask the Doctor, Living + Magazine, 1107 Seymour Street, Vancouver, BC, V6B 5S8 fax: 604-893-2251
email: askthedoctor@parc.org



Hormones gone haywire

Estrogen depletion, HIV, and antiretroviral therapy

by Carole Lunny

Healthy estrogen levels have been linked not only to the regulation of the immune system, but to healthier immune responses in HIV-positive women. Drug interactions with antiretroviral therapy (ART) may lower a woman's natural estrogen levels and adversely affect oral contraceptives. In some cases, it may lower artificial estrogen levels. Low hormone levels may be attributed to gynecological problems in women with HIV. These include anemia, menstrual disorders, early menopause, weight loss, gynecological infections, decreased sex drive, headaches, fatigue, energy loss, pregnancy issues, and loss of bone density.

One study linked estrogen depletion with HIV transmission. The study examined results from animal studies and concluded that after ovulation, when estrogen levels are low and progesterone levels are high, the incidence of HIV infection is greater. When estrogen treatment was administered, monkeys injected with SIV (simian immunodeficiency virus) were not infected.

Another study by the Municipal Health Service in Amsterdam, presented at the 8th Conference on Retroviruses and Opportunistic Infections last year, concluded that the decline of estrogen in post-menopausal and pregnant women might be associated with lower CD4 cell counts. Since levels of reproductive hormones differ between men and women, this link between estrogen and CD4 counts might explain gender differences in CD4 counts.

Several studies have examined the relationship between dehydroepiandrosterone (DHEA) and HIV. DHEA is a hormone produced by the adrenal glands, located on top of the kidneys. It is a steroid that can be transformed into testosterone, estrogen, or other steroids. Several studies have found that DHEA increases levels of IL-2, a chemical messenger that increases the production of CD4 (T-helper) cells and the ability of CD8 (T-killer) cells to destroy infected cells. DHEA might help to normalize the immune system. Another study concluded that a positive relationship existed between the immune status of patients with HIV-related illness and DHEA, leading to the hypothesis that low levels of DHEA may worsen immune status. Further studies concluded that DHEA levels are low in HIV, lower in AIDS progression, and higher in AIDS non-progressors.

PROTEASE INHIBITORS DECREASE THE LEVEL OF ESTROGEN AMONG WOMEN RECEIVING HORMONE REPLACEMENT THERAPY OR ORAL CONTRACEPTIVE PILLS.

Estrogen deficiency has been implicated as a risk factor in the development of severe neurodegenerative diseases and estrogen replacement may result in improvement of cognitive function.

Additionally, estrogen has extreme potent effects on the immune system, as evidenced by the increased prevalence of autoimmune disorders in women and by immunity during pregnancy. Further exploration is needed on the role of estrogens in the physiological control of the immune system and how estrogen affects HIV.

Protease inhibitors and estrogen depletion

Interactions between hormones and HIV therapy are a particular concern. Hormones and antiretroviral drugs interact with medications that are metabolized in the liver, including certain antibiotics, diphenylhydantoin, barbituates, bronchodilating agents, corticosteroids, and protease inhibitors.

Protease inhibitors decrease the level of estrogen among women receiving hormone replacement therapy (HRT) or oral contraceptive pills (OCP). They might also decrease the natural levels of estrogen in women.

With nelfinavir and indinavir, estrogen and progesterone levels decrease. With ritonavir only, estrogen levels decrease. If these antiretrovirals are being used, alternative contraception use is recommended. Women should also be aware of decreasing levels of estrogen and progesterone.

Oral contraceptive pills are also prescribed to regulate fluctuating hormone levels and irregular menstrual cycles. OCP contain relatively high amounts of artificial hormones, and increasing the dosage might cause problems such as increased risk of breast cancer, gallbladder disease, uterine cancer, and other side effects.

Loss of bone density, hyperthyroidism, cervical dysphasia, PMS, endometrial carcinoma, endometreosis, fibrocystic breast disease, headaches, ovarian cysts, and pelvic inflammatory disease have been associated with hormone imbalance and low estrogen and progesterone levels.

Estrogen therapy should always be balanced with sufficient progesterone levels. Estrogen dominance also brings with it related problems, such as breast, ovarian, and uterine cancers. Progesterone is used to balance estrogen and may be helpful in these three female hormonally dependent cancers. However, currently there is no research on the subject.

Estrogen levels go up and down during the course of a monthly cycle. For an accurate measurement of estrogen levels, you have three tests taken, in the first week of your cycle (when you are menstruating) followed by a test two weeks later and another four weeks later. These are taken with a simple blood draw. Some researchers suggest also looking at markers of pituitary function. Pituitary hormones stimulate progesterone and estrogen production.

Hormone replacement therapy and antiretroviral therapy

HRT is used to regulate menstrual flow and manage menopause or early onset menopause or PMS. It is also used to stabilize or reverse body composition changes. Those symptoms that may be attributed to low hormone levels may be alleviated or prevented by using HRT. However, some low hormonal level problems may not be treated with HRT, such as protease inhibitor interactions. Other options include using natural estrogen and progesterone creams. Progesterone cream is usually prescribed as the first treatment for hormone regulation. The artificial progestin has side effects that include sore and swollen breasts, dizziness, drowsiness, headaches, nervousness, backaches, and depression. Natural progesterone cream, sold without a prescription in the US, has not been regulated yet in Canada and is therefore not available.

The use of HRT has been linked to an increased risk of breast cancer and uterine cancers. In post-menopausal women, HRT has been linked to a decreased risk of heart disease and osteoporosis. Alcohol markedly increases estrogen levels for women who are on HRT.

Alternative therapies

Nutrition, herbs, supplements, exercise, and phytoestrogens

Table 1. Interactions between antiretroviral therapy (ART) and oral contraceptives

ART	Interaction	Percentage of increase or decrease	Dosage of oral contraceptive
Indinavir (Crixivan)	Moderately increases ethinyl-estradiol in the blood	24% increase in ethinylestradiol and a 26% increase in norethindrone	Change not necessary
Nevirapine (Viramune)	Significantly decreases ethinyl-estradiol levels in the blood	N/A	Increase in dose or alternative method of birth control recommended
Nelfinavir (Viracept)	Significantly decreases ethinyl-estradiol levels in the blood	47% decrease and norethindrone decreased by 18%	Increase in dose or alternative method of birth control recommended
Ritonavir (Norvir)	Significantly decreases ethinyl-estradiol levels	40% decrease	Increase in dose or alternative method of birth control recommended
Efavirenz (Sustiva)	Increases ethinyl-estradiol levels in the blood	Increase by 37%; has been shown to be a teratogen (an agent that can cause malformations of an embryo or fetus) in animal models	Not known whether a dose modification is necessary
Zidovudine	Ongoing study	N/A	Use alternative contraception
Saquinavir	Longer periods may occur; may lead to anemia	N/A	Use alternative contraception
Delavirdine	No data	N/A	Use alternative contraception
Amprenavir	No data	N/A	Use alternative contraception

Adapted from www.projectinform.org/fs/gyn.html

(compounds found in plants that produce estrogen-like effects in the body) are used as alternative therapies in maintaining healthy hormone levels.

Eating fresh, unrefined foods including fruits, vegetables, whole grains, soy products, beans, seeds, nuts, olive oil, and cold water fish (salmon, tuna, sardines, halibut, and mackerel) is important. Avoid alcohol, refined sugar, dairy products, and caffeine. Drink lots of water and avoid food sensitivities.

Eating a diet rich in phytoestrogens is equally important. Isoflavones and lignans are two kinds of phytoestrogens. The richest source of isoflavones is soy products. It has been determined that 50–150mg per day of isoflavones is sufficient intake. The major isoflavones of soy are genistein, daidzein, and glycitein.

ESTROGEN HAS EXTREME POTENT EFFECTS ON THE IMMUNE SYSTEM, AS EVIDENCED BY THE INCREASED PREVALENCE OF AUTOIMMUNE DISORDERS IN WOMEN.

Lignans are phytoestrogens that are modified by intestinal bacteria into compounds that have estrogen-like activity. Flaxseeds have 100 times more lignans than any other food. Flaxseed oil contains little if any lignans. Flaxseeds are inexpensive and when ground, provide fresh oil, protein, fiber, mucilage, some vitamins and minerals, and lignans. The recommended dosage is 2–4 tablespoons of ground flaxseed per day. Drink plenty of fluids in combination.

Vitamin B6 is recommended at 50–200mg daily. Women taking OCP and HRT often have low levels of B6. Evening primrose oil is associated with regulating hormonal fluctuations. The recommended dosage is 1500–3000mg daily. One hundred milligrams of gamma-oryzanol, three times a day, has been known to reduce side effects of low estrogen, including hot flashes. Vitamin E at 400–800 IUs per day has a similar effect.

Many researchers believe that black cohosh may act like a phytoestrogen by binding to estrogen receptor sites. Aside from occasional mild gastrointestinal distress, there are no side effects. Black cohosh may be incompatible with HRT, so you should consult with your doctor before taking it.

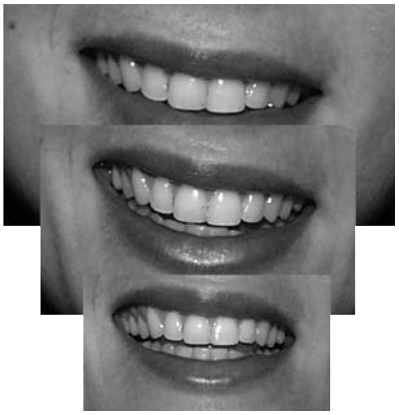
It may take two to three weeks to notice any significant results from herbs. Among herbs, licorice helps to support the adrenal glands that produce low levels of estrogen and progesterone. Red clover is a high source of isoflavones. Wild yam regulates the ratio of progesterone to estrogen. Chasteberry is taken for problems associated with hormonal changes and may prevent osteoporosis and reproductive cancers. Other herbs that may help include blazing star, dong quai, ginkgo biloba, ginseng, and motherwort.

Exercise and a balanced diet may be a regulator for hormones. Physical exercise should include aerobic activity, strength building, and flexibility exercises.

Maintaining healthy and balanced hormone levels may have greater importance to women who are HIV-positive than previously thought. Further research still needs to conducted. ⊕

Carole Lunny is the Outreach Coordinator for the BCPWA Society's Treatment Information Program.

Say cheese!



Problems with your mouth or teeth can make it difficult to get proper nutrition

by Jennifer Epp

Do you smile for the camera or are your lips suctioned together in all your photos? Whether or not you hide your pearly whites, they have additional benefits other than helping you put your best face forward. These little treasures help in the first steps of digestion and, therefore, play an integral role in your overall physical health.

When food enters your mouth, special glands produce saliva. Saliva contains mucus that lubricates the foods and enzymes that help break down carbohydrates (sugars and starch).

By chewing, you use your teeth to break up solid food into smaller, more manageable pieces. Having smaller pieces means there is more surface area, which makes it easier and faster for the digestive enzymes to do their job. Smaller pieces also make it easier for food to travel down the esophagus (the passage from mouth to stomach) to the next stages of digestion.

For people who are HIV-positive, maintaining oral and dental health is particularly important. Many PWAs need to ensure that they are getting proper nutrition in order to prevent weight loss, allow for healing, and help boost the immune system. However, for some it can be a struggle to meet requirements for vitamins, minerals, proteins, and calories. One of the barriers to getting enough food is having problems with your mouth or teeth. It's important to know what to do if you are currently suffering from mouth or dental problems and how you can prevent these problems from occurring in the future.

PERIODONTAL DISEASE SUCH AS GINGIVITIS MAY PROGRESS AT A FASTER RATE IF YOU ARE HIV-POSITIVE.

Keep in touch with your dentist

You should tell your dentist about your HIV status, even if you are concerned that you may be refused care. There are important reasons for disclosing this information. First, people with HIV have the right to a dental care environment that's safe and secure. You want to be sure that you won't be exposed to health risks at the dentist's office, and you want to ensure that you are not putting your dental providers at risk.

As well, your dentist may also be able to detect a problem in your mouth that a physician might miss. Periodontal disease such as gingivitis, for example, may progress at a faster rate if you are HIV-positive. If you have a white patch in your mouth, you may require a biopsy sooner than if you were HIV-negative.

In addition, as part of your healthcare team, your dentist needs to be aware of the medications you are taking so that he or she does not prescribe a drug that doesn't mix well with your HIV drugs.

It is recommended that you see your dentist twice a year for an oral examination and evaluation.

Preventing future problems

As a preventative measure, oral hygiene is particularly important for people who are HIV-positive, according to Dr. Sean Sikorski at the Portland Community Clinic. Routine oral hygiene involves daily brushing and flossing. Occasional use of a fluoride rinse may also be required to help arrest or prevent dental cavities.

Watch out for open sores or abscesses (infections) in your mouth. A tooth that is cracked or has a deep cavity can cause damage to the dental pulp, the soft core of the tooth, resulting in an abscess. An abscess is a very serious dental condition and requires immediate treatment. In most cases, the abscess can be effectively treated. However, if the infection is left untreated, it can destroy the bone around the tooth and eventually the tooth will have to be removed.

Oral health and nutrition

Diet and nutrition have a direct influence on the progression of tooth decay. In addition to regular brushing and flossing, you can be proactive in preventing oral health problems by the choice of foods you eat. Eating foods high in sugar is a major contributor to

dental decay. If you choose to eat sugary foods, you should eat them in combination with other foods at meals. Eating a combination of foods causes the stimulation of saliva, which helps to wash away food debris and, in turn, prevent damage. If you drink oral nutritional supplements between meals and you're not able to brush your teeth afterward, try to rinse your mouth with water after you finish the supplement.

Protect your teeth. Rather than snacking on chocolate bars, pop, candy, and donuts, eat foods that are lower in sugar, such as fresh fruits and vegetables, nuts, hard-boiled eggs, herbal teas, sandwiches, soups, cheese, and yogurt.

Nutrition and difficulties in chewing

If you are having difficulty chewing due to dental problems, you can still meet your nutritional requirements. Some people may be able to meet their requirements by modifying the texture of their food. Others who have more difficulty consuming an adequate amount of food or liquids may have to rely on homemade or commercially prepared oral supplements (nutrient- or calorie-dense beverages).

If you have trouble chewing, try some of the following tips:

- Eat small amounts frequently to help get enough calories and nutrients.
- Cut food into small pieces before using a blender or food processor.
- Mix equal parts of solids and liquids when blending to help to get the right texture.
- Use liquids such as gravy, vegetable juice, cream soups, cheese and tomato sauces, milk, and fruit juices when blending to increase the nutritional value, colour, and flavour of foods.

After blending foods, freeze leftovers immediately and use refrigerated portions within 48 hours.

Use the ideas from Tables 1 to plan for meals when you are unable to chew.

If you have difficulty chewing or you are awaiting dental care or recovering from a dental procedure, get in touch with your local dietitian or nutritionist to discuss your individual nutritional requirements and how you can best meet your needs. ⊕

Jennifer Epp, RDN, is a Community Nutritionist for the Vancouver/Richmond Health Board and a member of Vancouver Dietitians in AIDS Care.

Table 1: Mechanically altered diet

Food groups	Foods recommended	Foods not recommended
Beverages	Milk; malted milk, milkshakes; coffee, tea; carbonated beverages; hot cocoa.	Any containing raw eggs
Breads	Soft bread, pancakes, muffins without nuts or seeds, waffles; stuffing; breads and plain crackers softened in soup or beverage	Crisp rye, whole wheat crackers; popcorn; chow mein noodles; taco shells; cake and breads with nuts, seeds, raisins or dates; pita bread; rye or pumpernickel bread with seeds; bagels; French or sourdough bread
Cereals	Cooked cereals without added fruit or nuts; plain dry cereals softened in milk	Any with seeds, dried fruits, raisins or nuts; shredded wheat, granola, Grape-Nuts® or cereal that remains crunchy in milk
Desserts	Plain custards, pudding; sherbet; ice cream; fruit-flavoured ice and frozen pops; fruit whips; yogurt; gelatin; cakes and soft cookies without nuts and fruits	Any with coconut, seeds, nuts, or whole or dried fruits; fried, tough or chewy items
Fats	Butter or margarine; cream and cream substitutes; cooking fats and oils; smooth sauces and gravies; whipped topping; salad dressing, mayonnaise	Olives; nuts; seeds; bacon
Fruits	Cooked or mashed ripe fruits without seeds or skins; applesauce; mashed bananas; cantaloupe; stewed prunes; fruit cocktail, canned peaches or pears; watermelon with seeds removed; fruit juices	Citrus fruits, blueberries, cherries, grapes, pineapple, apples; dates, figs, dried prunes, raisins
Meat and meat substitutes	Soft, cooked meat and poultry with gravy or sauces added to moisten; soft, flaked fish without bones; casseroles made of ground meat; meatloaf; legumes in a mashed and moist form; tofu; smooth peanut butter; soft cheeses, cottage cheese, cheese sauces; scrambled eggs and egg substitutes	Dry or tough cuts of meat or poultry; fried fish, fish with bones; hot dogs; sausage, knockwurst, bratwurst; pork chops; steak; crunchy peanut butter; hard cheeses
Potato or substitute	Mashed, baked, or creamed potatoes, sweet potatoes; rice or noodles;	Hashbrowns, fried potatoes; potato skins; French fries
Soups	Broth, bouillon, consommé, blended strained soups; any made from allowed food items; cream soups	Any with chunks of meats and crunchy vegetables
Sweets	Clear jelly; honey; sugar; sugar substitutes; syrup	Any with coconut, nuts, or whole or dried fruits; granola bars; pies; chewy candy; hard, crunchy cookies; licorice; taffy; caramel
Vegetables	Well-cooked, soft vegetables without skin or seeds; mashed carrots; beets; finely chopped, cooked greens; mashed squash; vegetable juices	All others
Miscellaneous	Seasonings [eg. salt and pepper]; ground spices; smooth condiments	Nuts, coconuts, seeds

Bottoms up

Alcohol may make you feel good, but heavy drinking can wreak havoc on your body

by Diana Peabody

People worldwide have enjoyed and abused alcohol for a long time. Many cultures ferment various indigenous plant materials to produce some type of alcoholic beverage. In some religions, alcohol is banned altogether as evil, while other religions use it in sacred church rituals. People typically drink alcohol to relax, to party, to decrease stress, to combat depression, or to share a meal or intimate moment. Though drinking is commonplace and accepted, it has a downside. Alcohol use can take a heavy toll on a person's health, family, social well-being, and financial situation. Heavy drinkers are malnourished, have more accidents, miss more work, and often make poor choices in high-risk situations.

How alcohol affects the body

Alcohol is rapidly absorbed into the bloodstream through the stomach and intestines. It goes to the liver to be metabolized and causes changes in the central nervous system (brain). One or two drinks cause euphoria, relaxation, and a feeling of reduced anxiety. Three to five drinks leads to impaired motor coordination and sometimes increased aggression. With ten to thirteen drinks, you will feel sedated and possibly have memory loss and blackout.

How quickly you feel the effects of alcohol depends on how fast it is absorbed and how your body handles it. People have a different capacity for alcohol based on gender, body size and build, genetics, and liver function. It also depends on how fast you drink, if you drink regularly, and what you eat when you drink. Absorption is speeded up by an empty stomach, a large volume of alcohol at one time, hot drinks, stress, drinking before noon, and carbonated beverages. Fatty or spicy foods, gastritis, nausea/anxiety, and cigarettes slow absorption down.

Mouth and esophagus:

Heavy drinking increases the risk of getting cancer of the mouth, throat, and esophagus, especially with smoking tobacco. People who drink also have more problems with reflux (heartburn) because the esophagus is not as efficient at getting food into the stomach or keeping it there.

Stomach, small intestines, and pancreas:

At-risk drinkers have more gastritis because alcohol damages the protective lining of the stomach. Heavy drinkers are more likely to have malabsorption and diarrhea because of changes in the small intestine and are at risk of developing pancreatitis.

Liver:

The liver is the major metabolic factory in the body. It is responsible for metabolizing, storing, and transporting food and nutrients, breaking down medications, and detoxifying toxic substances. If the liver is damaged, the effects are widespread. Because the liver is the main site of alcohol detoxification, it is significantly affected by drinking. Detoxifying requires two main enzyme systems. The speed at which alcohol can be detoxified depends on the amount of enzymes that are available to do the job. Some people have low levels of these enzymes and either become drunk quickly or become flushed. Most people can metabolize about one drink per hour.

Alcohol is directly toxic to the liver cells and consumption of about two drinks a day for women and three drinks a day for men greatly increases the risk of developing alcoholic liver disease. As alcohol is metabolized, cytokines, free radicals, and other toxic substances are produced. These substances decrease the liver's ability to properly metabolize fats, carbohydrates, proteins, and vitamins/minerals. Major changes occur in the way fats are handled, often leading to a rise in serum triglycerides and accumulation of fats in the liver (fatty liver). Fatty liver is reversible if alcohol is avoided altogether. However, continued drinking could cause liver disease to progress to alcoholic hepatitis or cirrhosis, which is not reversible.

Alcohol and health

HIV/AIDS:

Alcohol decreases immune function, and heavy drinkers, even those who are HIV-negative, can develop alcohol-induced immunodeficiency. In alcoholic liver disease, a decrease in the number of T-cells occurs and the immune cells do not function properly. Free radicals and cytokines produced by alcohol metabolism may further impair the immune system, and they appear to be toxic to the liver mitochondria. Alcohol can also worsen the negative effects that antiretroviral medications have on the liver or pancreas. This worsening effect occurs with all HIV medications, but the ones to be especially careful about are ritonavir, efavirenz (Sustiva), delavirdine, nevirapine, ddI, abacavir, and 3TC.

Other Medications:

Alcohol should be avoided with many other medications, including acetaminophen (Tylenol). Be sure you are aware of interactions between alcohol and the medications you are taking.

Classifying drinking behaviour

Beyond low-risk drinking, drinking behaviour falls into four general classifications.

At-risk drinking:

At risk of having health problems from drinking: More than 14 drinks per week for men (seven for women) or more than four drinks (three for women) on one occasion more than once a week

Harmful drinking:

A pattern of drinking that has caused physical or mental damage.Can occur with more than 2–4 drinks per day for men (1–3 for women)

Alcohol abuse:

You met at least one of the following in the past 12 months:
Continued alcohol use despite recurring problems
Recurrent use in hazardous situations
Failure to fulfill major role obligations
Recurrent legal problems

Dependent drinking:

You meet at least three of the following:
Tolerance; Withdrawa; Loss of control; Compulsion to drink; Progressive neglect of alternate activities, Increased time spent on obtaining alcohol or recovering from use; Persistent drinking despite evidence of harm

One drink is equal to 12 ounces of beer or 5 ounces of wine or 1 ounce of hard liquor.

The CAGE test

The CAGE test can help you evaluate your drinking habits. One positive answer may indicate a drinking problem.

Have you ever felt you should cut down on your drinking?
Have people annoyed you by criticizing your drinking?
Have you ever felt bad or guilty about your drinking?
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

Hepatitis:

Alcohol should be completely avoided by people with hepatitis. Liver disease could progress more rapidly to cirrhosis, which increases the risk of getting liver cancer.

Cardiovascular disease:

One or two drinks a day reduces the risk of getting heart disease, increases HDL, the good cholesterol, and may decrease blood pressure. However, more than two to four drinks per day increases blood pressure (hypertension), triglyceride levels, and the likelihood of having a stroke.

If you are on HIV medications and have a high triglyceride level or hypertension, the health risks of drinking probably outweigh any benefits. Be aware that smoking and drinking together dramatically increase the chance of getting high blood pressure or heart disease.

Malnutrition:

At-risk drinking usually results in nutritional deficiencies due to poor diet, malabsorption, and depletion of the body's vitamin stores. This situation is made worse if the liver is damaged and cannot metabolize nutrients properly. Alcoholics typically suffer from B vitamin, folate, vitamin C, and zinc deficiencies. Food choices when drinking are usually not very healthy ones, and although an adequate amount of calories may be consumed, protein, vitamins, and minerals are usually lacking. Malnutrition is particularly detrimental to the immune system and may hasten HIV progression.

Osteoporosis:

Heavy drinking increases bone loss because it has a negative effect on bone and calcium metabolism. Alcohol also may have a direct toxic effect on osteoblasts, which are the bone cells that are incorporated into the bone.

Women:

Women get intoxicated more quickly because they are generally smaller and have less body water to dilute alcohol. They also tend to have less of the enzymes needed to break down alcohol. Women tend to get alcoholic liver disease more easily and it can progress more quickly. They may experience menstrual problems, depression, and have a greater chance of getting breast cancer. At-risk female drinkers often experience more violence in their lives. Alcohol should be completely avoided during pregnancy or when trying to become pregnant. Drinking while pregnant can cause serious life-long health problems for the child, as well as complications in the pregnancy.

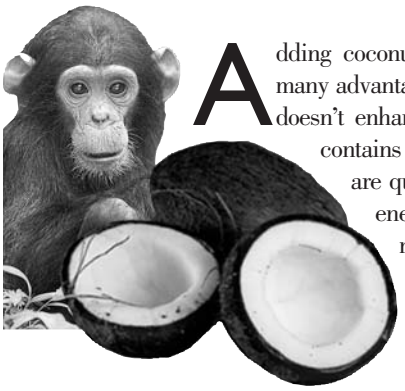
The bottom line

- Know your drinking habits. Heavy, harmful, or dependent drinking has serious long-term health hazards. If you are an at-risk drinker, take steps to decrease alcohol consumption.
- Alcohol can increase stress on the liver caused by antiretroviral medications. If you are on therapy, consider whether you really need to drink. If so, limit it to one drink per day. If your liver function tests are already high, do not drink at all.
- If you have hepatitis, do not drink at all.
- If you are pregnant or trying to get pregnant, do not drink at all.
- Alcohol may worsen high triglyceride levels. If you have a high triglyceride level, avoid alcohol or limit it to a few drinks per week.
- Consume alcohol with food, drink slowly, and limit yourself to two drinks per day (one per day for women). Drinking one drink a day is better than drinking all seven drinks at one time.
- Make sure you stay well nourished and take a multivitamin to prevent nutrient deficiencies. ⊕

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

Going ape over coconuts

by Tom Mountford



Adding coconut products to your diet may have many advantages. Coconut oil is a neutral oil that doesn't enhance or suppress immunity. Coconut contains medium-chain triglycerides which are quickly absorbed and turned into fast energy, not stored as fat. In fact, the medium-chain triglycerides have a fat-burning effect. One gram of fat provides twice as many calories as either 1g of protein or carbohydrates.

Almost 50% of coconut oil is lauric acid, which is one of the principal fats in human breast milk. It protects a baby's intestines until the child's immune system is capable of protecting them on its own. Foods with lauric acid help to maintain the integrity and health of the digestive tract as well as fight and kill a range of pathogens. Lauric acid, an inactivating fatty acid, converts to monolaurin in the small intestines. This powerful yet safe antimicrobial inactivates microbes by disrupting their lipid membranes.

ANECDOTAL INFORMATION INDICATES THAT PEOPLE ON AND OFF HIV THERAPIES EXPERIENCE SIGNIFICANT VIRAL LOAD REDUCTIONS WHEN TAKING COCONUT OIL.

A small clinical trial in the Philippines compared HIV viral load responses using monolaurin or coconut oil. One group ingested one tablespoon of coconut oil three times a day. Two other groups took different dosages of a monolaurin supplement. Over 50% of the participants in the study had reduced viral load levels and one-third had a favourable increase in their CD4/CD8 ratios. Overall, the coconut oil group appeared to do as well as or better than the groups taking monolaurin.

Increasing anecdotal information indicates that people on and off HIV therapies experience significant viral load reductions when taking coconut oil. They added 3–4 tablespoons of coconut oil to their daily diet to yield 25g of lauric acid a day. Mark Konlee of Keep Hope Alive is collecting data from individuals' experiences in order to study monolaurin further.

Recent studies on mice combined fish oils (good for lowering triglyceride levels) with natural, unrefined coconut oil. The results showed decreased levels of inflammatory cytokines, tumor necrosis factor (high levels are associated with wasting), and interleukin-6, while stimulating production of anti-inflammatory cytokines such as interleukin-10.

Coconut oil contains about 8% caprylic acid, which is a remedy for intestinal yeast infections such as candida. Caprylic acid also shows significant activity against herpes simplex, chlamydia, and HIV-1.

The daily dose of 25g of lauric acid (4 tbsp. of coconut oil) can be ingested in many ways. Coconut oil can be used on hot cereal, rice, potatoes, beans, or pasta; to sauté vegetables; mixed with peanut butter; as salad dressing with lemon juice; or in blender drinks. A cooked egg yolk helps the oil to emulsify in the blender. Coconut milk can be added to drinks and pancakes and used in baking (4oz=11g lauric acid).

One half-cup of desiccated coconut or shredded fresh coconut yields 11g and 6g of lauric acid respectively. Other good sources of lauric acid from coconut are macaroons and certain ice creams. The fat digestive enzyme lipase may increase its effectiveness. Light coconut milk contains very little lauric acid.

Warning: Do not consume coconut, fresh or dried, with Crixivan (indinavir). Dried coconut could also aggravate digestive problems. ⊕

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

Getting an annual bus pass and on DBII?

If you are on Disability Benefits Level II, and you are applying for an annual bus pass, please see AIDS Vancouver access case management for assistance. AIDS Vancouver will pay $25 toward the $45 annual fee.

Call the AIDS Vancouver Access Office for more details at 604.893.2270.

Stopping prophylaxis

by Amanda Armer

Prophylaxis is the use of drug therapy to prevent opportunistic infections (OIs) that take advantage of a weakened immune system. Primary prophylaxis attempts to prevent a first occurrence of an OI. It is only administered if CD4 cell counts fall below a certain level and the patient is deemed at risk. Many OIs only occur when a CD4 cell count falls to a certain level. Secondary prophylaxis is administered to prevent OIs from recurring and is commonly known as maintenance therapy. This therapy consists of giving smaller doses of the drug used to treat the disease, and like primary prophylaxis, is only prescribed when the CD4 cell count is at a risk level.

In recent years, prophylaxis has been overtaken by highly active antiretroviral therapy (HAART), which experts now believe is the best way to prevent OIs. As a result, HIV patients can discontinue prophylaxis for some diseases if they have a good response to HAART, meaning an increased and sustained CD4 count. Despite the less frequent occurrence of OIs, they are still a real threat.

For several years, the US Public Health Service and Infectious Diseases Society of America (USPHS/IDSA) guidelines for the prevention of OIs in persons infected with HIV have suggested that it may be safe to stop prophylaxis for some diseases when CD4 and T-cell counts have increased to recommended levels.

Among those diseases, general research shows that for pneumocystis carinii pneumonia (PCP), it is safe to discontinue both primary and secondary prophylaxis if a CD4 count is sustained and stable above 200 for three months or more.

Cytomegalovirus (CMV) is a herpes virus. Infection usually occurs at a young age and remains buried in the body, occurring generally when CD4 count is less than 50. Studies reveal that stopping prophylaxis for CMV is successful and the disease stays away for longer periods when a sustained CD4 count is present.

Mycobacterium avium complex (MAC) is caused by bacteria found in contaminated water, food, and soil. It is also known as mycobacterium intracellulare (MAI). This disease becomes a risk when the CD4 count is less than 50. Prophylaxis can be discontinued when a CD4 count is above 100. Treatment should restart if CD4 count falls below 50.

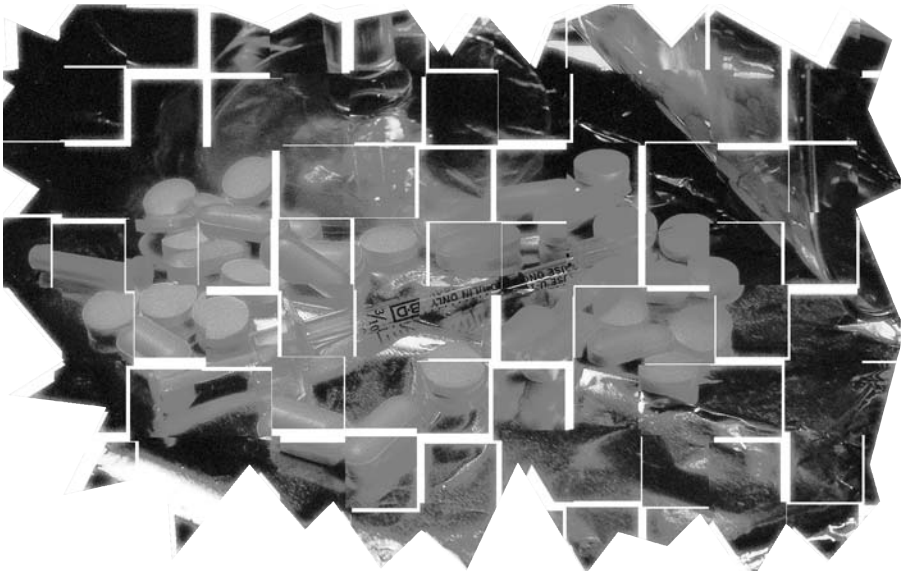
Toxoplasma gondii is a parasite found in cat feces, soil, and contaminated meat. Therefore, use caution if handling raw meat or cleaning cat litter. Toxoplasmosis commonly occurs when a CD4 count is lower than 100, but prophylaxis can be discontinued if the CD4 count increases and is sustained at a level higher than 200.

Stopping prophylaxis is not a straightforward decision. Many mitigating factors must be considered, including individual immune recovery, consideration of viral load, probability of CD4 decline, seriousness of disease, and current expert research. In situations where HAART fails, prophylaxis may need to be restarted.

There are advantages and disadvantages to prophylaxis. It will only be administered if there is a real risk of infection, since prolonged use of prophylactics can cause problems such as drug resistance or toxicity. Still, there are many benefits to discontinuing prophylaxis, including a decreased pill burden, simplified treatment regimen, reduced cost of treatment, and the reduced possibility of drug interactions.

If you and your doctor decide to stop your prophylaxis, remember to learn the early warning signs of different OIs, so that you can promptly get it treated in case of disease. ⊕

Amanda Armer is a Researcher with the BCPWA Society's Treatment Information Program.



Treating addiction: the options and challenges

by Thomas Kerr

Substance use occurs in cultures throughout the world. People have long been ingesting a variety of substances in the quest for altered consciousness. While substance use continues in a relatively safe fashion for many individuals, for others substance use can result in significant harm. One obvious indicator is the high number of HIV infections that have occurred among people who inject drugs. For people living with HIV/AIDS, substances that were once not a problem may become intolerable or eventually cause considerable harm. Indeed, the interactions between recreational drugs, HIV/AIDS, and antiretroviral therapies are complex and much research and education is needed to address these problems. (For a detailed discussion, check out "drug interactions" under the "treatment" link at www.thebody.com).

Many terms are used to describe substance use that leads to harm, including "problem substance use" and "addiction". According to the Addictions Task Force in BC, problem substance use "is use or involvement associated with physical, psychological, economic or social problems or which constitutes a risk to health, security, or well-being or well-being of individuals, families and communities." Addiction, however, is defined as "a primary and chronic disorder with genetic, biopsychosocial, spiritual and environmental factors that influence its development and manifestation" and is "characterized by a loss of control, preoccupation with disabling substances or behaviours and continued use or involvement despite negative consequences." Whatever the preferred language, substance use can become problematic and lead you to seek help.

The challenges of seeking help

While most experts agree that addiction is a health issue, many people still view problem substance use as a reflection of moral weakness. Seeking help for addiction can be extremely challenging for those who have been already stigmatized because of social or health conditions such as homelessness or HIV/AIDS. Accessing support for addiction can be further complicated by the difficulties associated with navigating the service system. Identifying an appropriate service or support is no easy task, and choices are often limited.

One source that can help is the *Directory of Addiction Services in British Columbia*, produced by the Kaiser Foundation and the Ministry for Children and Families. A free copy of the directory is available at any regional office of the Ministry for Children and Families, and online versions are available at www.kaiserfoundation.ca. Another source of information is the Alcohol and Drug Information and Referral Service at 604-660-9382 (Lower Mainland) and 1-800-663-1441 (outside the Lower Mainland).

Available services and support in BC

In British Columbia, addiction services and support for adults are broken into categories that are designed to address particular types of treatment needs:

Outpatient treatment: Outpatient treatment is offered in most municipalities and involves initial assessment, referral to other services, and various forms of counselling and support. This type of service is a good place to start when first trying to figure out how to address a substance use problem.

Outpatient treatment is generally appropriate for people with stable living environments. Withdrawal management or detoxification programs are designed for people who want to become free of intoxicating substances and include medical and non-medical support to help reduce the worst physical effects of withdrawal. Support for detoxification is given to people in their homes or established facilities. Day programs are intensive therapy groups that individuals attend every day for four weeks and are generally offered to people

who have stable living arrangements and a social support network.

Residential treatment: Residential treatment involves intensive live-in group therapy for 4–6 weeks and is suitable for people who lack stable housing and require a safe environment well away from drugs. The approaches used within these services vary somewhat, and while many use group therapy formats based on modified 12-step programs, others include forms of individual counselling and expressive arts therapies.

Recovery houses: Several unregulated recovery houses also exist throughout the province. These services provide an alternative environment for people needing time away from drugs and typically involve regular house meetings. The majority of recovery services employ an abstinence-based, spiritual, 12-step approach that encourages people to work through a series of steps beginning with the acknowledgment of a higher power and the admission that one is powerless. Because these recovery facilities are not regulated, they vary in quality. Those interested are encouraged to question both the operators and residents about the living conditions.

Methadone maintenance: Methadone maintenance is a form of substitution therapy used to reduce the harms associated with heroin use and is overseen by the BC College of Physicians and Surgeons. Methadone is administered under strict guidelines and the care of a physician. Needle exchange programs fall under addiction services and include the provision of sterile syringes, bleach kits, and referrals to drug treatment. These types of programs are essential to reducing needle-sharing and the spread of HIV among injection drug users.

SEEKING HELP FOR ADDICTION CAN BE CHALLENGING FOR PEOPLE WHO ARE ALREADY STIGMATIZED BECAUSE OF SOCIAL OR HEALTH CONDITIONS SUCH AS HOMELESSNESS OR HIV/AIDS.

Private counsellors and therapists: Many private counsellors and complementary therapists also offer treatment for substance use, although typically clients bear the costs of these services.

Support groups: Various mutual support groups, including Alcoholics Anonymous and Narcotics Anonymous, provide programs that typically use variations of the 12-step approach.

Special programs: A few programs designed specifically for pregnant women and the dually diagnosed (e.g., people living with substance use problems and mental illness) are also available.

While it appears as though there is an array of services for people with substance use problems, many shortcomings exist in the provincial addiction care system, particularly in availability, accessibility, and scope. The provincial Ministry for Children and Families emphasized this point in a review of addiction services for children and families that stated that the "impact of the lack of adequate resources cannot be overstated. The simple fact is: there is not enough of anything, there are waiting lists for everything and we are chronically under-serving many. There is not only a need for more of the same, but new and innovative approaches need to be developed to attend to emerging trends and issues."

Low threshold programs

Perhaps what are most urgently needed are low threshold programs. Threshold refers to the eligibility criteria for entrance into programs and the state of readiness of individuals to participate and meet the demands of the various programs. High threshold programs, such as intensive residential treatment, typically demand strict attendance and require that participants are completely abstinent from drugs and alcohol. Medium threshold programs have less strict requirements and include services like outpatient treatment. Low threshold programs such as needle exchanges and safe injection facilities aim to reduce drug-related harm while requiring little commitment from participants.

Low threshold services tend to reduce harm (such as keeping people alive, reducing the spread of disease) among people who continue to use substances. Given the ongoing spread of HIV, hepatitis C, and fatal overdoses among people who use drugs, it is evident that more low threshold services are needed. A review of local addiction services indicates that most programs are high or medium threshold and, therefore, are primarily available to those who are able to meet program demands and show up at set appointment times. Furthermore, research from the US and Switzerland shows that medium and high threshold services only attract 5–20% of all active drug users. This raises the question of what we should do for the other 80–95% of people who use drugs.

Substance use problems affect people using drugs and alcohol, their families, and communities. Seeking help for a substance use problem is not always easy. Problems of stigmatization, access, availability, and scope, all pose barriers to care and support. Further, it is clear that more should be done to help those people who are at risk for extreme forms of drug-related harm. In order for this to happen, society and the system of care may first have to change their view of what is really a very old and very common problem.⊕

Thomas Kerr is a community health researcher and a doctoral student in educational psychology at the University of Victoria.

Recruiting HIV trials address urgent questions

by Jim Boothroyd

How do we boost immune systems? How can we reduce the toxicity and increase the tolerability of antiretroviral drugs? How do we treat people who are no longer responding optimally to conventional therapies? These are three of the questions addressed by the following clinical trials currently recruiting at the Canadian HIV Trials Network (CTN).

To find out more about these trials, please visit the CTN Web site (www.hivnet.ubc.ca/ctn.html) or call 1-800-661-4664.

Immune-boosters

The ESPRIT (CTN 110) trial is evaluating the effects of giving an immuno-reconstituant called recombinant interleukin-2 (rIL-2) to HIV-infected people with CD4 cell-counts of at least 300/mm^3. In BC, the research is being conducted at Cool Aid Community Health Centre in Victoria.

SILCAAT (CTN 145) is assessing whether or not rIL-2 makes a difference in slowing the progression of HIV infection in seropositive people who have been on at least two antiretroviral agents for the last four months, with CD4 cell counts between 50 and 299 cells/mm^3. The BC research site is Providence-St.Paul's Hospital in Vancouver.

Toxicity and tolerability

CTN 124 is examining the effectiveness of therapies containing and not containing protease inhibitors in people recently infected with HIV. The BC research site is the Downtown Infectious Diseases Clinic (IDC) in Vancouver.

CTN 148 (Gender Differences in Lipodystrophy Syndrome) is described in the sidebar.

The DAVE (d4T or Abacavir plus Vitamin Enhancement) trial, CTN 169, is assessing both the effectiveness of switching from d4T to abacavir and the effectiveness of taking vitamin supplements (riboflavin and thiamine) in combination with d4T and abacavir in normalizing lactic acid levels. The BC research site is Providence-St.Paul's in Vancouver.

CTN 161, the Simplified Protease Inhibitor Trial, is testing the effectiveness and safety of simplified dosing schedules for two protease inhibitor therapies (saquinavir and ritonavir, and indinavir and ritonavir) for HIV infection. The BC research sites are the Canadian biotechnology company Viron Therapeutics and Providence-St. Paul's, both in Vancouver, and Cool Aid Community Health Centre in Victoria.

Rescue therapy

The first major controlled study of planned drug holidays (also known as structured treatment interruptions or STIs) is CTN 164. Eligible volunteers must have a viral load between 1,000 and 500,000 copies/mL despite being on a combination antiretroviral therapy that includes a protease inhibitor or a non-nucleoside reverse transcriptase inhibitor. The BC research sites are Downtown IDC in Vancouver and Cool Aid Community Health Centre in Victoria.

The most ambitious trial ever undertaken in Canada is OPTIMA (Options in Management with Antiretrovirals), CTN 167. The trial is examining a variety of strategies—standard antiretroviral therapy (ART) and mega-ART with or without structured treatment interruptions—for treatment-experienced individuals who are no longer responding optimally to conventional combination therapies. The trial aims to enroll 1,700 patients in the United Kingdom, the United States, and Canada over the next two and half years. The BC research sites are Providence-St. Paul's and the Downtown IDC in Vancouver and Cool Aid Community Health Centre in Victoria. ⊕

Jim Boothroyd is Programme Head, Communications and Information, at the Canadian HIV Trials Network.

Women needed

An innovative clinical trial examining differences in the way women and men are affected by lipodystrophy is seeking women volunteers.

CTN 148 (Gender Differences in Lipodystrophy Syndrome) will compare changes in lipid levels, glucose levels, and body composition between men and women after one year and again after two years of antiretroviral therapy containing a protease inhibitor.

To enter this study, you must be about to start a therapy with a combination of drugs containing a protease inhibitor. Previous treatment with a protease inhibitor is not allowed.

"The importance of this trial is that it is forward-looking and will show how the problem is and the rate at which changes develop in men and women," says principal investigator Dr. Sharon Walmsley of Toronto Hospital.

This observational trial is recruiting at four sites in Quebec and Ontario.

Sugestiones alimenticias para controlar la nausea

by Ramón Hernández

La nausea se puede controlarse con medecinas (prescribidas por su doctor) y con algunos ajustamiéntos en la selección de los alimentos. Las sugestiones sugerencias subrayadas aqui le ayudaran a mantener una alimentacion adecuada en presencia de la nausea.

Para controlar su nausea

Trate de tomar liquidos a intervalos muy frequentes: Una toma adecuada de liquidos le ayudara a mantenerse bien hydratado y asentara su estomago. Los liquidos siguientes en general son bien tolerados.

- bebida carbonadas (gingerele, etc.)
- jugos de frutas (algunas veces disueltos con agua)
- sopas claras (consome, caldos etc.)
- leche (leche descremada, leche de chocolate, y o otras variaciónes)

Algunas comidas tienen un alto contenido de liquido y eso puede contribuir a su toma cotidiana de liguidos. Algunos produstos alimentarios con alta concentración de liquidos que son géneralmente bien tolerados incluyen los siguientes:

- Jello (gelantina)
- paletas de hielo
- sorbetes
- leche fria
- costardas
- pudines
- yorgur
- cereales cocidos (avena)
- nieve

Pequeñas raciones: Quizas usted se sienta mejor con una pequeña cantidad de comida en su estomago. Para comenzar el dia trate de comer pequeñas raciones cada media hora. Los alimentos para comenzar su dia deben ser secos o almidonados, por exemplo:

- galletitas crakers
- cereales secos
- arros blanco
- pan tostado
- batones de pan seco
- "noodles" instantaneos

Una vez que la nausea se pase, usted puede introducir una variedad más grande de alimentos, y aúmentar el tamaño de las porciones, progresandos hasta comer seis veces al dia con bebidas entre comidas. Algunas alimentos que son genéralmente bien tolerados incluyen los siguientes:

- cereales con leche
- sopas de arros o noodles
- quezo cottager
- frutas enlatads
- quezos y galletas (crackers)
- 1/2 sandwich

Bebidas (sodas o refrescos), de futas aveces se toleran mejor, una ves que estos ya son abiertos durante unos minutos y pierden lo gazeoso.

Evitar ciertas formas de prepación de limentos: Si el olor de la comida, cuando esta se esta preparando o cociendo, hace que empeore la nausea. Consecuentemente trate de evitar la cocina cuando la comida se esta preparando. deje que los alimentos caliente se enfrien a una tempreatura mediana antes de servidos. Si usted mismo prepara sus alimentos, selecciónе alimentos que pueden comerse frios o compre comida ya lista para comerse.

Evalue su condición diariamente: Si el problema con la nausea le perciste a pesar de medecinas contra la nausea y siguiendo esta sugerencias, mencionelo a su doctor o enfermera para ver si es necesario tratar otras medidas que quiza,en su caso particular le sean más utiles. ⊕

Ramón Hernández is a Treatment Counsellor for the BCPWA Society's Treatment Information Program. Información sobre tratemientos anti VIH via correo electronico nuestro e-mail es treatment@parc.org

The Buzz from HepHIVE

Alcohol and hepatitis

by Ken Winiski and Bill Firby

At HepHIVE, we tell people that alcohol is one of the worst substances they can consume and that they should be careful even using small amounts of it. Alcohol is one of the most toxic substances to the liver: compared to most other recreational substances, alcohol causes the most liver damage. That does not mean, however, that other recreational substances are not harmful to your body.

Alcohol, in itself, is not the substance that actually harms the liver. Rather, the metabolic byproduct is responsible for most of the damage. The liver converts alcohol to acetylaldehyde, then to acetate, and then to carbon dioxide and water. It is the intermediate compound, acetylaldehyde, that can cause the most damage to the liver. During the formation of this compound, free radicals are thought to be generated. These free radicals deplete the body of antioxidants and can damage liver cells.

Having a liver virus or using powerful antiviral drugs also depletes the body of antioxidants, and the combination of the two may accelerate liver damage. Some alcohol is also broken down by the cytochrome P450 system, which may affect the metabolization of other drugs and thus raise or lower the blood levels of those drugs. Alcohol can be metabolized through mitochondrial pathways, which may already be weakened through long-term use of antiretrovirals.

Liver damage can increase the time it takes to metabolize alcohol. This slowed rate of processing can enable alcohol to cause greater damage to other tissues in the body. The metabolization of alcohol creates an excess of hydrogen equivalents in the liver, which can lead to a number of metabolic disturbances, including lactic acidosis, ketoacidosis, hyperuricaemia, and glucose imbalances. These conditions may already be present as a result of side effects from liver disease and highly active antiretroviral therapy (HAART). So limiting alcohol intake is prudent for people on HIV therapy.

If you have a disease like hepatitis, are co-infected, or must take drugs such as HAART, your liver may already be weaker than average. Your liver might not be able to deal with the added stress of processing alcohol. Limit your alcohol consumption to one or two drinks at a time. Evidence suggests that people who consume over 50g of alcohol per day, which translates to about three beers, can have rates of fibrosis double those of abstainers with similar health profiles.

Vancouver Native Health Society
Positive Outlook Program

449 East Hastings, Vancouver, BC V6G 1B4
604.254.9949 ext.232
fax 604.254.9948
1.800.994.2437
ken.winiski@hephive.org
darlene.morrow@hephive.org

BRITISH COLUMBIA PERSONS WITH AIDS SOCIETY

BCPWA email listserv

- sent out 2 to 3 times a week
- provides information on recent HIV/AIDS news, developments, and events from B.C. and around the world.

To receive the list, send an email to bcpwa@parc.org with the word subscribe in the subject line of the message.

Project Talk

Why We Ask for Your Member Number

You are being asked for your member number so BCPWA may better plan programs and services to meet members needs. This information is used on a group basis (i.e. how many members access a particular service), not on an individual basis.

There are very few individuals who have access to the membership database. Staff and volunteers hold membership information in the strictest privacy. Membership information is not open to use by other members, organizations or government representatives.

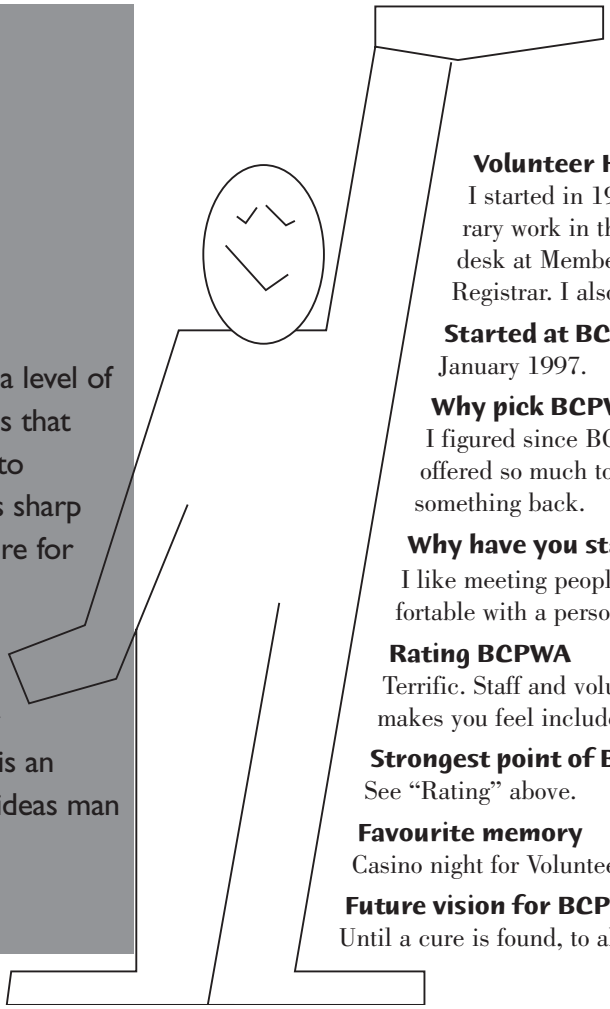
In order to justify funding and assure that we serve all communities, the Board of Directors has asked all departments to collect member information.

Volunteering at BCPWA

Profile of a volunteer: RYAN KYLE

"Ryan brings with him a level of committment and focus that make his contribution to BCPWA invaluable. His sharp attention to detail, desire for efficiency and sense of responsibility are a integral part of the Member and Volunteer Resources team. Ryan is an ideas man and a good ideas man at that!"

CYBELLE RIEBER



Volunteer History
I started in 1997 in the BCPWA lounge. I did temporary work in the Support office, then moved to the front desk at Membership and assisted the Membership Registrar. I also help out at the AIDS Walk.

Started at BCPWA
January 1997.

Why pick BCPWA?
I figured since BCPWA was such a great organization that offered so much to me as a member, that I wanted to offer something back.

Why have you stayed?
I like meeting people, though I am a shy guy until I feel comfortable with a person. Also I like the data entry work.

Rating BCPWA
Terrific. Staff and volunteers all working as one unit really makes you feel included and valued.

Strongest point of BCPWA
See "Rating" above.

Favourite memory
Casino night for Volunteer Appreciation.

Future vision for BCPWA
Until a cure is found, to always be here to help our members.

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

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 January 28.

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.

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

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

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: pride-healthservices@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.

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.

XTRA WEST:
offers free listing space (up to 50 words) in its "PROUD LIVES" Section. This can also be used for "In Memoriam" notices. If a photo is to be used there is a charge of $20.00. For more information call XTRA West at 684.9696.

RESOURCES

PACIFIC AIDS RESOURCE CENTRE LIBRARY:
The PARC Library is located at 1107 Seymour St. (main floor). The Library is a community-based, publicly accessible, specialized collection of information on HIV and AIDS. Library Hours are Monday to Friday, 9 to 5. Telephone: 893.2294 for more information. Information can be sent to people throughout BC.

SUPPORT GROUPS & PROGRAMS

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

HIV-T SUPPORT GROUP:
(affiliated with the Canadian Hemophilia Society). Our group is open for anyone who is either hemophiliac or blood transfused and living with HIV/AIDS. Should you need more information, please call 604.688.8186 (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, education, retreats, social opportunities, referrals, and skills-building opportunities. Cell phone: 808.7209. Office: 688-1441. E-mail: information@youthco.org. Website: www.youthco.com

AIDS GROUPS & PROGRAMS

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

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

AIDS VANCOUVER:
PARC, 1107 Seymour Street, Vancouver, BC V6B 5S8. Phone: 681.2122. Fax: 893.2211. 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 - CHS B. C. CHAPTER:
Many services for Hemophiliac or Blood Transfused HIV+ individuals. HIV-T Support Group. Address: PO Box 78039 N. Side, Port Coquitlam, BC V3B 7H5.

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.

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.island-net.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.

Upcoming BCPWA Society Board Meetings

Date	Time	Location	Reports to be presented
January 9, 2002	3:00	PARC Training Room	Executive Committee / Written Departmental Reports
January 23, 2002	3:00	PARC Training Room	Standing Committee / Written Executive Director Report
February 6, 2002	3:00	PARC Training Room	Director of Support Services Presentation / Written Departmental Reports
February 20, 2002	3:00	PARC Board Room	Executive Committee / Written Executive Director Report
March 6, 2002	3:00	PARC Board Room	Standing Committee/ Written Departmental Reports
March 20, 2002	3:00	PARC Training Room	Director of MVR Presentation / Written Executive Director Report

The Pacific AIDS Resource Centre (PARC) is located at 1107 Seymour St., Vancouver.
For more information, contact:
Katharine McEachern, Manager, Executive Operations
Direct: 604-893-2292
Email: katharin@parc.org

A shadow of his former self

by Denise Becker

As aficionados of climatology know, February 2 is a special date in North America. That's the day that the little albino rodent, that celebrity prognosticator of meteorology, Wiarton Willie, pops his head out of his hole and makes his annual prediction. Will Willie see his shadow? Can we expect six more weeks of winter or an early spring?

In the winter of 1999, my husband Lloyd and I travelled from British Columbia to the Becker family home in Ontario to celebrate my 40th birthday. We were lucky enough to be staying just ten miles from the town of Wiarton, and I was eager to catch my first glimpse of the furry weather wonder. On the morning of February 2, we awoke at 5am and stepped out into the dark on a snowy morning to make our way, along with hundreds of others, to the hallowed turf of groundhogs.

As we drove into Wiarton, the streets were already filled with odd characters that you only see at events like this. Three men from London, dressed up in furry suits and sporting pink pigs' noses, were drinking something other than coffee in their travel mugs. Women danced along the street and wore T-shirts with "I love Willie" logos. Half-asleep children were being ushered by their mothers into the local community hall as a folk band played "I'm Alright" from the movie Caddyshack.

Given the unusual crowd milling around, we were surprised to meet two people we knew from BC—Andrew Tolson and his wife, Mel. We had met Andrew, a photojournalist, three years before when he was looking for an HIV-positive woman for a photo essay for the 1996 World AIDS Conference. That expanded into an award-winning story for the Abbotsford News, as he became part of our family for six months and documented our daily life as a family affected by HIV. Lloyd and I became good friends with Andrew and Mel. Later they moved to Toronto, where Andrew accepted a position with the National Post.

When we spied each other at the Wiarton community hall, there were hugs all around and we all laughed at the coincidence of meeting at this event. Andrew was on assignment for the newspaper. With a quick "Catch ya later," he took off, scurrying around and taking photographs of pilgrims who had made the annual trip from as far away as Kitchener. Occasionally, we saw his head popping up and down among the crowd as he looked for something else to photograph.

Eventually, he came back and looked forlornly at Mel.

"What the hell am I going to do?" he muttered.

Mel sent him off to buy some hot chocolate, and when he was out of earshot, she leaned forward and whispered behind her hand.

"Andrew's desperate. He's been told by his editor he has to find a new angle on the story and nothing's paying off."

The crowd was thinning out and people were making their way outside. We joined them to hear the last strains of "O Canada" played by a piper as the dignitaries arrived. We all stood in chattery excitement staring at Willie's bunker door. The sun began to rise just as a man dressed in a white top hat and tails came to the podium and read a brief, prepared statement.

"It is with great sadness that we announce Willie's death during hibernation...."

A stunned hush fell on the crowd. People looked down and shuffled their feet. A child sobbed.

Suddenly the silence was broken by a distant "Yes! Yes!" We stared across the mourning crowd and picked out a solitary figure, jumping up and down, pumping the air with his fist. "This is going to go national!" Andrew gleamed.

As a distant trumpet played "The Last Post," we hurried to the nearest Tim Horton's. Andrew phoned his office, and we sought directions to the local motel, where Willie's body was being laid in state.

That day, Willie's death was announced in the House of Commons, a country mourned, and one photojournalist was very, very happy. ⊕

Denise Becker, animal lover, is expecting to return to Wiarton on 020202 to see Willie Jr., Willie's albino son, who has answered the call from the wild.