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BRITISH COLUMBIA
PERSONS WITH AIDS
SOCIETY



The British Columbia Persons With AIDS Society seeks to empower persons living with HIV disease and AIDS through mutual support and collective action. The Society has over 3,500 HIV+ members.

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Jeff Anderson, Wayne Campbell, Glen Hillson, Joel NC Leung, Richard McNab, Tom Mountford, Michael Scroda

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Meaghan Byers, R. Paul Kerston, Ramon Hernandez, Glen Hillson, Tom Mountford, Kath Webster

Managing Editor Jeff Rotin

Design/Production Britt Permien

Copyediting Darren Furey

Positively Happening

Kasandra Van Keith

Contributing Writers

Alejandro Alvarado, Denise Becker, Michele Blanchet, Jim Boothroyd, Dr. Jack Forbes, Rob Gair, Enrique Lopez, Janet Madsen, Malsah, Roy Parrish, Diana Peabody, Ron Rosenes, Dr. Ken Rosenthal, Lori Scheckter, Trena White

Photography John Kozachenko,
Britt Permien

Director of Treatment Information
Paula Braitstein

Director of Treatment Information Programming
Angela Guglielmucci

Director of Communications and Marketing
Naomi Brunemeyer

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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

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think+

opinion and editorial

A child's eye view of HIV

by Denise Becker

In 1996, I wrote my first speech on what it was like being the mother of a nine-month-old baby who died of AIDS. Two years later, I stood in front of a class of 16-year-olds and showed them a video of my baby when she was dying. Yet in some ways it was more difficult to write this editorial on what it is like being a child living with HIV/AIDS. How could I possibly express a child's view of HIV?

Leafing through my book *How to Improve Your Photography*, I found a chapter entitled "Finding Your Viewpoint." It states that toddlers are usually photographed from the point of view of a "big person," and it recommended getting down to or below the toddler's height to achieve a more intimate view. That's what I needed to do in this case.

Ultimately, only children and young people themselves can tell us what it means to them to live with AIDS. The challenge is to work with them in a way that respects their views and gives them the freedom to participate on their own terms. The International Declaration of the Rights of the Child states that the child has a right to "express his or her opinion freely and to have that opinion taken into account in any matter or procedure affecting the child."

I asked the HIV-positive child whom I know best to contribute something for this editorial. The child was too busy just being a kid and declined. I respected and supported that decision. Undaunted, I found two Web sites, Unicef and Camp Heartland, with inspirational words written by courageous children infected and affected by HIV/AIDS. Their verbatim

comments convey more than I could ever hope to express.

Susie (Canada) Age 9: *aids caln kill it is killing my sister so keep your self safe*

Damian and Sean (Armenia) Age 12: *I am scared of HiV Me and my best friend are really scared*

Amber (US) Age 13: *doNT BE AFRAID OF PEOPLE W/AIDS CUZ I HAVE IT AND I DON'T LIKE IT WHEN PEOPLE LOOK AT ME DIFFERENTLY.*

Ashley (US) Age 13: *Some day its all going to be ok I know how you feel I lost a father from aids and its not a good thing to see some one in so much pain but someday it all will be ok.*

Augie (US) Age 12: *Hi! My name is Augie. I am 12 years old and am in 6th grade. My older brother and I live in California with our Gram Pam and our Gramp Steve, since our mother passed away in 1992, when she was barely 22 years old..... It's hard to talk about myself or my life without the subject of HIV and AIDS, since it has to do with every part of my life.... I feel like I am a "special" kid and not in a good way. Being "special" ... means always being different.*

I hate having to take 18-20 pills a day and having to have IVIG treatments and needles stuck in me every 3 weeks. I can't even play sports anymore because it makes me too tired and runs my system down too much....

I invite you to read this edition of *Living +* to find out what it means to be a child living with HIV. Crouch down and take the time to see things that only they can see. ⊕

Denise Becker is the founder and former Chair of the Hummingbird Kids Society and a former board member of the BCPWA Society.

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

NEWSREEL



News from home and around the world

BC eliminates HIV/AIDS division

BC's HIV/AIDS Division was a victim of the provincial government's restructuring announcement on January 17. The HIV/AIDS Division administered the funding contracts for provincial AIDS organizations, which will be shifted to the new Regional Health Authority in April.

AIDS organizations expressed concern about the transfer of contracts because the issues of HIV/AIDS exceed geographic boundaries. The same level of services for PWAs may not be available in all areas.

The BC government now has the thinnest force in Canada to lead the fight against HIV/AIDS. The sole remaining staff working for the provincial government will focus on HIV prevention work.

Discovery may lead to improved HIV/AIDS treatment

Canadian Blood Services' Dr. Donald Branch, together with other researchers in Toronto and Winnipeg, has discovered a new protein that helps HIV to infect cells. The protein, called VPAC1, is found on the surface of many cells, including those that can be infected by HIV. This discovery may lead to improved treatment in the prevention of HIV infection.

The research team found that the protein VPAC1, when present, greatly facilitates HIV infection of cells. When very little of this protein is present or when it can be decreased on the surface of the cells, HIV infection is absent or decreased.

The identification of this new protein may be a breakthrough to new approaches to treatment strategies.

HIV/AIDS advisory committee dissolved

The BC government also disbanded the Minister's HIV/AIDS Advisory Committee on January 17. The committee was originally created after community-wide consultation in the mid '90s and was an example of the government's leadership role in responding to the AIDS epidemic.

The committee, composed of stakeholders from across the province, provided guidance based on their collective expertise.

Combined with the shifting of the responsibility of HIV/AIDS to the new Regional Health Authorities, this effectively ends the provincial government's investment in community consultation in HIV/AIDS, and its position as a national leader. This will likely lead to result in an increase in HIV infections, decreased overall health of BC's communities, and long-term fiscal costs.

Heads up! If you receive Schedule C benefits

If you receive Schedule C benefits, you may be required to prove your expenses for your Schedule C Allowance. Please keep your receipts. If you need more information on the list of items included in your award, contact the BCPWA Advocacy Department at 604.893.2223.

Montaner wins \$1 million for AIDS research

Dr. Julio Montaner has been awarded \$1 million for his pioneering work in developing new AIDS treatments. Montaner, Director of Clinical Activities for the BC Centre for Excellence in HIV/AIDS at St. Paul's Hospital in Vancouver, is one of the world's leading experts in the field. Last year, Montaner and his research

team overturned the conventional "hit hard, hit early" practice in antiretroviral drug therapy, making individualized treatment possible.

The international award, from pharmaceutical firm Boehringer Ingelheim, will be used to endow a professorship in health-outcomes research at the University of British Columbia.

New labelling rules for herbal products

Ottawa plans stringent safety regulations for herbal medications and other products. The changes would allow manufacturers to make health claims, provided they are backed by evidence.

The new rules will apply to such herbal preparations as echinacea, ginseng, and St. John's wort. They will also apply to vitamins, minerals, traditional medicines, plants, and homeopathic preparations.

The products will have to be licensed and manufacturers will have to submit detailed information to the government, including the medicinal ingredients, potency, and recommended use.

Labels will include such information as the recommended use and purpose of the product, recommended dosages, health cautions, all ingredients, and potency of the ingredients. The label must also include expiration dates, storage conditions and a description of the source material of the medicinal ingredients.

Source: The Globe and Mail

US reports increases in new AIDS cases

After decreases in reported new AIDS cases every year from 1995 through 2000, from 2000 to 2001, the Centers for Disease Control and Prevention (CDC) reported that AIDS cases went up 8% in



NEWSREEL

News from home and around the world

the US from 2000 to 2001. The declines were 12%, 20%, and 13% in years 1996, 1997, and 1999, respectively. These were shortly after the advent of highly active antiretroviral therapy and protease inhibitors. Without knowing of any official explanations, perhaps the overall benefit waned as adherence and drug resistance emerged.

Source: www.natap.com

Health Canada advises against kava

Health Canada is advising consumers not to use kava or kava-containing products until it has completed a safety review of the herb. Kava and its extracts are commonly used to treat anxiety, nervousness, difficulty falling asleep, pain relief, and muscle tension.

Health Canada issued the advisory because of reports of severe liver damage among kava users in Germany and Switzerland.

Kava has had a relatively good safety

profile in Canada with no cases of liver toxicity being reported in this country. Health Canada advises consumers to “consult with their health care practitioner if they have experienced any adverse effects from taking products containing kava.”

Signs that may be associated with liver problems include jaundice (yellowing of the skin or whites of the eyes), brown urine, nausea, vomiting, unusual tiredness, weakness, stomach or abdominal pain, or loss of appetite.

Source: *CATIE News*

Garlic reduces saquinavir blood levels

A study at the U.S. National Institute of Allergy and Infectious Diseases found that garlic supplements reduced blood levels of the protease inhibitor saquinavir by 51%.

The garlic preparation, an amount equivalent to about two 4-gram cloves per day, was taken for 21 days by healthy HIV-negative volunteers. Then saquinavir

was given for four days, and compared to a baseline four-day saquinavir dosing before the garlic was started.

After a 10-day washout with no saquinavir and no garlic, the volunteers were given a third 4-day dose of saquinavir. Even after 10 days off garlic, the saquinavir blood levels after a third four-day dosing only reached 60-70% of the original baseline blood levels—indicating a persistent effect of the garlic. ⊕

Clarification

In disability benefits article (p.12) in the last issue: if after previously receiving income through CPP, and after returning to work you find you can't continue working, you will be reassessed for CPP. The new amount may be lower. Therefore, the BCPWA Society Advocacy Department cautions PWAs to make informed choices before returning to work.

On January 25, activists staged a rally in Vancouver defending the Canadian healthcare system, to coincide with the premiers' meeting on healthcare reform. Speakers included Jim Sinclair, President of the BC Federation of Labour (pictured below), as well as Shirley Douglas, healthcare activist and daughter of Medicare founder Tommy Douglas, and BCPWA Society Chair Glen Hillson, who spoke on behalf of the BC Health Coalition. Over 1,000 people attended the rally.



photos: britt permien

Buddy Bites



Tools to help you advocate for yourself and others

Can't pay your Income Tax debt?

Is the federal government keeping your GST cheque?
Is the stress of your debt hurting your health?

Canada Customs and Revenue Agency has a Fairness Program that allows your debt to be set aside. That means you will not have to make any more payments on your debt until your financial situation improves. If and when that happens, you can arrange a repayment plan and apply for cancellation of the interest and penalty charges.

STEP 1

Gather the following important information

- Your last Canada Customs and Revenue Agency tax bill showing how much money you have left to pay
- All your income tax papers from all of the tax years involved
- Proof of income (welfare stub, bank statements, etc.)
- A list of the reasons why you can't pay your tax debt (this list will help you do the paperwork)

STEP 2

Make a doctor's appointment to ask for a letter of support.

- The letter must provide the following information:
 - Date of your HIV/AIDS diagnosis
 - Your current CD4 and viral load counts
 - Side effects, symptoms from medications, etc.
 - Other medical concerns or conditions
 - A statement that you are unable to work at any regular employment
 - A statement that stress management/relief is essential to improve your overall health and combat HIV (income tax debt creates a lot of anxiety for you)
 - A brief statement, when applicable, on depression, complications, inability to take medications, co-infections with HCV, etc., indicating the unlikelihood of you re-entering the workforce for regular employment
- The doctor may charge you a fee for the letter of support.

STEP 3

Contact BCPWA Society Advocacy at 604-893-2223 or 1-800-994-2437 for the following forms that you need to fill out:

- Income and Expense Assessment
- Assets and Liability Assessment

STEP 4

Before mailing your package, review this checklist. Have you included the following documents in your envelope?

- Your signed letter requesting debt relief
- The letter from your doctor
- Your completed Income and Expense Assessment
- Your completed Assets and Liability Assessment
- Your proof of income or bank statements

STEP 5

Make a photocopy of everything you plan to send for your records.

STEP 6

It is important to maintain contact with your collection officer throughout the process.

Tax Services Offices try to make decisions on fairness applications within 30 days. However, in certain cases, Canada Customs and Revenue Agency may require additional information, which may delay decisions.

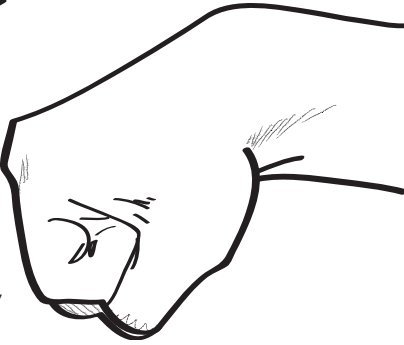
STEP 7

If they say "NO," contact an advocate!

TIP: Keep your cool. The government may change some of the steps in the process and ask you for more information after receiving your letter.

Breaking the

silence



Childhood sexual abuse makes people vulnerable to HIV

by Paula Braitstein

Child sexual abuse isn't exactly dinner conversation, which is almost surprising given how many people have experienced it. Most people don't talk about it. It's too painful.

For many years, people accepted Freud's notion of hysteria as an explanation of claims of sexual abuse. In recent years, some child sexual abuse claims have been dismissed as false memory syndrome. But real abuse has probably been sublimated by survivors in a kind of amnesia resulting from trauma—that is, not remembering abuse.

It is difficult to know precisely how many people have experienced child sexual abuse. Family and cultural factors, such as spoken or unspoken pressure, intimidation, or threats of violence to prevent disclosure of abuse; different age definitions of “child”; and different definitions of “abuse” (What if there wasn't penetration? What if the victim/survivor experienced orgasm or didn't explicitly say NO?) could all be reasons people don't talk about this problem.

A researcher named Finkelhor investigated several different studies from 19 developed countries. He found that child sexual abuse was prevalent in each country at a rate of 7–36% of women and 3–29% of men. Most studies found that women were three times more likely to have been abused than men and that incest accounted for one-third to one-half of all experiences for girls. Incest was found to be less frequently experienced by boys. Other more recent studies of the general non-HIV population have found that at least 14% and as many as 30% of women and between 1–20% of men have experienced child sexual abuse (see Table 1). In HIV populations, the amount ranges from 20–70% (see Table 2). Child sexual abuse is apparently endemic in our society.

A large number of studies show associations between child sexual abuse and a wide variety of emotional, cognitive, interpersonal, biological, and behavioural effects. Emotional associations include

depression, mood disorders, and anxiety disorders, as well as the inability to deal with anger, fear, low self-esteem, guilt, and shame.

Some cognitive effects are massive denial, repression, dissociation, and post-traumatic stress disorder, while the list of interpersonal effects include sexual dysfunction, problems with intimacy, being prone to revictimization, and becoming a victimizer.

Aggressive and antisocial behaviour, eating disorders, suicidal behaviors, risky sexual behaviour, and substance abuse are some of

the behavioural effects. Finally, chronic pain (especially pelvic), headaches, gastrointestinal problems, and a variety of other chronic disorders such as arthritis

In the non-HIV population, one in five people have experienced child sexual abuse. Among people living with HIV, the rate is at least one in three.

are some of the biological effects.

Survivors of child sexual abuse also use the healthcare system a great deal more.

Probably anybody reading this is thinking “Hey—that describes me!” regardless of whether you have actually experienced sexual abuse or not. Although we all get depressed, anxious, and have diarrhea from time to time, the scale, severity, and complexity of the effects are what distinguish trauma survivors from others.

Not everybody will experience negative effects after being abused. A child who discloses abuse to a parent who takes immediate steps to protect and support the child will probably have a much easier time coping with the assault than a child whose parent chooses to look the other way. Many other mediating factors can influence how devastating child sexual abuse can be for someone. These include how frequently the abuse occurred, how violent or physically invasive it was, whether the perpetrator was a close family member, or whether other severe family dysfunction was happening at the same time, such as alcoholism, neglect, or physical abuse.

Because of the bravery and courage of the participants in the Vancouver Injection Drug Users Study (VIDUS), researchers at the BC Centre for Excellence in HIV/AIDS have been able to

learn the extent to which child sexual abuse has played a role in the life circumstances of the participants.

Of the 1437 participants in the study, 505 were women and 932 were men. The 113 (12%) men in this study who experienced child sexual abuse (defined as experiencing the first incident of sexual violence at age 12 or younger) were on average about two years younger than girls at their first experience of sexual violence, though both boys and girls were very young, at ages 10 and 12 respectively. For boys, the perpetrators were more likely to be either male relatives of the child or men known to the child. Only 13% of the men who had been abused had ever disclosed their abuse prior to the research interview. Only 5% of these men had ever received any counselling regarding the abuse. Approximately 10% of the men who had been abused had been revictimized.

Among the 167 (33%) women in this study who experienced child sexual abuse, most had also been abused for the first time by a male relative or a man known to them. Shockingly, 15% of the women who had been abused reported that the perpetrator the first time was a female stranger. Nearly half the women in the study who experienced child sexual abuse had never disclosed the abuse prior to the research interview, only 16% of them had ever received counselling, and more than 50% have been revictimized. While men seem to be most vulnerable as children, women are vulnerable as children but their vulnerability remains high as they grow older.

The men in the study who had survived child sexual abuse were more likely than the other male injection drug users to have been in the sex trade. They were also more likely to share needles/ribs with known HIV-positive people, to have accidentally overdosed, to be living with a diagnosed mental illness, and to binge on alcohol.

Similarly, the women in the study who had survived child sexual abuse were more likely to have been in the sex trade and to have entered the sex trade at an earlier age than other female IDUs. The female survivors of child sexual abuse were also more likely to have

started injecting drugs at an earlier age, to have borrowed needles/ribs from known HIV-positive people, to use heroin more than once per day, and to binge on alcohol. As well, they were more likely to be living with a diagnosed mental illness and to have attempted suicide.

All analyses controlled for fixed sociodemographics, including being aboriginal. Thankfully, aboriginal men and women in VIDUS were no more likely than anyone else to have experienced child sexual abuse.

Nobody wants to talk about it. Nobody really has any answers or cures or quick fixes. That's because there are no easy solutions for experiences that shut down some of the fundamental ways in which we exhibit our humanness: trust, innocence, play, sexuality. Because so many perpetrators are emotionally close to their prey, love gets twisted in terrible ways, ways in which hearts and minds become confused and damaged, sometimes permanently.

This isn't somebody else's problem. In the non-HIV population, one in five people have experienced child sexual abuse. Among people living with HIV, the rate is at least one in three. That's a lot of people and a lot of pain. We need to recognize, publicly and collectively, that there is no shame in having experienced sexual abuse, no matter what the circumstances. We need to support ourselves and take care of each other when our worlds fall apart. We need wide-scale prevention campaigns to break the cycles of violence and to protect our children, and we need comprehensive counselling and support programs to get through to the other side. As cheesy as it may sound, we need to break the silence. ⊕

[The full report is available at the PARC library, and is called "Sexual Violence Among a Cohort of Injection Drug Users" by Paula Braitstein.]



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

Table 1. General population estimates of the prevalence of child sexual abuse

Authors	Year Published	Prevalence
Molnar et al. National Comorbidity Survey, US	2001	n=5877 13.5% of the women, 2.5% of the men Of those: 6% incest among girls, <1% for boys
Bensley et al., Washington State Behavioral Risk Factor Surveillance System, US	2000	n=3473 29% of the women 9% of the men
Kendler et al. Virginia Twin Registry, US	2000	n=1411 female adult twins 30% overall, 42% of them incest
Fleming et al. Australia	1997	n=6000 women 20% overall, 50% of them incest
Romans et al. New Zealand	1995	n=3000 women 16% overall, 45% of them incest

For more information on any of these studies, you can do a literature search at <http://www4.ncbi.nlm.nih.gov/pubmed/> using the author's name.

Table 2. Prevalence estimates of sexual violence among HIV-positive and at-risk populations

Authors	Year Published	Population	Prevalence
Gielen et al.	2001	HIV-positive women	41% (lifetime)
Paul et al.	2001	Men who have sex with men	20% (childhood)
Parillo et al.	2001	Female non-injecting sex partners of IDUs	33% (childhood and adolescence)
Cohen et al.	2000	HIV-positive or at-risk women	25% (childhood overall) 31% (HIV-positive) 27% (HIV-negative)
Liebschutz et al.	2000	HIV-positive women in primary care	68% (sexual or physical)
Pao et al.	2000	HIV-infected psychiatric adolescent patients	50% (childhood)
Simoni & Ng	2000	HIV-positive women	50% (childhood) 68% (adulthood)
Zierler et al.	1996	HIV-positive women	43% (lifetime) 20% (childhood)
Allers et al.	1991	HIV-infected	65% (childhood)

photo britt permien



How do you tell your kids?

The challenges of disclosing HIV to children

by Lori Shekter

People who have had to face the reality of an HIV diagnosis, whether their own or that of a close family member, must decide whom to tell and when. The issue is even more complicated when children are involved. Whether the children are affected by HIV or are infected themselves, telling children about HIV in the family is a troubling prospect for parents. Mothers and fathers from many diverse backgrounds struggle to find the best time and the right words to communicate this sensitive information. In their efforts to accomplish the disclosure in the least traumatic way possible, parents often prepare by seeking help from professionals.

A Canada-wide study on disclosure

To understand and learn from the disclosure experiences of families was the purpose of a 1999 multi-centered study by a group of Canadian clinical social workers at treatment centres for children and families living with HIV. This research was led by Dale DeMatteo and a team from the Hospital for Sick Children in Toronto.

The researchers interviewed 53 children and 57 parents from across Canada about their disclosure experiences. Participants included persons in a broad range of life stages. Children's ages at disclosure ranged from 2 to 23 years. Family backgrounds included young parents with small children, parents with school-

aged children and teens, families with adult children, one- and two-parent families, as well as parents in heterosexual and in same-sex relationships. Several uncles, grandparents, and adoptive parents were included to reflect the impact of extended family disclosures. Urban and rural families were represented, as well as people of various ethnic and cultural backgrounds, including First Nations people.

Many parents began their disclosures immediately following the diagnosis. However, a similar number of parents delayed even thinking about disclosure for up to nine years. Mothers put off disclosure to give children a "normal" childhood and to give themselves time to deal with their new realities. Fathers delayed mainly because they felt their children would not understand.

Preparing for disclosure

Parents often prepared for the disclosure by discussing it with someone they trusted. Half the parents rated prayer as playing an important role in their preparations. More women than men prepared by reading related materials. Very few children suspected HIV prior to the disclosure. No child in the study was told about HIV in the family by a sibling, although many older children and many of the infected children knew before other children in the family.

The study revealed two distinct parenting approaches based

on varying beliefs about childhood, parents' roles, and their own coping styles. Some parents viewed children as innocent and vulnerable and saw their role as protecting their children from painful information. Other parents viewed children as persons whose autonomy and self-sufficiency was to be encouraged and supported. These parents felt that the children must be told and saw their own role as actively determining when and how to tell

not reject the parents.

- Trust in the family as a whole—that children need to be involved in both the good and the bad things that happen and that together the family will cope with what lies ahead.

- Trust in others who make up their support networks—that relationships with extended family, friends, and others will survive and grow and that the children will be cared for no matter what happens

- Trust in the community and larger society—that telling children about HIV will not increase the risk of discrimination or lead to isolation, that healthcare will be available, and that children, if orphaned, will receive the opportunities they need for a satisfying life.

In a Canadian study, many parents began their disclosures immediately after diagnosis; a similar number waited for up to nine years.

them and to ensure that supports were in place.

Parents of HIV-infected children were more likely to actively prepare for the disclosure by gathering related information, creating an appropriate environment, and arranging supports. Most of the disclosures took place at home. About half of the adults in the study recalled their child had an emotional reaction, while the other half reported that their child showed little or no emotion. Disclosures to infected children were the most carefully planned and were framed with hopeful messages.

Gender differences occurred in the children's reactions.

Boys often expressed the desire to have been told immediately after the diagnosis of HIV. Boys often said they felt okay about knowing and seemed to take a long-range optimistic view of things. Girls did not like talking about HIV and none wished to have been told sooner. Nearly all of the children interviewed reported sad feelings. Most children said that they experienced sadness occasionally, but others said that some sadness was always present. Things that helped them included talking with friends or adults, turning to activities they enjoyed, having a cry, eating, sleeping, and playing with a pet.

The importance of a trusting relationship

A critical issue that repeatedly emerged in the parents' responses was trust. Essentially, disclosure is an act of trust. Trust must exist at many levels before adults feel willing to tell their child and before a child can understand and accept this difficult information. These levels of trust include:

- Trust in themselves as parents—that they are ready to disclose, prepared with information, and able to present the information in a calm, supportive manner.

- Trust in their child—that the child will understand the information and be able to cope with it, that the information will not harm the child, and that the child can be trusted with the secret and/or make wise disclosure decisions.

- Trust in the parent-child relationship—that the relationship will endure, that the bond is strong, and that the child will

The parents in the study made these recommendations to other parents preparing to disclose to children:

- Take care of yourself first. Gain control over your emotions, learn to live with HIV, educate yourself about HIV. Seek the help you need. Disclose when you feel the time is right.

- Know your child. Treat each child as an individual. Monitor the child for indications of maturity.

- Build strong parent-child relationships prior to disclosure. Introduce information gradually. Help children develop a strong faith.

- Provide children with additional support. For example, provide a pet, arrange counselling, and supply information with a hopeful message.

- Access professionals for help when needed.

Children involved in the study repeatedly identified three things that they needed from parents: love, support, and information. In addition, they valued good communication, hopefulness, a positive attitude, and being treated normally. The children offered these suggestions to parents preparing to disclose to their child:

- Deal with your own feelings and fears first. Be calm. Be prepared to answer questions. Ask if your child has questions. Plan, if possible, to disclose when the person who has HIV is in good health. Be hopeful and positive. Be truthful and honest.

- Provide your children with support and reassurance.

- Ensure that your children understand that other family members are not at risk of becoming infected from living in the same household as the person infected.

- Let children know that other children are also dealing with this situation in their families.

- Provide a quiet home environment for disclosure.

- Give hugs.

Deciding when to tell

Parents in the study felt strongly that disclosure decisions belong to them. Disclosure can be a continuous process of partial truth-telling which takes place over time. Parents must consider many factors, including the ages, maturity, and temperament of each of

their children. Discussions are best kept short, uncomplicated, and not too technical. The vast majority of children in the study felt good about how they were told. All the children admitted that it was better to know about HIV in the family than not to know.

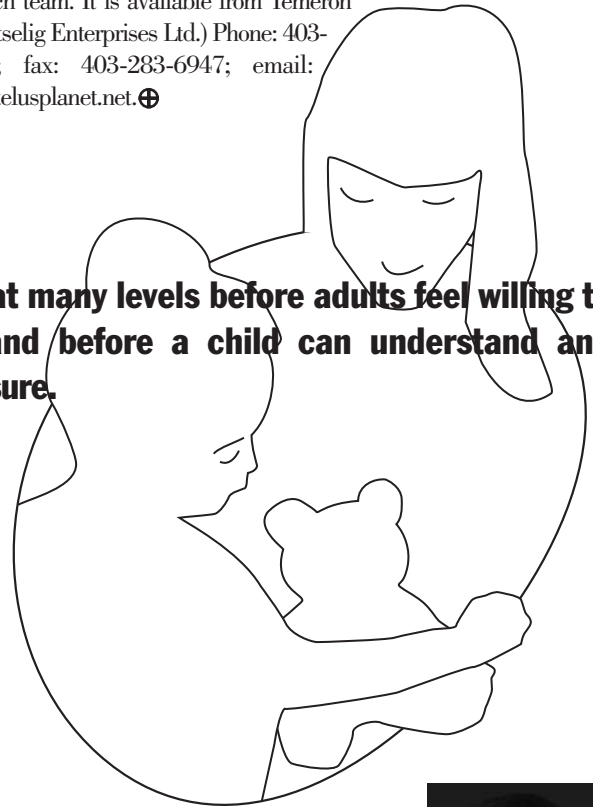
Over the past twelve years, I have counselled families at Oak Tree Clinic in Vancouver and have helped many parents plan and carry out disclosures of HIV in the family to their children. In all of the instances where parents planned the disclosure and did it with care, the children seem to have taken the news well. Parents have reported to me that their HIV-infected children have become more cooperative in taking their medications. Affected children have become more helpful at home and more sensitive to the needs of the family member who is living with HIV.

Many of these BC children have now attended Camp Moomba, the Western Canadian Pediatric AIDS Society's camp for children living with and affected by HIV/AIDS, and have become friends with similar children from this province and Alberta. These resilient children do not appear to have been traumatized by their knowledge of HIV. Instead, they are living their lives with increased awareness, enhanced self-esteem based on validation of their maturity and capacity to handle sensitive information, better communication with their parents, and community support.

The findings of this study were the basis of a book called *Disclosing HIV/AIDS to Children: The Paths We Take* by Dale DeMatteo and Jillian Roberts. Published in 2001, this book was developed by family members who took part in the study and by

the research team. It is available from Temeron Books (Detselig Enterprises Ltd.) Phone: 403-283-0900; fax: 403-283-6947; email: temeron@telusplanet.net ☎

Trust must exist at many levels before adults feel willing to tell their child and before a child can understand and accept the disclosure.



Lori Shekter is a clinical social worker at Oak Tree Clinic in Vancouver. She specializes in HIV counselling with children, women, and families.

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A father's secret: a personal perspective

by Malsah

Like all parents diagnosed with HIV, I agonized over how and when to disclose my status to my child.

After three years of chronic illnesses, I was diagnosed with AIDS in November 1994. (A review of my medical records concluded that I had been HIV-positive since 1981. I was unaware that I was infected prior to the AIDS diagnosis.)

My wife and I deliberated over when and how to disclose to our daughter that I was ill. She had just turned six. How much could she truly comprehend? She did not know what death was and had never experienced a loss.

What if I became ill and died without having disclosed my HIV status to her? Would she grow up resenting us for not disclosing and allowing her that time? Could she grow up as a normal, typical child knowing that her father was ill and could die any day? Would knowing cause instability and insecurity for a child who loves and depends on her father? Would she be herself and not refrain from expression to compensate for my illness—would she show anger when she was mad at me? How would she manage the sadness in her heart? Could she be trusted not to tell other kids and should she be burdened with that responsibility?

Would she be ostracized or suffer guilt by association if other kids knew? Would knowing alleviate any of her suffering upon my death?

We wondered if we had a good enough understanding ourselves in order to educate her.

We did some research and determined that the age of six was definitely too young to disclose such profound knowledge. Not only would she not comprehend, it could have psychological effects on her as she matured. It would alter her reality of the world and could impair her ability to love unconditionally.

Knowing would not make my passing any easier. You cannot truly prepare a child for that.

We concluded that to tell her would be selfish and self-serving. We would be doing it to seek sympathy. It would serve to dismiss the responsibility of the parent due to illness. Telling her would put her at physical and emotional risk because she might tell someone, and society is still not totally accepting of persons with HIV/AIDS.

We learned from child psychologists that we should always answer questions honestly but sometimes need to exercise dis-

cretion and that when a child is ready to know, he or she will start asking questions. The likely age that children will ask such questions is probably early teens. It is best to provide general knowledge about HIV/AIDS before disclosing one's personal status. It is important to present information from a positive perspective, allow for hope, and avoid gloom and doom. Many PWAs continue to lead prosperous, productive, quality lives two decades after becoming infected.

Be prepared to offer other resources for information and support. Your child may not feel comfortable talking to you. Your child might not want you to witness his/her sadness, tears, or anger. He/she might have difficulty accepting or understanding the disclosure, which could result in denial and rejection. Children need time to adjust and may need professional

What if I died without having disclosed my HIV status to her? Would she grow up resenting us for not disclosing and allowing her that time?

support throughout the transition. It is never easy for a child to learn of a loved one's terminal illness, especially if the loved one is a parent.

My daughter turned thirteen this past November. It has now been seven years since my AIDS diagnosis, and I assume that she has her suspicions about my status. I spend many hours on the phone talking about HIV/AIDS, I have literature about it all over the house, and I do volunteer work in the field of HIV/AIDS. I also spend much of my time managing the illness and the side effects from the drugs. My daughter knows that I am ill most days, and I do have an intestinal disorder, Crohn's disease. However, I still await that fateful day when she utters the words, "Daddy, do you have AIDS?" I will answer her honestly. ⊕

Signed, a loving father.

Malsah is Vice Chair of the BCPWA Society.



AIDS education in BC elementary schools is slim to non-existent

by Trena White

When I was an elementary school student thirteen years ago, my exposure to AIDS education was superficial. Once I reached high school it didn't improve. I came from a conservative school district in BC where the norm for family life classes and sex education involved watching old episodes of *Degrassi Junior High* while my fellow students sat tight-lipped, listening to our embarrassed PE teacher dance around health and sexuality issues.

I had hoped this situation would have changed and that children today in the BC school system would be exposed to frank discussions about HIV infection and AIDS while in school, but that doesn't seem to be the case.

According to Bill Forst, President of the BC School Counsellors' Association, a branch of the BC Teacher's Federation, there is "an awful lot of discretion that individual teachers have, and the way CAPP [Career and Personal Planning] is brought up varies from school to school."

From grades 4-7, the BC Ministry of Education recommends teachers devote 5% of their instructional time to personal planning, a broad subject that includes health issues, career planning, and personal development. According to the *Grades 4-7 Curriculum Handbook for Parents*, "the purpose of this curriculum is to assist students to gather information that can be used to plan and make informed choices about their health, safety, personal lives, and career development."

But when it comes to AIDS education, the curriculum is strangely silent. For example, the grade five learning outcomes for "Healthy Living" say that students are expected to

- Give examples of how people can achieve balance in their lives
- Identify factors that influence their attitudes regarding healthy living
- Describe Canadian health issues

These goals are vague at best, and leave topics of discussion to the discretion of individual educators and school districts. With

no explicit mandate to address HIV/AIDS in the elementary school classroom, the subject may be ignored altogether. If teachers are too embarrassed to discuss HIV/AIDS with their students, the curriculum permits them to avoid discussing it at all.

It isn't until grade eight that the Ministry states that one of the learning outcomes for "Healthy Living" is "to demonstrate a knowledge of key lifestyle practices associated with the prevention of HIV/AIDS, sexually transmitted diseases, and other communicable diseases." No comparable learning outcomes are required for school children from kindergarten to grade seven, which means BC schools do not have to address HIV/AIDS with their students until they are thirteen years old.

This late address of AIDS in our schools is a problem, according to Jenn Horgos, Program Coordinator of GAB Youth Services at The Centre in Vancouver. "The younger you start with teaching good information, the better," she says. "It's better to start talking about these issues before they establish a pattern of behaviour. Young people, especially those around 11 years old, have lots of questions about sexuality, so it's a great age to start [discussing HIV/AIDS]."

Horgos takes issue with the argument that parents should be responsible for educating their children about HIV/AIDS. "Parents have a role in passing on their beliefs, but there's a lot of technical information about sexual health that parents may not have," she says.

Given that many parents are also uncomfortable discussing AIDS with their kids, and BC teachers are not required to address it with their students, a large gap exists in the elementary school curriculum that could be filled by mandating that teachers provide their students with basic information about HIV/AIDS. ⊕



Trena White is a freelance writer based in Vancouver.

TREATMENT INFORMATION
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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.

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HIV-positive children in British Columbia

by Dr. Jack Forbes

As of the end of 2001, about 1,300 children had been born to HIV-infected mothers in Canada and were being monitored by pediatric HIV clinics. Of these children, about 15% were born and live in British Columbia.

The number of infected children has steadily declined since 1997, when doctors began offering antiretroviral therapy (ART) to HIV-infected pregnant women. Women start ART during pregnancy and continue during the delivery. The infant receives ART for the first six weeks of life. This therapy has decreased the rate of transmission from mothers to the infant from 25% to less than 2% when combination antiretroviral therapy is

used and mothers have a low viral load at the time of delivery.

be aware of their HIV disease so that they can be offered therapy both for their own health and to greatly decrease their risk of having an infected infant. HIV disease tends to progress more rapidly in infected children than in adults. Before the use of ART, most children developed symptoms at 5–6 years of age and many died at 8–10 years. Since 1997, the use of combination antiretroviral therapy, including protease inhibitors, has greatly decreased the rate of disease progression. The therapy decreases the amount of virus, thus reducing the rate of damage to the immune system. The stronger immune function is then able to resist opportunistic infections and

decrease the rate of complications from HIV disease. The outcome for children has greatly improved as a result, and the mortality rate in children on therapy has been less than 1% since 1999.

Before the use of antiretroviral therapy, most HIV-positive children developed symptoms at 5–6 years of age and many died at 8–10 years.

However, combination antiretroviral drugs have side effects, and children may show the same adverse effects that adults experience. Therefore, careful monitoring of children at pediatric HIV centres is essential.

continued on page 14

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The average age of the HIV-positive children monitored at the Oak Tree Clinic is eight years. This year, twelve children will be 10–14 years of age. Fifty percent of the infected children in BC are in the care of one or both parents and 40% are in foster care. All these children enjoy busy lives in their communities. Those who are old enough to go to school do attend and fully participate in school activities.

The treatment of HIV disease in children and in pregnant women is complex. The Oak Tree Clinic is a provincial resource facility for all HIV-positive pregnant women, their infants, and HIV-infected children. The clinic is located at the Children's and Women's Health Centre of British Columbia on Oak Street in Vancouver and has a multi-disciplinary team of healthcare professionals offering consultative care and access to clinical research. Outreach staff work in the Vancouver Downtown Eastside to facilitate access to healthcare and to advocate for HIV-positive women and their families.

Since 1997 far fewer children are becoming infected with HIV disease. Those children who are infected have had dramatic results from combination therapy, with decreased morbidity and mortality. ⊕

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.



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No more “one size fits all”

Treatment regimens are now individualized

by *Glen Hillson*

Until recently, approaches to prescribing antiretroviral therapy were relatively uniform for all patients. Many doctors encouraged all of their HIV-positive patients to take the drugs. The dosage for each drug was the same regardless of size, age, sex, or other factors.

When to start

No rigorous randomized clinical trial has yet tried to determine when the best time is to start therapy. Since the advent of triple combination therapy and its dramatic impact on the course of the AIDS epidemic, many doctors have preferred to treat all who are infected, or at least start treatment very early in the course of the disease. While there was no hard evidence to support this approach, there was nothing to refute it. Many scientists encouraged doctors to treat patients early and conducted research to prove their theories that early treatment was best. Among the theories:

- Delayed treatment would result in a greater accumulated total viral burden with HIV stored away in lymph nodes and other reservoirs.
- Delayed therapy would allow the virus to mutate and become more genetically diverse, thereby compromising the success of future therapy.
- The immune system might suffer irreversible damage if therapy was delayed.

Recently, experts began to recognize a gap in their knowledge of how to use drug treatments most effectively. They began to examine various research designs. It proved very challenging to find a method that would provide accurate, reliable answers and at the same time be practical and affordable.

The BC Centre for Excellence in HIV/AIDS took a simple approach. They examined the outcomes of patients in the drug treatment program in BC to see what differences resulted from delayed versus early treatment. Published late last year in the *Journal of the American Medical Association (JAMA)*, their findings showed no apparent advantage to starting early (when CD4 counts are around 500) as opposed to starting later (with CD4 counts between 200 and 350). *JAMA* editors described the Centre's work as “very important.”

In the past year, hundreds of BC patients who may have started treatment earlier than necessary have now stopped, while others are delaying starting for the first time, resulting in

a savings of several million dollars. It also means that patients can delay the risks and inconvenience of antiretroviral drugs.

Resistance testing

After years of research, resistance testing is now available. Doctors in BC can now order resistance tests for patients to determine which drugs are likely to have the greatest effect in controlling HIV replication. Previously, patients starting treatment for the first time were assumed to have “wild type” virus, which is susceptible to all of the marketed drugs. When it was necessary to switch drugs, the change was usually based on the patient's treatment history. This guesswork approach involved trying anything that hadn't previously failed for that patient. The different methods of resistance testing—genotypic, phenotypic, and virtual phenotypic—all measure how susceptible a sample of HIV is to each of the drugs.

Therapeutic drug monitoring

In the past, if a drug combination did not keep the virus in check, doctors assumed either that the patient was not taking the drugs properly as prescribed or that the virus had mutated into a resistant form. If a treatment proved to be too toxic for an individual, it was attributed to the characteristics of that person. Dosage was determined by taking the average response of all participants in a “dose-ranging” clinical trial. This approach did not consider size, age, and sex differences, which might have a significant impact on the amount of a drug a particular individual needs and can safely tolerate.

Doctors in BC now have a new tool at their disposal which allows them to measure the amount of drug in the blood at various stages of the dosing interval to determine if the patient is getting enough drug but not too much. Therapeutic drug monitoring (TDM) may require spending a few hours in the hospital and having several blood samples taken in one day.

These innovations mark significant improvements in managing the risks versus the benefits of HIV drugs. Until we have safer, more effective treatments, until we have a cure, learning to use our existing tools more effectively is a step in the right direction. ⊕

Glen Hillson is the chair of the BC Persons With AIDS Society.

Dinner dilemma

Children with HIV have special nutritional needs

by Diana Peabody

Malnutrition has always been common among people with HIV. The consequences of malnutrition in children are even more devastating because they have unique needs related to the demands of growth and development.

Children living with HIV are at high risk of growth failure, which means that they do not keep up to their expected rate of growth over time. Sometimes they have difficulty gaining weight even if they continue to grow in height, which makes

weight gain are strongly linked to nutritional factors such as inadequate dietary intake resulting from loss of appetite, nausea, stomach pain, diarrhea, or abnormal taste sensation.

In the developed world today, most children receive aggressive antiretroviral therapy (HAART) from a very early age. This treatment has greatly decreased the incidence of poor growth, but some children still struggle with maintaining steady gains in weight. This problem is often a result of side effects of HIV medications, which children experience in the same way as adults. Children on HAART also experience metabolic complications such as high triglyceride levels and lipodystrophy. These issues present further nutritional challenges because dietary restrictions, such as decreasing fat intake, make it even more difficult to keep the child well-nourished and growing appropriately.



photo Heinrich Stuhr

Feeding children at the best of times is difficult. A chronic disease such as HIV infection can turn mealtimes into a battleground.

them progressively skinnier. Undernourished children can have decreased functional capacity, decreased quality of life, and increased susceptibility to infection. Poor growth and

Moreover, with increasing reports of low bone mineral density in adults on HAART, it is important to consider the bone health of children on antiretroviral therapy. Because adolescence is the time of life when children develop peak bone mass, they must maximize bone-strengthening strategies during this critical period.

Micronutrient deficiencies appear to be common in children living with HIV. In a small study at the Oak Tree Clinic, we found that an unexpectedly high number of infected children had low serum levels of at least one micronutrient. These children were well-nourished and growing well and did not appear to have malabsorption, which suggests that inadequate dietary

intake was not the primary cause. They did tend to have more advanced disease, lower CD4 counts, and higher viral loads, which imply that the disease process of HIV infection plays a role in the decline of serum micronutrients.

Psychosocial factors such as the health status of an infected parent, cultural practices, home environment, financial concerns, and lack of social support also influence the ability to meet the child's nutritional needs. Thus, it is important that agencies and healthcare professionals working with families living with HIV ensure that the families have access to appropriate services and supports.

One of the most prevalent and difficult problems children face is loss of appetite. Most healthy children express hunger and ask for food and drinks frequently throughout the day. However, many children with HIV rarely say they are hungry or ask for food. Adults who experience loss of appetite can usually force themselves to eat a small amount for the good of their health. Children usually refuse to eat altogether when they are not hungry, and it is difficult to coax them to eat.

This situation can lead to a distorted feeding dynamic between child and caregiver. The caregiver is worried about the health of the child and knows the child has to eat. The child does not want to eat and may be highly selective about which foods to eat. Caregivers often find themselves spending an inordinate amount of time preparing food, offering food, feeding the child, or coaxing the child to finish a meal. The child then faces constant food pressure throughout the day. The result is that

both child and caregiver feel frustrated and stressed.

Feeding children is difficult at the best of times. A chronic disease such as HIV infection amplifies normal challenges, which sometimes turns mealtimes into a battle. It is important to normalize the feeding relationship between caregiver and child to decrease the stress around meals and create a more positive attitude towards food.

HIV-positive children should have a regular nutrition assessment to facilitate early nutrition strategies designed to maintain normal growth and development, to prevent deficiencies, to support the immune system, and to maintain quality of life. Intervention in children tends to be more aggressive than with adults because of the exceptional needs for growth. This approach may involve dietary modifications, use of nutritional supplements, or even insertion of a gastrostomy feeding tube.

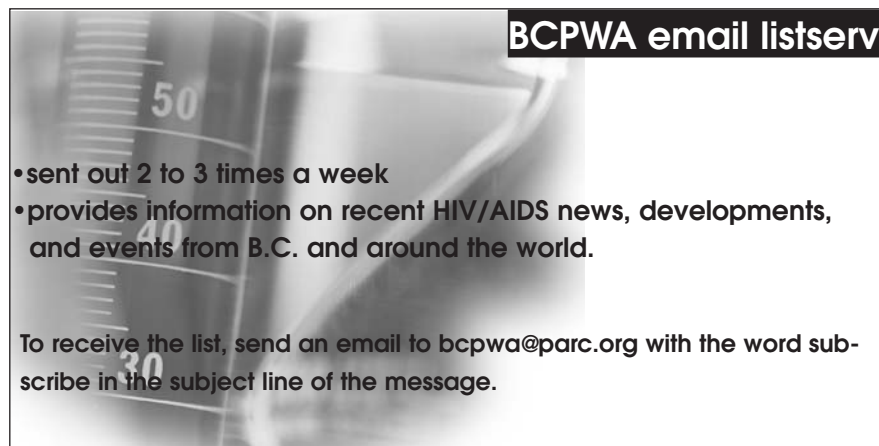
Nutritional needs of HIV-infected children are closely tied to medical and social issues. To meet the very complex needs of these children, they need follow-up and support by a team of healthcare professionals, such as the dietitians at Oak Tree Clinic, and community support people.⊕



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

oops...

Correction to "Bottoms up" article in the last issue of *Living +*: One drink is equal to 1 1/2 ounces of hard liquor. Incorrect information appeared in the article.



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More bites for your buck



How to get the most nutrition on a limited budget

by Michele Blanchet

Diet plays an important role in living with HIV and staying healthy. In addition to helping delay the progression of HIV, good nutritional health helps you maintain a healthy immune system, reduce the complications of HIV disease, achieve maximum benefit from drug therapies, and increase your energy level.

Although many factors influence what people eat, including preferences, health conditions, and availability, financial issues are often the largest obstacles for individuals with low income. Financial hurdles can dramatically affect the quality and quantity of nutritious food and overall health. When money is sparse, food is often the first place people look to save money.

The types of food and nutrients consumed vary dramatically with income. Studies have shown that people with low incomes often eat a narrower range of foods than those with a higher income. Individuals on a restricted income often eat far fewer fruit and vegetables, drink and eat fewer milk products, consume more fats and oils, and have an overall lower intake of vitamins, minerals, and fibre.

Healthy eating on a limited budget

How can you save money on your grocery bill and maintain your nutritional health? It is possible to eat well, even on a tight budget. The key is learning how to plan a menu and shop smartly. For some, eating healthily on a budget may mean giving up

some convenience foods, making meals from scratch, or even learning how to cook.

Here are some helpful hints for getting the best nutritional value for your dollar.

Plan your menu ahead of time

- Try some new low-cost recipes by searching the Internet.
- Use items that you already have in your cupboards, refrigerator, and freezer and include them in your menu.
- Use the grocery store flyer to choose the main items of your meal: meat, fish, poultry, or meat alternatives, such as eggs, dried beans, split peas, lentils, nuts, and seeds.
- Choose low-cost nutritious foods from each of the four food groups to balance your meal using the list provided (see “Best Buys” sidebar) and store flyers. Buy fruit and vegetables that are in season.

Make a shopping list

- Post a list on your refrigerator and make a note of things as they run out. Before heading to the store, check if you already have a suitable substitute that can be used first. For example, whole wheat flour for white flour.
- Before shopping, complete your list by using your menu.
- A grocery list will keep you on track to purchase only needed items and avoid impulse buys.

Before heading to the store

- Plan to purchase your fruit and vegeta-

bles at a produce stand where they will be less expensive. Shop at a large grocery store for the rest of your purchases.

- Don't go shopping on an empty stomach. For some, this technique can save up to 20% off the total food bill.
- If you have kids, leave them at home. The same goes for partners and friends who can't resist impulse buying.

At the store

- Compare costs using unit prices: Check the white tab on the supermarket shelf that displays the price per gram or ml;
- Or, using a calculator, take the price of the product and divide by the number of grams or ml in the food package. Multiply by 100 to get a unit price of either 100g or 100ml.
- Buy no-name brand items. They are usually less expensive but have the same nutritional value.
- Purchase small quantity foods such as herbs and spices in the bulk food section.
- Only use coupons for items you normally buy or you may end up with unneeded items or items you really don't like.
- If you have a little extra money, stock up on non-perishable foods at the sale price. Canned items such as tuna, salmon, tomatoes, kidney beans, and black beans frequently go on sale for \$0.99. I always make sure I have these five staples stocked in my cupboards.

Food clubs and programs

In the Greater Vancouver area, several food clubs and programs offer effective

ways to optimize your food budget or provide assistance for those in need. In addition to the resources listed below, refer to the Positively Happening section of this publication for further resources.

- Learn to cook by joining a community kitchen, where groups of people meet regularly to cook and eat together for a small fee. Call the Vancouver Community Kitchen Project at 604-254-8300.
- Use your green thumb in a Community Garden. These programs allow you to grow your own vegetables and other fresh produce by renting a small plot of land for a nominal fee. Check out www.cityfarmer.org/communitygarden7.html for contact information for community gardens in Greater Vancouver and Victoria, as well as some other communities across Canada.
- Check into food co-operatives. You receive larger quantities than usual because you buy in bulk with several other people. There are food co-ops throughout Canada. To find one in your community, check out the online Canadian & US Food Co-op Directory at www.prairienet.org/co-op/directory.
- Food banks provide emergency food assistance to individuals in need. For the Vancouver Food Bank, call 604-876-3601.
- AIDS Vancouver Grocery also provides food and some personal hygiene products for those with an annual income below \$20,000.00.

• Some organizations provide home-delivered frozen and hot meals at a reasonable cost. In the Greater Vancouver area, A Loving Spoonful provides free nutritious meals to people living with HIV/AIDS, when they meet specific criteria. They can be reached at 604-682-6325.

HIV is a condition that requires a special diet. Individuals on social assistance can apply for a diet allowance of \$40 per month. Those receiving BC Disability Benefits Level 2 may be eligible for a nutritional supplement benefit of up to \$225 a month. When regular dietary intake is not sufficient to aid in recovery from weight loss or other complications of HIV, short-term supplies of Ensure or Boost can be provided. You will need a written prescription from your doctor that specifies your specific diagnosis, prescribed product, quantity needed, and expected duration of need. This prescription should be forwarded to your financial aid worker.

Variety is important

Even when viral load is undetectable, individuals with HIV have higher energy, protein, vitamin, and mineral requirements than the average healthy Canadian. Canada's Food Guide, which emphasizes four food groups, can provide the nutrients you need to be healthy. Each of the food groups provides the nutrients your body requires, but variety within each group is

also important. The different foods within each group also provide different nutrients. Educate yourself and look closely at your unique requirements, making sure you are meeting your nutritional needs and spending your food budget wisely. Ask to see a Registered Dietitian specializing in HIV to offer you guidance. Call the AIDS Vancouver help line at 604-893-2222 or e-mail helpline@parc.org for a contact list. ⊕

Other money-saving tips

- Entertain more often by throwing potluck parties. It's an excellent way to increase your collection of yummy recipes.
- Pack your lunch and carry a snack instead of eating out.
- Join a cooking class to increase your confidence and enjoyment of cooking and baking. Contact The Heart of Richmond AIDS Society at 604-244-3794 for more information.
- Invest in pots and pans, decent knives, or other equipment that will inspire you to cook more often.

Michele Blanchet is the Registered Dietitian at Gilwest Clinic, a Richmond clinic that specializes in HIV, methadone, and hepatitis. She can be reached at 604-244-5118.



Best buys when shopping by the food groups:

Dairy products

Milk (4 L jug), Skim milk powder, Yogurt

Meats and alternatives

Meats: Inside round steak, Stewing beef, Medium ground beef (fat drained), Pork shoulder roast, Ham, Boneless chicken thighs

Fish: Canned tuna, salmon, sardines, mackerel

Meat alternatives: Peanut butter, eggs, canned or dried beans: kidney beans, garbanzo beans, navy

beans, black beans, lentils and split peas

Fruits and vegetables

Fruits: Oranges, apples, bananas, Frozen orange juice, Canned fruit (when on sale)

Vegetables: Canned tomatoes, potatoes, carrots, onions, frozen peas and corn

Grain products

Whole wheat bread, soda crackers, dried pasta, long grain brown rice, barley, regular cooking oatmeal

A bitter pill to swallow

The sorry state of safety surveillance of drugs after they're approved

by *Glen Hillson*

Undeniably, a great deal has been achieved in the development of drug treatments during the relatively short lifespan of the HIV/AIDS epidemic. These products have provided enormous benefit in recent years, and the expanding number and variety of treatments continue to enhance efforts to slow disease progression. However, one of the most difficult barriers to assessing the available options effectively and making quality decisions is the lack of comprehensive and current information about the safety of prescription drugs. This has been so since the late '80s, when AZT arrived on the scene as the first antiretroviral drug. Today, the challenge is greater than ever.

Roughly fifteen antiretroviral drugs, falling into three different classes, are taken in combination. Moreover, antiretrovirals only account for some of the drugs prescribed to PWAs. The efforts of the federal government and its regulators, as well as manufacturers, to design and implement systems that provide safety information have been stagnant during the past decade and the inadequacy of those efforts has become more glaring.

Unbridled euphoria accompanied the arrival of protease inhibitors and triple therapy in 1996. The experts clamoured for lime-light with clever sound bites, predicting a cure that must surely be just around the next corner. Before long, it became painfully evident to PWAs that much was yet to be learned about the new drugs. Very little attention was paid to what happens to people who take the drugs for long periods of time. Since then, AIDS treatment activists in Canada have made post-approval surveillance (PAS) of prescription drugs a top priority and demonstrated unprecedented leadership among health consumers on this issue.

The task of collecting safety information about licensed prescription drugs is not adequately dealt with anywhere in the world. In Canada, where most aspects of drug regulation are in shambles,

the situation is worse than many other countries. Generally, PAS systems are not well designed to gather and process information about drug reactions. They are guided by an ideology that does not recognize consumers as central to the equation.

People who actually take the drugs and experience the symptoms of drug reactions are barely considered qualified as informants, let alone experts, on such matters. Most systems are voluntary and impose very little actual responsibility for event reporting or information processing. Even in the eleven countries with legislated mandatory reporting, enforcement is often difficult.

A 1998 commentary in the *Journal of the American Medical Association (JAMA)* observed that 51% of approved drugs have adverse effects that were not detected prior to their approval. In identifying adverse drug reactions as a leading cause of death in the United States, JAMA noted that every year, 1.5 million people in the US require hospitalization and 100,000 die from injuries caused by prescription drugs.

The systems in place in the US and Canada rely on spontaneous anecdotal reporting. The JAMA editors identified several shortcomings of this method, noting firstly that "it is difficult or impossible to estimate reliably how often adverse events

might be occurring since, according to FDA estimates, only about 1% of adverse events are ever reported."

More recently and closer to home, awareness of our own grim reality is rising among Canadians. A high-profile case, in which the drug cisapride (Prepulsid) caused 105 deaths before it was withdrawn from the Canadian market in August 2000, led to a Canadian inquest last year that offered fourteen recommendations for improving PAS in Canada.

In a subsequent editorial, the *Canadian Medical Association Journal (CMAJ)* endorsed the creation of a parallel agency in Canada for the surveillance, investigation, and dissemination of information about adverse drug reactions (ADRs)

Every year, 1.5 million people in the U.S. require hospitalization and 100,000 die from injuries caused by prescription drugs.



photo britt permien

that is independent of pharmaceutical companies and of Health Canada. Proponents of such an agency say its advantage lies in not being accountable to someone who is elected. This view casts a rather cynical light on the fundamental framework of our political system, at the core of which resides public accountability of elected officials. The Patented Medicines Prices Review Board (PMPRB) is a parallel agency and has been ineffective thus far in managing recent excessive price complaints specific to HIV drugs.

NDP MP Judy Wasylycia-Leis has called for mandatory reporting. Dr. Stuart MacLeod, a clinical pharmacologist from McMaster University, disagrees. "Instead of mandatory testing," the CMAJ quotes him as saying, "Canada needs targeted investigations of certain drug classes so that it can conduct prospective epidemiologic studies, and it needs to monitor all new drugs." In other words, it should focus resources on certain drugs targeted for proactive data collection, rather than subjecting all products to an equal level of scrutiny.

"One might expect an adverse event to be reported only if the physician has a sufficiently strong suspicion that the reaction was caused by a drug; judges that the event is worth reporting; has time to report it; and, depending on the circumstance, is willing to admit a mistake, or to report a colleague's mistake," say the editors of CMAJ. CMAJ also notes that once data is collected, Health Canada must then make a determination whether a drug caused it.

CTAC discussion paper

In December 2000, the Canadian Treatment Action Council (CTAC) published a commissioned discussion paper

entitled *Improving our Health: The Need to Enhance the Post-Approval Surveillance System for HIV/AIDS Drugs in Canada*.

The report, which focuses on HIV/AIDS drugs, identifies problems in three broad categories. What follows is some of those problems:

REPORTING PROBLEMS

- Pharmaceutical companies are not required to report adverse drug reactions.
- Health care professionals or consumers are not required to report adverse drug reactions, nor are they actively encouraged to do so.
- No formal process exists for consumers to report adverse drug reactions.
- Even when people living with HIV/AIDS do report adverse drug reactions to their healthcare professionals, these reports are often not forwarded to the national surveillance system either directly or through pharmaceutical companies.
- Healthcare professionals are not always sure which drug may have caused an adverse reaction.

SYSTEMIC PROBLEMS

- PAS is not a priority within the Health Protection Branch.
- It is not clear whether a portion of the Drug Information Number (DIN) fees collected annually from drug companies are being assigned to PAS.
- PAS does not have adequate resources.

PROGRAMMATIC PROBLEMS

- Pre-marketing clinical trials fail to identify many adverse reactions.
- Few Phase IV (post-approval) clinical trials are conducted.
- Information from other countries is lacking.

The first guiding principle identified in the discussion paper recommendations is that a PAS system should be consumer-centred. People taking drugs are the primary source of information and the system should elicit, recognize, and reflect their experiences and observations. First and foremost, it must serve the needs of those same people ahead of any other stakeholder. The report also recommends that an effective system should be easily accessible, open and transparent, and respect individual confidentiality.

Working Group on HIV/AIDS

In 1998, after an intense lobbying campaign by Canadian AIDS activists, the Health Protection Branch embarked on a consultation with stakeholders that resulted in the formation of the Working Group on HIV/AIDS. A year later, this group made recommendations for better drug regulation that included both pre- and post-approval activities by the federal regulator. A broad range of stakeholders in HIV/AIDS and other therapeutic areas subsequently endorsed these recommendations. The federal Health Minister's Science Advisory Panel, chaired by Dr. Roberta Bondar, agreed.

The first and key recommendation of the committee is that "The Government of Canada should immediately allocate sufficient resources to enable the implementation and maintenance of the recommendations of the Working Group on HIV/AIDS."

As a member of that working group and the subsequent but now defunct Advisory Panel on Product Licensing, I can report that little progress has been made in the more than two years that have elapsed since the recommendations were made. This is despite ongoing advocacy efforts by CTAC and other groups, including lobbying members of government caucus, who have met with senior officials in the offices of both the health minister and the prime minister.

Community-based research

In addition to its advocacy efforts, CTAC embarked on its own research effort to develop ideas and knowledge on what was needed in a PAS system that would serve the needs of people living with HIV/AIDS.

Several members of the CTAC council, along with outside experts, formed a PAS committee. The committee produced a research protocol to pilot test four separate methods of data collection that are all innovative and consumer-centred. Considerable time and effort has also gone into the solicitation of funding needed to conduct the research. That funding is now

Conclusions

With the passing of time and the introduction of new and hopefully improved HIV drugs, the relative threat to PWAs of adverse drug reactions compared to HIV itself is increasing. This trend will continue. Many of the world's leading physicians and researchers have predicted that substantial numbers of patients with HIV will be injured and even die from causes related to their treatment.

In addition to holding governments accountable for their culpability in these outcomes and convincing them to supply the will and resources for progress, it becomes increasingly vital for PWAs to

People who experience the drug reactions are barely considered qualified as informants, let alone experts.

in place and the six-month project will begin in the next few months.

Four different methods of data collection for events related to antiretroviral drugs will undergo testing to evaluate their effectiveness and to compare outputs to those of the current system. These methods are listed below.

- A toll-free number that participants can call to report events that they believe are related to their antiretroviral medication. The community-based site coordinator who answers the phone will complete the standard report form.
- Participants will fill out the same standard form, which they can mail or fax to the data collection site.
- Participants will fill out the same standard report form with the assistance of a community-based site coordinator in a face-to-face interview.
- Three focus groups will collect data from aboriginal people for the pilot study.

assume an informed and active role in monitoring all aspects of their health. When making treatment decisions and while on therapy, it is important to be familiar with information that is available about HIV drugs and to evaluate your choices according to your own medical circumstances. You need to be alert to any symptom you are experiencing that could be related to your medication. The sooner you and your doctor are able to identify a reaction and intervene appropriately, the safer you will be. ⊕



Glen Hillson is Chair of the BCPWA Society.

A river runs through it



Ron demonstrates the fine art of using a neti pot, definitely something you want to do in the privacy of your own bathroom.

Neti is the ancient practice of nose cleansing

by Ron Rosenes

Remember how your mother always told you to keep your nose clean? She wasn't kidding, and she wasn't just telling you to stay out of trouble. Finding new ways to cleanse the nasal passages has made a world of difference for me in preventing those nasty recurring bouts of sinusitis that so many of us endure. But a word of warning: What follows is not for the faint of heart or those who fear death by drowning.

Chronic sinusitis has long been associated with reduced immune status. The nasal passages are a fertile breeding ground for bacteria, and it is difficult for antibiotics to penetrate there. Sometimes we have no choice but to use antibiotics and corticosteroidal sprays, but the goal should be to avoid them in the first place. Once you have seen a physician to rule out allergies or structural obstacles such as narrow passages or a deviated septum as possible causes of your sinusitis, you are ready to learn about the joys of nasal cleansing.

In the ancient practice of Indian yogis, *neti*, the cleansing of the nose with lukewarm salt water, was as common as brushing one's teeth. In Scandinavia, nose cleansing was used as a simple remedy to prevent colds and infections. Old fishermen tell of sniffing salt water from the hand or a small bowl and spitting it out through the mouth. Scandinavian pharmacists at the turn of the century sold small glass pots for this purpose. One military base in Sweden kept a barrel of salt water with a tap and a hose attached to the bottom. If the soldiers felt a cold coming on, they would put the hose to the nose and let the water run through.

Neti is very refreshing when done correctly and leaves the nose feeling open and purified of mucus, dust, pollen, and allergy-inducing particles.

When you examine the physiology of the nose and sinuses, it makes sense to keep these channels clear. Microscopic hairs called *cilia* are found in the sinus and mucus membranes. Under a microscope, they look like a cornfield swaying in the wind. These cilia are coated with a layer of mucus that catches all the dirt, dust, and pollen, transporting them like a conveyor belt through the nose,

down the throat, and into the stomach. Cleansing with salt water keeps the mucus moist, stimulates the cilia hairs, and removes offending substances before they can enter the body.

By now you have rushed to the Internet to order a *neti* pot online to find out what you've been missing. Once you have received your ceramic or metal pot and gotten over the fact that it has a small spout that looks like a dildo sticking out the side of it, you are ready to cleanse.

Fill the pot with lukewarm water and dissolve a teaspoon of ordinary salt in it. Avoid using sea salt because it may cause an allergic reaction. This water has the same concentration of salt as in the body so it feels comfortable running through the nose. Lean over the sink, put the spout in one nostril, tilt the head, and let the water run out through the other nostril. Relax the back of the throat and the water runs out on its own. When you're done, hang your head over the sink, and, covering one nostril at a time with your index finger, gently blow until the nose is dry. I said gently.

And don't forget to clean the sink.

Neti can be performed once a day, usually in the morning. Adjust the frequency and amount of water and salt according to the condition of your sinuses.

If you are the type of person who prefers an electric gadget for the job, then consider ordering Dr. Grossan's attachment for the Water Pik online. I've tried the Water Pik attachment, but I remain faithful to my small ceramic *neti* pot, which travels with me everywhere. ⊕

[You can find neti pots online in Canada at www.yogaessentials.com. Dr. Grossan's website is at www.ent-consult.com.]



Ron Rosenes is a member of the board of the new Sherbourne Health Centre in Toronto, the Canadian Treatment Action Council, and AIDS Action Now! and an Honorary Director of the AIDS Committee of Toronto.

The rear guard against HIV

Scientists explore the role of antibodies in neutralizing the virus

by Ken Rosenthal and Paula Braitstein

Despite the many advances in treating AIDS, another dubious milestone will soon be reached in this disease's history. AIDS is about to overtake the Black Death as the worst pandemic on record. To have a real impact on the global epidemic of HIV/AIDS, particularly in developing countries, we need a safe, effective, and affordable vaccine. Achieving this goal, though, has proven more difficult than originally anticipated. An effective HIV vaccine will need to trigger long-lasting immune responses that act against the many different strains of HIV, as well as trigger antibodies that can neutralize the virus.

What antibodies are and how they work

Antibodies are immune system substances specific to particular antigens or microbes, such as viruses or bacteria. In fact, viral antigens are only parts (specific shapes or sequences) of viral molecules to which antibodies bind. Produced by white blood cells, called B-cells, antibodies are responsible for the arm of immune defense called humoral immunity. Once the humoral arm of the immune system is alerted to the presence of an antigen, antibodies attach to the antigen and either cover it up so it can't do damage or mark it for removal by other immune mechanisms.

Antibodies come in two forms, neutralizing and non-neutralizing. Neutralizing antibodies bind to molecules on the surface of a virus, preventing it from infecting target cells. However, during an infection, many antibodies are produced that can bind to parts of the virus but are not able to prevent infection. These are the non-neutralizing antibodies. In terms of HIV, only antibodies that glob onto the envelope spikes of the virus are believed to neutralize or block its infectious properties.

HIV envelope spike: sugarcoated master mutator

HIV has 72 envelope spikes embedded in its surface membrane. The envelope spikes are comprised of viral glycoproteins, gp41 and gp120. In fact, the mature form of the envelope spike consists of a gp120 molecule with three molecules of

gp41 twisted or coiled around it and each other to form what is called a trimer. The virus uses its envelope spikes to bind to receptors on cells such as CD4 and CCR5 and then to infect those cells. These envelope spikes are also the targets of neutralizing antibodies against HIV.

During natural HIV infection, many antibodies are made against the envelope antigens of HIV, but only a very small fraction of these antibodies can neutralize the virus. Many of the antibodies are produced in reaction to antigens on the envelope spikes that are no longer accessible once the molecules twist and coil around each other. Think of it this way: if you put your hands together, prayer style, you can't see your palms. If antibodies are made against your palms, they can't get in to bind to them when your hands are folded together. That's why many envelope-based HIV vaccines have not worked so far. They have relied on an injection

The drastic delay in the generation of neutralizing antibodies during primary HIV infection may be why people infected with HIV have such high viral loads at first.

of single subunits of the envelope spike—like a single molecule of gp120—that display different envelope antigens from the mature coiled-up trimer spike.

In addition, HIV hides or masks important envelope antigens (targets for neutralizing antibodies) under a heavy carbohydrate or sugar coating. In fact, about 50% of the molecular weight of the envelope spike comes from this coating. Once neutralizing antibodies are formed against HIV, the virus is also able to rapidly mutate its envelope antigens. Therefore, HIV, the master mutator, can escape from neutralizing antibodies.

Late to the party

During HIV infection, neutralizing antibodies appear very late, usually one to three months after someone is infected and well after HIV viral load has declined to its set point. This late appearance of neutralizing antibodies also occurs with hepatitis B virus (HBV) and hepatitis C virus (HCV) infections in humans.

However, during these infections, non-neutralizing antibodies appear much earlier.

Although this delay in the appearance of neutralizing antibodies is not well understood, experiments with mice suggest two mechanisms that may account for it:

- General immunosuppression caused by the immune system killing infected immune cells (mainly macrophages, dendritic cells, or CD4 helper T-cells).
- Specific infection of B-cells that produce neutralizing antibodies to HIV and their subsequent destruction by anti-HIV killer T-cells. B-cells that make neutralizing antibodies to HIV display these antibodies as their antigen receptors on their cell surface membrane. These B-cells can then bind and get infected by HIV, which would make them susceptible to recognition and killing by anti-viral CD8 killer T-cells. Since viral antigens seen by non-neutralizing antibodies are not expressed on the surface of HIV viral particles, B-cells capable of producing non-neutralizing antibodies would not be susceptible to viral infection.

The drastic delay in the generation of neutralizing antibodies during primary HIV infection may be why people infected with HIV have such high viral loads at first, and why the immune system isn't able to clear the virus on its own. In fact, the delay in production of neutralizing antibodies probably helps HIV establish a persistent or long-lasting infection in people.

Summary

Until recently, the role of antibodies in HIV infection has received scant attention. However, the importance and need for neutralizing antibodies was recently driven home by studies showing that vaccines that only trigger killer T-cell or cytotoxic T lymphocytes (CTL) responses to HIV (see Issue 15 of Living+ for more on this) eventually fail to control the virus because of viral mutation. In these studies, only a single mutation in the virus was required for HIV to escape from T-cell immune control. In order to design effective HIV vaccines, we will have to better understand how to trigger and maintain high levels of neutralizing antibodies to HIV. ⊕

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 rosenth@mcmaster.ca. Paula Braitstein is Director of Treatment Information for the BCPWA Society.



Indinavir and kidney stones

by Roy Parrish

Indinavir (Crixivan) is one of the protease inhibitors used successfully for the suppression of viral load in patients with HIV. One of the most significant side effects associated with this drug is the formation of kidney stones, or nephrolithiasis. In fact, up to 10% of people taking indinavir will develop urological problems such as kidney stones.



kidney stones

How to reduce the risk

Patients on indinavir therapy are advised to maintain a fluid intake of at least 1–2 litres of water per day. During the warmer months, the amount of water required may need to be increased to 2–3 litres per day.

When to take indinavir

The first four hours after taking indinavir are crucial. The kidneys need water at this time to help facilitate the removal of the excess amounts of the drug that may be in the body. Many doctors suggest patients avoid taking their antiretrovirals (if they include indinavir) at bedtime precisely because of this need for water. Patients who find they do not have to urinate during the night may be experiencing dehydration.

The combination of indinavir and ritonavir may also increase the incidence of kidney stones. Since dehydration is the main risk factor for developing stones, ritonavir-associated gastrointestinal side effects, particularly nausea and vomiting, may explain the increase. ⊕

Ray Parrish is a Treatment Counsellor with the BCPWA's Treatment Information Program



Double whammy

Update on HCV and HIV co-infection research

by Glen Hillson

Liver illness is a common problem for people living with HIV/AIDS. Evidence of impaired liver function comes in various forms, including elevated enzymes (ALT and AST), which may only be noticed during routine blood monitoring; clinical symptoms such as loss of appetite, nausea, bloating, and jaundice; or by more sophisticated diagnostic procedures such as ultrasound or liver biopsy. Liver illness is always potentially very serious and even life threatening.

One of the most difficult challenges for HIV-positive people with liver problems is to determine the underlying reason(s). HIV itself affects many body systems, including organs such as the liver. Combination drug therapies can also affect liver function because the body relies heavily on the

Recent research suggests people with HIV disease may be biologically more vulnerable to HCV through sexual transmission.

liver to process most drugs. Different drugs can adversely affect the liver through different biological processes that are generally not well-defined medically. For example, nucleoside drugs can cause serious liver failure by interfering with the function of cell mitochondria throughout the body and cause a condition called lactic acidosis, leading to terminal liver failure. Non-nucleosides and protease inhibitors can also add to liver stress, either through rapid adverse reactions or by adding to other compound stresses. Viral illnesses such as hepatitis A, B, and C are well-known causes of liver disease and damage.

Shortfalls in the HCV screening process

Hepatitis C virus (HCV) was only discovered in 1989, and scientists still need to learn a great deal about it. Because HCV is transmitted through blood, medical practice has generally viewed blood transfusion recipients and injection drug users as the only populations at risk of becoming infected. Consequently, they are frequently the only people to receive the test normally used to identify HCV.

This medical approach to screening for and diagnosing hepatitis C has proven unreliable for many, especially gay men and people with HIV/AIDS, for several reasons. People with diminished immune capacity may be HCV-infected but may not have antibodies to the virus because they may have developed them and then lost them; therefore, they may have false negative test results.

Recent research suggests people with HIV disease may be biologically more vulnerable to HCV through sexual transmission. Although experts generally report that the risk of sexual transmission is low, they also acknowledge that risk is greater for individuals with multiple sex partners. Finally, Canadian research suggests that men who have sex with men and those who practice rimming and fist-

ing may be at greater risk.

Last year, the BC Centre for Excellence in HIV/AIDS advised HIV-treating physicians not to rely solely on antibody testing for HCV identification in people with HIV who have unexplained liver illness. They suggest qualitative polymerase chain reaction (PCR) testing, which is designed to identify HCV itself rather than antibodies. (This method of identification is similar to HIV viral load testing, which genetically identifies and measures HIV.)

Many other theoretical risk factors for HCV transmission need to be tested through research. Timely detection of HCV is

just one of many issues for people who are co-infected. Many people who have HCV never find out how they were infected. In addition to the routes of transmission previously discussed, many other possibilities exist that are not well understood, such as toothbrushes, razors, and body piercing.

Optimal strategies for the concurrent medical management of HIV and hepatitis C are highly experimental, as are many of the combinations of drugs that are used to treat each disease separately.

Progression rates in co-infected people

HCV disease progression is relatively slow. Many people who are HCV mono-infected will remain free of symptoms. One in five will eventually develop cirrhosis of the liver, and one in twenty patients will experience liver failure or liver cancer.

Most research studies of people who are also infected with HIV show faster rates of progression than in mono-infected HCV patients. The reason for this difference in rate of progression has never been explained, and in most cases, it is attributed to the fact that people with HIV have a weaker immune response to HCV.

A recent report in the journal *Gastroenterology* suggests that it is possible to have advanced chronic hepatitis C even while ALT levels remain at normal levels. This finding is important since access to expensive HCV therapy is based solely or primarily on ALT levels in some jurisdictions.

One report characterized some of the most frequently occurring differences between HCV and HCV/HIV patients. In co-infected patients

- HCV viral load was higher
- Liver fibrosis was more pronounced
- Response to interferon treatment was poorer
- Higher HCV viral loads were associated with low CD4 counts
- Progression to cirrhosis was accelerated.

Other factors shown to increase the rate of HCV disease progression include being overweight, old age at time of infection, and alcohol consumption.

Treatment of HCV

Standard therapy for HCV is treatment with a combination of interferon alfa-2b and the nucleoside ribavirin. Newer “pegylated” forms of interferon alpha-2b have also been developed. Treatment response seems to be improved with the pegylated versions and injection dosing is weekly, compared to three times per week or daily. Both these advantages are the effect of pegylated interferon’s longer serum half-life. This means it stays in the body longer and maintains target drug levels more consistently—sort of like a time-released version.

Because HCV disease progression is slow and a majority of patients never require treatment, people normally don’t receive treatment until their disease is at least somewhat advanced. Other factors that support this approach are the high cost and poor safety profile of HCV medication. However, in a German study of recently infected patients published in the *New England Journal of Medicine*, 43 of 44 subjects were able to clear their HCV completely. Further research is necessary to identify which patients are more likely to benefit from early treatment.

Long-term follow-up of patients from three large international

In co-infected patients, HCV viral load is higher, liver fibrosis is more pronounced, and response to interferon treatment is poorer.

studies looked at 395 patients who responded to therapy (no detectable HCV) and had sustained response for at least 24 weeks after discontinuing treatment. Only 10 of the patients who remained undetectable 24 weeks after stopping treatment relapsed and all of those relapses occurred within the first 2.5 years. Although factors such as viral load and HCV genotype are known predictors of initial response to treatment, they did not appear to be related to relapse.

Other research studies seem to provide further confirmation that even in patients categorized as “non-responders” to treatment because they don’t eliminate HCV altogether, treatment can provide clinical benefits. Even among non-responders, the progression of fibrosis was often slowed or reversed. The risk of liver cancer may be diminished and reversal of cirrhosis may be possible. All of these factors are likely to extend life.

For patients starting with standard treatment, one study suggests that starting patients on higher doses of interferon, then later reducing dosage in two stages according to the rate of viral load decline, might provide a better response. Frequent viral load monitoring is not likely available in most clinical settings, but this research could improve treatment methods in the future.

Liver transplantation is a topic of increasing interest for people with HCV. The success rate for the procedure has improved and is now increasingly available to people with viral hepatitis. In patients with consistently detectable viral load, a transplanted liver will also become infected soon after surgery. Nonetheless, liver transplant does offer extended survival to patients with severe liver disease. Larry Kramer’s recent highly publicized transplant may increase availability of transplants to people who are co-infected. ⊕

Love, no glove

Women and men are demanding microbicide development

by Janet Madsen

We are twenty years into the AIDS epidemic, and infections in women are increasing. The public health messages women receive are “abstain from sex,” “be monogamous,” or “use condoms.” For many women, these messages are inadequate or unrealistic at best. At worst, they are life threatening. Millions of women lack both the power within relationships to insist on condom use and the social and economic resources to abandon partners who put their health at risk.

Sexually transmitted diseases (STDs), including HIV/AIDS, represent an emergency in women’s health. Not only are women at greater risk of acquiring STDs than men, but in most cases, the consequences of contracting STDs—including infertility, ectopic pregnancy, and cervical cancer—are more serious and permanent for women.

Millions of women around the world lack the power within relationships to insist on condom use.

Women need products other than condoms that can protect them against HIV/AIDS and other STDs. Research is now underway to develop such products, known as microbicides, substances that could substantially reduce the transmission of HIV and other STDs when used in the vagina or rectum. Microbicides could come in many forms, including gels, creams, suppositories, films, sponge, or vaginal ring. There was hope that the spermicide nonoxynol-9 could serve as a microbicide, but studies revealed that N-9 actually irritates both vaginal and rectal tissues, potentially making it easier for HIV to get into the bloodstream.

For women who are seldom or never able to use condoms, microbicides could lower their overall risk of infection. Women want microbicides: a recent survey in the US estimated that 21 million women are interested in a microbicide product. In studies conducted in countries in Africa, both women and men expressed willingness to use microbicides. Gay men who want an alternative between condoms and barebacking could use microbicides or “chemical condoms,” as San Francisco sociologist Michael Scarce calls them. Scarce says microbicides would allow us “to imagine a life without latex, prioritizing pleasure as well as safety. Don’t we deserve that?” Absolutely.

With sufficient human and scientific effort, a microbicide product could be available within five years. Large pharmaceutical companies are simply not interested in investing in microbicide development. They are skeptical about whether microbicides would be profitable after the costs of research and marketing are met because such products would have to be inexpensive to be made available globally. They have also raised concern over issues of liability, since microbicides would promise to offer some protection against life-threatening illnesses. As a result, several universities and small independent pharmaceutical firms have taken the lead on microbicide research. Some promising microbicides are being developed (including research being done in Quebec), and we have everything we need to bring a microbicide to market within five years—except the money. Researchers estimate that it costs up to \$50 million to complete research on an existing compound and twice that to start from scratch with a new compound—far more than many of these small companies and non-profit entities have the capacity to invest.

Without federal leadership and funding, a microbicide is not likely to be available anytime soon. Positive Women’s Network and the BCPWA Society are part of Microbicide Advocacy Group Network (MAG-Net), a national coalition working to educate and advocate for microbicide awareness and development. For more information, contact MAG-Net Coordinator Lilja Jonsdottir at liljaj@cdnaids.ca or 1-800-884-1058, ext. 116. For more information on microbicides, contact the Global Campaign for Microbicides at www.microbicide.org.

Microbicides will give women all over the world one more way to protect themselves against the ravages of HIV/AIDS and other STDs. We need them now. ⊕

Adapted by Janet Madsen from an article by Anna Forbes (Global Campaign for Microbicides). Janet Madsen is the Communications Coordinator at Positive Women’s Network.



let's get clinical



To the rescue: large trials test approaches to rescue therapy

by Jim Boothroyd

No fewer than 600 Canadian participants are being sought for two major clinical trials that aim to help HIV-positive people on failing drug regimens.

The first, Options in Management of Antiretrovirals (OPTIMA, or CTN 167), is the most ambitious trial ever undertaken by the 11-year-old Canadian HIV Trials Network (CTN). The publicly funded tri-national trial seeks to determine the best methods for managing the treatment of patients with advanced HIV for whom first- and second-line highly active antiretroviral therapy (HAART) has failed.

The objective of the randomized, controlled trial is to compare the effect of different management strategies on survival, time to AIDS-defining event, virologic and immunologic response, quality-of-life measures, and other health outcomes during an average of two years of follow-up.

Investigators will compare mega-ART (five or more anti-HIV drugs) versus standard-ART (up to four anti-HIV drugs) and a three-month antiretroviral drug-free period versus no drug-free period.

Among other criteria, eligible participants

must be 18 or older, HIV-positive, and have had the failure of at least two different multi-drug regimens containing drugs of each class that the patient can tolerate.

OPTIMA began recruiting in December. The BC sites are Providence-St. Paul's and Downtown Infectious Diseases Clinic (IDC), both in Vancouver, and Cool Aid Community Health Centre in Victoria.

"This made-in-Canada trial answers last- ing questions that trouble a growing number of treatment-experienced people the world over," says principal investigator Dr. William Cameron. "New medications alone will not address their needs, and this clinical trial will evaluate different medical management strategies of restarting combination treatment, which may include new medications as they are available."

The second study, Structured Treatment Interruptions (STI, or CTN 164), is a randomized, open-label clinical trial, designed and led by Dr. Sharon Walmsley at Toronto General Hospital.

This study aims to determine the best method of managing treatment of patients for whom first-line HAART has failed.

Participants assigned to the control arm are switched immediately to a salvage regimen based on their personal treatment histories, genotype, and phenotype. Those assigned to the STI arm stop their antiretrovirals for 12 weeks before beginning a salvage regimen tailored to their histories, genotypes, and phenotypes.

To ensure the safety of participants, those in the STI arm are monitored monthly.

Eligible volunteers must be 19 or older and have a plasma viral load between 1,000 and 500,000 copies/ml despite being on a combination therapy.

STI is funded by the Canadian Institutes of Health Research and is enrolling at 20 sites across Canada. The BC sites are 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.

Other CTN trials enrolling

110 (ESPRIT), Subcutaneous Interleukin-2 (rIL2). BC site: Cool Aid Community Health Centre, Victoria

124 Protease-Inhibitor-Containing vs. PI-Sparing in early HIV. BC site: Downtown Infectious Diseases Clinic (IDC), Vancouver

145 (SILCAAT), rIL2 to slow progres-

sion of HIV. BC site: Providence-St.Paul's Hospital, Vancouver

148, Gender Differences in Lipodystrophy Syndrome. No BC site; four sites in Quebec and Ontario.

161 (SPRINT), Simplified Protease-Inhibitor Trial. BC sites: Viron and Providence-St. Paul's, Vancouver; Cool Aid Community Health Centre, Victoria

169 (DAVE), d4T or Abacavir with Vitamin Enhancement. BC site: Providence-St.Paul's, Vancouver

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.

Out of the doldrums

Stress and depression may also drag down your CD4 counts

by Rob Gair

In the past decade, more than thirty published studies have attempted to examine the effects of various psychological factors, such as stress, depression, and social support, on HIV progression. A 1997 article entitled “The Psychobiology of HIV Infection” in *Critical Reviews in Neurobiology* reviewed these studies. Because of design and execution problems with some of these studies, many of the data are conflicting or inconclusive.

The issues are complex, which shouldn't be surprising considering what is occurring. The immune system, already weakened by HIV infection, may be further weakened by chemicals produced in the body in response to various social and psychological stressors. Intuitively, this contention seems to make sense, but this complicated neuro-endocrine response to stress is not well understood in humans. The variability and extent to which

strain, drug abuse, malnutrition, co-infections with other pathogens, viral resistance to medications, and medication intolerance or non-compliance. On their own, however, these factors do not explain the wide variability with which individuals progress to AIDS, and many scientists are attempting to identify and study co-factors that might influence this process.

Stress response

Theories have been proposed for how the neuro-endocrine response to stress affects the immune system. While they bear discussion, most of these theories have been studied only in animals or in the test tube, and their application to people infected with HIV is largely unproven.

Under conditions of psychological stress, the brain produces a cascade of chemicals that eventually results in the release of cortisol and other related hor-

would increase the number of HIV-infected CD4 cells. Cortisol may also render the HIV-infected CD4 cells more susceptible to cell death and hinder the production of replacement cells.

Conditions of stress also result in the release of adrenaline and norepinephrine from the adrenal gland and brain into the blood stream—the “fight or flight” response. Like cortisol, increased levels of these hormones may also increase the rate at which CD4 cells come into contact with HIV. They may also suppress the effects of CD8 cells, which destroy HIV-infected cells before replication and viral shedding takes place. Activation of these hormones may indirectly affect the outcome by impairing immune system control of opportunistic infections.

Stressful experiences

Natural disasters, bereavement, divorce, unemployment, and disability have all been shown to activate stress responses. The number of “generic” stressful events in a person's life has not been shown to affect HIV progression. More clearly, it appears to be how one copes with specific, highly stressful events that has an impact. For example, HIV infection is itself a major stressor. In several small studies of HIV-infected individuals, positive coping responses and “fighting spirit” were associated with slower progression to AIDS. By contrast, negative expectations, denial, and hopelessness have all been associated with faster progression to AIDS. Several studies document positive effects from stress-management training, meditation, and hypnosis. However, other studies show no

Studies reveal that monkeys with SIV that had less frequent social interaction or high levels of conflict had higher rates of death.

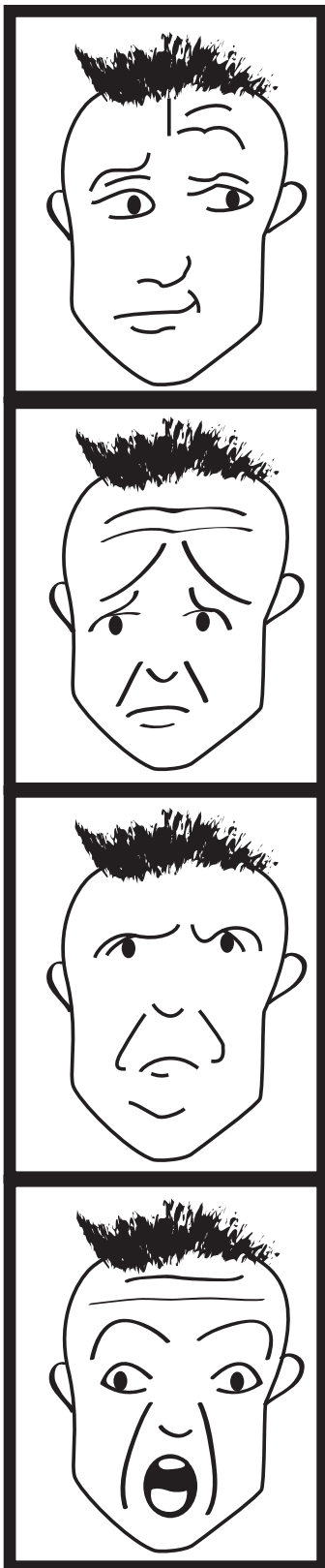
it occurs in different people and the subjectivity of what constitutes a stressor further complicates interpretation of results.

This article will attempt to clarify some of these issues by examining possible mechanisms by which stressors affect the immune system.

HIV progression

Various factors influence progression to AIDS, including genetics, type of viral

mones from the adrenal gland. These hormones help the body adapt and respond to the stressor. Most stressors do not result in high cortisol concentrations, but when they do, the cortisol appears to affect certain factors of immune function. Specifically, high cortisol levels may increase the rate at which CD4 cells come into contact with free virus. Cortisol has also been shown to hasten HIV replication in CD4 cells that are already infected. Both influences



effect with interventions like cognitive-behavioural or experiential therapy.

Another major stressor that has been associated with higher risk of HIV progression is bereavement, especially if the grief is accompanied by depression. The association is even stronger if the depressed mood is dominated by self-blame for the death of the loved one. Those who find meaning from the experience tend to fare better.

Depression

Clinical depression, characterized by sleeping problems, poor appetite, and feelings of sadness, has a more complex relationship with immune function, in part because the relationship between stress and depression is not distinct. That is, depression may be triggered by a stressful event, or it may itself be a stressor. Of course, not everyone who experiences a major stressful event gets depressed.

Not surprisingly, data are conflicting. Some rather large, long-term studies show no relationship between CD4 cell count decline and depression. One small study showed a faster decline in CD4 cell counts in men who had depressive symptoms. Several small studies where individuals were treated for their depression with medications showed improvement in depressive symptoms but no effect on CD4 levels.

Some experts suggest that current measures of depression may be tainted by accompanying bereavement, HIV-induced psychiatric problems, or physical symptoms, and that these issues need to be factored out before a clear relationship between depression and HIV progression can be established.

Social support

Positive social reinforcement has been linked to better health. This phenomenon has not been well studied in people with HIV, and data are conflicting. Some studies show that people with positive social interactions have lower rates of CD4 cell count decline. Conversely, other studies find that people who are lonely have lower rates or that there is no effect. Studies reveal that macaques with simian immunodeficiency virus (SIV)—

the monkey version of HIV—that had less frequent social interaction or high levels of conflict had higher rates of death.

Another social trait that may be linked to faster progression to AIDS is inhibition of thoughts or feelings. It is thought that people who “hold back” are more likely to experience problems earlier. People who are closeted about their sexuality and those who fear rejection are also more likely to have faster CD4 cell count declines. It’s unclear whether faster progression to AIDS is a manifestation of these social problems or whether it’s a result of the specific personalities of the individuals.

Conclusion

Numerous studies have examined the effect of stress and other social problems on HIV progression, but the scope of this issue is likely much larger than the number of studies would indicate. Knowledge about how these stressors affect the immune system is lacking, and results from current studies are conflicting.

Nevertheless, certain trends are emerging. Highly stressful events, like certain coping responses to HIV infection and bereavement, have consistently been linked to faster HIV progression. Concealing one’s sexuality and fear of social rejection are also linked to faster CD4 cell count declines. The link is not so clear when it comes to depression or social isolation.

Several limitations are inherent in studies examining the problem. One of the biggest problems for scientists studying this issue is the ability to recruit enough people for sufficient time to obtain meaningful results. Other problems include difficulty controlling for non-psychological variables that may influence HIV progression over the study period. More studies are needed to determine whether psychological interventions will result in improved outcomes. ⊕

[The information in this article is based on “The Psychobiology of HIV Infection,” by S.W. Cole and M.E. Kemeny, *Critical Reviews in Neurobiology*, 1997; 11(4):289–321.]



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



Presencia Latinoamericana en la Conferencia NATAF 2001

by Alejandro Alvarado & Enrique Lopez

Por primera vez Vancouver fue sede de la conferencia NATAF 2001 (North American AIDS Treatment Action Forum), siendo esta la primera ocasión que se realiza fuera de Estados Unidos.

Este evento tuvo lugar en un conocido hotel de la ciudad del 2 al 5 de diciembre de 2001. La coordinación estuvo a cargo de la National Minority AIDS Council representado por Carlos Arboleda de Colombia y como anfitrión BCPWA Society.

Este encuentro representó una gran oportunidad para estrechar lazos de cordialidad con nuestros colegas hispanos que viven en Estados Unidos, México, Centro América, el Caribe, Sudamérica y Canadá.

Todos ellos trabajando para organizaciones en la lucha contra el VIH/SIDA. Dentro de esta jornada de 3 días de trabajo, los temas más sobresalientes y por supuesto de interés para la comunidad lati-

na viviendo con VIH, fueron los relacionados al acceso a los cuidados a tratamientos para inmigrantes que viven con VIH en Estados Unidos y Canadá.

La problemática actual que viven los países en vías de desarrollo para obtener medicamentos y como algo extraordinario en el campo de la ciencia, fue la participación del Dr. Julio Montaner, que dentro de su discurso de clausura dio a conocer que hoy en día es recomendable que una persona diagnosticada seropositiva se someta a una terapia antirretroviral a partir de por lo menos 200 en el conteo de su células (CD4), siempre y cuando el nivel de carga viral no sea demasiado alto o presente síntomas de enfermedades oportunistas.

Esto significa el inicio de una terapia antirretroviral "oportuna", reduciendo así los recursos económicos y lo más importante la exposición temprana a los

efectos secundarios que pueden causar las terapias antirretrovirales.

Esperamos que todo el entusiasmo generado en este foro se desborde en acciones concretas para educar e informar en beneficio de la comunidad latina en general y en especial a las personas viviendo con VIH.

!!Felicitaciones BCPWA!! ⊕

Información sobre tratamientos anti VIH via correo electrónico nuestro e-mail es treatment@parc.org

Información en Español

BCPWA Treatment Information Program (TIP)

Ofrecemos información en español sobre terapias y tratamientos para la infección de VIH y SIDA.

Consejería individual es disponible todos los Miercoles 10:00AM a 5:00PM.

Visitenos a nuestra dirección:

BCPWA Programa de Información sobre los Tratamientos

1107 Seymour Street, Vancouver, BC V6G 5S8

A la entrada, a un lado de la librería "PARC"

O llámenos a nuestra línea directa: Tel: 604.893.2243

Volunteering at BCPWA

Profile of a volunteer:



Darren serves the membership in a respectful, professional manner as a peer and as a resource person. His sense of humour and his creative suggestions are assets to the department as well as to the members.

JACKIE HAYWOOD

DARREN JAMES

Volunteer History

I started volunteering for BCPWA in the Lounge. I then volunteered for the information desk. I am now in the Support Office doing the Complementary Health Fund project in the BCPWA lounge.

Started at BCPWA

February 1993.

Why pick BCPWA?

I picked volunteering at BCPWA because the organization was a big help when I moved to Vancouver and when I needed support. I just wanted to be more than a member. I wanted to be a member who gives a helping hand to those in need.

Why have you stayed?

I have stayed at BCPWA because I feel I have a lot to offer to the members. I want to show the members that just because you're HIV-positive, it is not the end of the world. If you're positive, think positive—you'll be around much longer.

Rating BCPWA

The staff and volunteers are a riot. All members are guaranteed to exit with a smile.

Strongest point of BCPWA

Honesty, and supportive to all who visit.

Favourite memory

There are many favourite memories. If I have to pick one, it would be our Members' Christmas dinners.

Future vision for BCPWA

Being there until the cure is found, and even at that, continuing to educate people about the disease.

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 March 25.

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

631-5327 or 1-800-661-4664

Ministry of Health Information

1-800-665-4347

Sexually Transmitted Diseases Clinic

660-6161

St. Paul's Hospital

Infectious Disease Clinic 806-8060

Patient Information 806-8011

Pharmacy: 806-8153 and 1-888-511-6222

Social Work Dept. 806-8221

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, BC, 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 contact 604.893.2213, leave a message or speak to Danielle on Mondays 1:30-4:00 or Albert on Tuesdays 10:00-1:00

DROP-IN LUNCH FOR POSITIVE WOMEN:

In the Positive Women's Network kitchen. Drop in lunch Tuesday and Thursday 11.30AM-3.30PM. For more information or to become a PWN member call Nancy at 692.3000.

FRIENDS FOR LIFE SOCIETY: DINNER WITH MOM:

Sundays 5.30 pm at Diamond Centre for Living at 1459 Barclay. Call us at 604.682.5992 for more info.

POSITIVE ASIAN DINNER:

A confidential bi-monthly supper and support group for positive Asian people at 210-119 West Pender. Visit our website at www.asia.bc.ca.

VANCOUVER NATIVE HEALTH SOCIETY HIV OUTREACH FOOD BANK:

Tuesdays 12NOON-2:00PM 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, t 608.1874 f 604 608.4259.

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.

GILWEST CLINIC:

Comprehensive health care for persons with HIV/AIDS. Also methadone maintenance program. Richmond Hospital, 7000 Westminster Hwy.,

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.



Richmond, fax 604.244.5118. Drop-in Monday 9AM-11AM and Thursday 4PM-7.30PM

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.

PENDER COMMUNITY HEALTH CENTRE:

specializing in treatment of addiction and HIV. Located at 30 Blood Alley Square. Phone: 669.9181. Drop in Monday 9AM-11AM and Thursday 3PM-6PM

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.

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 8:30AM to 4:30PM, 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, t 899.5405 f 899.5410 www.wingshousing.bc.ca

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 604. 893.2223 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. Clinics every other Thursday from 6PM-8PM. 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 9:30AM to 4:00PM, 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., 8:30AM- 8:30PM

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.



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.

LOWER MAINLAND

Monday

LULU ISLAND AIDS/HEPATITIS NETWORK:

Weekly support group in Brighthouse 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.

SUPPORT GROUP: For HIV positive

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.

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 604-515-2134

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.

The Law Students' Legal Advice Program (U.B.C.) provides legal services for:

wills, traffic violations, small claims, residential tenancy issues, minor criminal matters, and other legal matters
The clinic does not provide services for family law issues.



Every other Thursday from 6 - 8pm BCPWA Advocacy Department

To make an appointment, call Stephen in the Advocacy Department at 604-893-2223.

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.

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

CHEE MAMUK, ABORIGINAL PROGRAM:

To provide culturally appropriate on-site community based HIV/AIDS and Sexually Transmitted Disease education and training to Aboriginal communities, organizations, and professionals within BC. Their mission is to share information and build skills around the subject of HIV/AIDS, Hepatitis and STDs. To help participants explore their lives and lifestyles in a way that encourages spiritual, mental, emotional and physical health. 655 West 12th Avenue. For more information call Lucy Barney at 604.660.2088 or Melanie Rivers at 604.660.2087. Fax 604.775.0808. Email: lucy.barney@bccdc.ca, or melanie.rivers@bccdc.ca. Website: www.bccdc.org/stdaids/stdeducation/BCAAAP/BCAAAPindex.shtml

CANADIAN HEMOPHILIA SOCIETY - CHS B. C. CHAPTER:

Many services for Hemophilic 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. ABORIGINAL HIV/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. 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. 6254.

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. Wednesday 2PM-3PM: PWN's Network Drop-in group for HIV+ women interested in talking about getting clean, staying clean or even thinking about being clean. This is not a 12-step group. Call Sangam at 604.692.3006 for more info. Thursday 1PM-3PM: Positive Women's Network Sharing Circle for HIV+ women. A time to share stories and support each other. Call Stacie 604.692.3005. Thursday 6PM-8PM: 'Taking a break' group for HIV-Positive women. Discussions around intimacy, self-esteem, sexual and emotional health. Lots of support and lots of laughs. Call Sangam 604.692.3006 for info and sign up

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

SURREY HIV/AIDS SUPPORT NETWORK:

for people living with HIV/AIDS, providing support, advocacy, counselling, education and referrals. Hours of Operation: Monday and Thursday from 10AM-5PM. Support group meets regularly. For more information call 604.588.9004.

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 t 604.530.1115 f 604.530.8851 www.langleyhospice.com

PEACE ARCH COMMUNITY SERVICES:

Provides individual counseling and support groups to persons infected or affected by HIV and Aids in the South Surrey/White Rock area. Also assist individuals with referrals and information. Phone: 604-515-2134

VALLEY AIDS NETWORK:

Biweekly Wednesday evening support group in

Abbotsford. For information call Nicole Giesbrecht at 604.850.6639.

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.

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 1601 Blanchert Street, Victoria, BC V8W 2C5. 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. Contact the office closest to you for Support Group Meeting places and times. Courtney office: NIAC, 355-6th St., Courtenay, BC V9N 1M2. Phone 250.338.7400 or toll-free 1.877.311.7400. Fax 250.334.8224. Campbell River: NIAC, 684B Island Highway, Campbell River, BC V9W 2C3. Phone: 250.830.0787 or toll-free 1.877.650.8787. Fax: 250.830.0784. Port Hardy Office: NIAC, 8635 Granville Street, Ground Floor, Port Hardy, BC V0N 2P0; mailing address: PO Box 52, Port Hardy, BC V0N 2P0. Phone and fax: 250.902.2238. Cell phone: 949.0432.

VICTORIA AIDS RESPITE CARE SOCIETY:

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

VICTORIA PERSONS WITH AIDS SOCIETY:

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

THOMPSON-OKANAGAN

HEALTH

OUTREACH HEALTH SERVICES:

Full STD/HIV testing and counselling; health care, pregnancy, and contraception counselling; needle exchange. Suite 102, 1610 Bertram Street, Kelowna,

BC. Phone 250.868.2230 Fax 250.868.2841.

VERNON - NORTH OKANAGAN-YOUTH AND FAMILY SERVICES OUTREACH HEALTH AND NEEDLE EXCHANGE:

Information and support available to individuals affected by HIV and AIDS. 2900 -32nd Street, Vernon, BC V1T 2L5. Phone 1.250.545.3572. Fax 1.250.545.1510.

AIDS GROUPS & PROGRAMS

AIDS RESOURCE CENTRE - OKANAGAN & REGION:

Information, referral, advocacy, peer support, social & support groups, 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@silc.net. Penticton Office 800.616.2437, Princeton Office 800.616.2437.

AIDS SOCIETY OF KAMLOOPS (ASK):

437 Landsdowne, 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 Ctr. PO. 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

Upcoming BCPWA Society Board Meetings

Date	Time	Location	Reports to be presented
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
April 3, 2002	3:00	PARC Training Room	Executive Committee / Written Departmental Reports
April 17, 2002	3:00	PARC Board Room	Standing Committee / Written Executive Director Report
May 1, 2002	3:00	PARC Training Room	Director of Fund Development Presentation / Written Departmental Reports
May 15, 2002	3:00	PARC Training Room	Room Executive Committee / Written Executive Director Report
May 29, 2002	3:00	PARC Training Room	Standing Committee / Written Departmental Reports

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

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 1.250.565.6674.

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 AIDS Outreach and Support Society

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 responsibility 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.

HIV+ male, 44 years old, looking for HIV+ female for long-term companionship or marriage.
Kids okay. Call Parvez at 604.710.7037

Yes! I want to receive living+ magazine

name _____

address _____ city _____ province/state _____

postal code/zipcode _____ country _____

phone _____ fax _____ email _____

I have enclosed the following for 6 issues of living+

- \$25 Canadian (non-BCPWA members) \$40 USA \$45 International
- I want to donate the above subscription to a PWA who can't afford it
- I am a PWA and can not afford the full subscription price
- Enclosed is my donation of \$_____ for living+
- Please send me more information about Planned Giving
- I want to become a member of BCPWA

Cheque payable to BCPWA



www.bcpwa.org

living+

1107 Seymour Street
Vancouver, BC
Canada V6B 5S8



Down with dumbbells

by Glen Hillson

I've never been big on New Year's resolutions, but last December I decided to get a head start on the annual rush for personal redemption and revitalization. I packed my kit one morning and trudged off to a gym for the first visit in several years. For more than a decade, my contribution to the acquisition and maintenance of lean body mass has been almost entirely financial, and that arrangement has suited me very nicely. Every month, the people at Fitness World extract money from my bank account, and in exchange, I refrain from darkening their doors or causing any bother.

Despite the mesmerizing pharmacopoeia of prescription drugs and the endless cascade of medical procedures blended into concoctions for better health and longer life with HIV, it seems as if every time I turn around some obnoxious holistic zealot is touting exercise as a cure for this or that. As if the Ally McBeal syndrome isn't enough, now we have to contend with this whole nasty business of HIV drugs clogging arteries and triggering fat and muscle cells to relocate themselves in all the wrong places. It's not fair. Why can't we just be sick like normal people who lay about eating bonbons and watching Oprah?

"You have one of the older-style membership cards," observes the perky

six-pack wonder of the world standing behind the counter when I arrive.

"It hasn't had occasion to venture out of my wallet in several years," I reply, hoping with one swipe to erase both his smirk and my vague appreciation of what a teenage boy might feel when producing a condom that bears an expiry date from the previous century. "If you notice any commotion and a motionless body on the floor, it's likely me, and I would be ever so grateful if you would be kind enough to call 911 immediately."

I scurry away in search of the smoking section.

While arranging myself into a smart, vintage Woody Allen-meets-Richard Simmons sweat ensemble and complaining out loud about the unheated tile floors in the locker room, I am reminded why I abandoned the trappings of a youthful lifestyle in favour of a more refined existence.

My gym is divided into three basic sections: women, beefcakes, and intellectuals. Thankfully, the hard body dullards are caged on a separate floor and even have their own locker room, so I am spared the humiliation of a gaggle of gorillas jousting to see who can be the first to grunt forcefully enough to knock me clean off my feet. The women's section seems like a good bet for making

new friends, but in the interest of not attracting undesirable attention, I arrive inevitably at door number three.

I don't excel at technology. Innate inability to master the gimmickry of electronic treadmills, bikes, and stair-climbing machines without incurring the need for reconstructive facial surgery can be a barrier to optimizing one's workout potential. When the first setting on a weight machine is too heavy to budge, that also presents a challenge. Fortunately, I am in the section with other similarly non-gifted bravehearts who are savvy enough not to look sideways. I cast anxiously about the room searching for some wisp of dignity to grasp.

In 45 minutes flat, I am out the door.

I made it back four more times before the new year but have now decided that since I am already enjoying a medically necessary treatment holiday from all my HIV and hepatitis C drugs, a vacation from the fitness component of my regimen is also in order. I'm thinking seriously about going back next month. Until then, I sustain myself with the comfort and righteousness of continuing to make a monthly cash donation to this very important and worthwhile cause. ⊕

Glen Hillson is a proponent of the holistic health benefits of facials, manicures, and pedicures.