

- [02] **THINK +**
What it's like to be a gay, HIV-positive Asian.
- [03] **NEWSREEL**
HIV/AIDS-related news snippets from around the world.
- [05] **BUDDY BITES**
You may be eligible to apply for welfare to pay for your moving costs.
- [06] **SEX, GENDER AND HIV IN MEXICO**
A capacity-building project aims to help HIV-positive Mexican women.

features

- [09] **WHEN EAST MEETS WEST**
Asians PWAs in Vancouver and the rest of Canada often find themselves on a collision course with Old World customs and sensibilities.
- [12] **PREVENTION INITIATIVES**
The challenges of getting prevention messages out to Vancouver's Asian community.
- [20] **CULTURAL BARRIERS TO HEALTH CARE**
Asian Pacific Islanders tend to be lumped together for healthcare services, but their needs are as diverse and distinct as the numerous communities they come from.
- [23] **A LOCAL PERSPECTIVE**
Dr. Brian Conway shares some of his experiences treating HIV-infected Asians.

treatment information

- [13] **SIDE EFFECTS**
Incidences of both HIV and diabetes are increasing in BC's aboriginal population.
- [15] **SYMPTOMS AND SIDE EFFECTS**
Learn to recognize the signs of depression, and prevent it from dragging you down.
- [16] **COMPLEMENTARY THERAPIES**
 - > L-carnitine is viewed by some as the body's premier energizer
 - > Treating HIV symptoms with acupuncture
- [19] **CANADIAN HIV TRIALS NETWORK**
Three clinical trials are examining the potential immune-boosting uses of interleukin.
- [24] **IMMUNOLOGY**
Our innate immune system provides early defense against infections.
- [26] **ANTIRETROVIRALS**
 - > Why you should stick to your drug regimen.
 - > A new test is in development to detect mitochondrial toxicity before a host of side effects develop.
- [28] **NUTRITION**
Why it's difficult to make scientific-based recommendations for nutrition supplements.
- [30] **TREATMENT ADVOCACY**
A transcript of BCPWA Chair Glen Hillson's presentation to the Reference Drug Program Panel
- [34] **POSITIVELY HAPPENING**
Your comprehensive guide to HIV/AIDS resources and support groups in BC.
- [40] **LAST BLAST**
Sometimes healthcare professionals probe just a tad too much.

Credit omission: The sketch on the cover of the last issue was by Gerald Obre.



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.

Living + Editorial Board

Wayne Campbell, Glen Hillson, Joel NC Leung, Richard McNab, Tom Mountford,

Treatment Information Program (TIP) Editorial Board

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

Jim Boothroyd, Dr. Brian Conway, Cristhofer Cuadros, Pamela Ferguson, Nicole Gutfrucht, Tamil Kendall, Ed Lee, Sunny Lee, Enrique Lopez, Diana Peabody, Hilda Perez-Vasquez, Dr. Ken Rosenthal, Ippei Yasuda

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

Funding for Living + is provided by the British Columbia Ministry of Health and by subscription and donations

Living + Magazine
1107 Seymour St.
Vancouver BC
V6B 5S8

TEL 604.893.2255

FAX 604.893.2251

EMAIL living@parc.org

BCPWA ONLINE www.bcpwa.org



think +

opinion and editorial

ASIAN, QUEER AND POSITIVE

by Joel Nim Cho Leung

As I approach the tenth anniversary of my HIV diagnosis, I have mixed feelings about how both the Asian community and the rest of society has responded to the epidemic. In my years of involvement with the Asian Society for Intervention in AIDS (ASIA) and the BCPWA Society, I have had the opportunity to meet and work with many dedicated and caring people. Yet, as an Asian gay man, I find there is little understanding among others of what it is really like to be Asian, gay, and HIV-positive.

Young Asians are at a disadvantage very early in life because they are not empowered to make healthy choices to prevent the spread of HIV. Homosexuality and HIV are taboo topics in most Asian families. For many other children, the home is where health education begins. In Asian households, even discussing sexual orientation or HIV is enough to bring shame.

The lack of attention given by the public education system to these topics places all children at risk, but it is usually worse for Asian children, since potentially life-saving information is also withheld in the home. Young Asians who come out as gay are often taken by their families to an Asian doctor who will recommend psychiatric intervention. For young gay Asians, the long and frustrating struggle to find competent yet culturally sensitive medical care often begins this way.

While many HIV-positive Asians would prefer to access primary healthcare from Asian providers, it can be difficult to find competent, knowledgeable HIV care within our culture.

The community of AIDS service organizations has been slow to acknowledge the HIV disaster that is looming in the Asian community and slow to develop strategic programs for prevention and services that are culturally sensitive to Asians. I raised this topic at the most recent meeting of the Pacific AIDS Network and was left feeling that other participants thought that “diversity” was sufficiently covered with the amount of attention being directed toward aboriginal Canadians.

Unsafe sex is common among Asian gay men. Many feel an expectation to do whatever it takes to please their white partners by being compliant, including having unprotected sex. Racism underpins this notion that casts Asian gays as second-class citizens, not only in society at large but also in the context of supposedly loving, caring relationships.

In addition to pressures that may be distinct to Asians, many of the same factors that fuel the spread of HIV in other populations are also present. Widespread use of recreational drugs is every bit as common among young Asians as it is in other cultures.

British Columbia has a large and growing Asian population. It may soon be too late to avert a catastrophe of HIV infections in our community. Targeted prevention messages, culturally specific healthcare, and a stronger network of community support are all badly needed—and soon. ⊕

Joel Nim Cho Leung is the Secretary of the Board 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.

NEWS REEL

News from home and around the world

AccolAIDS award winners

The winners of BCPWA's AccolAIDS awards banquet were announced on April 28 at Performance Works on Granville Island. The event, a partnership initiative between the BCPWA Society and Granville Island and the Public Market, honours achievement in the BC AIDS movement.

All proceeds from ticket sales and a live art auction will benefit BCPWA programs and services.

Awards recipients for 2002 are: Social Political & Community Action – John Kozachenko; Health Promotion and Harm Reduction – Dr. Michael O'Shaughnessy; Science, Research & Technology – Dr. Julio Montaner; Philanthropy – Starbucks Coffee Company; Innovative Programs – Lois Brummet; Service Delivery – ANKORS; Kevin Brown PWA Award – Joe Average; Lifetime Achievement Award – Dr. Alastair McLeod.



Joe Average

"I know that the Advisory/Nominations Committee found the awards selection process very challenging," said BCPWA Director of Development Melissa Davis. "There have been so many remarkable contributions over the past two decades."

Davis cited BCPWA Chair Glen Hillson's closing remarks from the AccolAIDS event program: "It is both our

hope and our intention to make AccolAIDS an annual event – honouring the extraordinary dedication, determination, and compassion that so many have exhibited in response to the AIDS epidemic – until each and every hero is acknowledged."

Access to free eye exams for PWAs

Before last November, anyone receiving social assistance (with or without DBL II status) had eye exams covered by the Medical Services Plan (MSP). When MSP reduced its coverage of eye exams, the Ministry of Human Resources announced that it would not cover the additional costs.

However, if you are HIV-positive, you may be eligible for free eye exams every 12 months, but you must disclose your HIV status to your optometrist. You have the right to share that information only with your optometrist, and you do not have to tell the receptionist.

The exam must be billed by the optometrist with the diagnostic code for HIV/AIDS, which is 27910.

The BCPWA Society has written a letter to the BC Association of Optometrists on behalf of the membership alerting them to the situation that many HIV-positive individuals are not accessing medical care because they are not aware of the need to disclose their status or feel uncomfortable in doing so.

Zerit safety warning

Manufacturer Bristol-Myers Squibb issued a safety alert about Zerit (stavudine, D4T), following reports of rare occurrences of rapidly ascending neuromuscular weakness that mimic the clinical presentation of Guillain-Barré syndrome, including respiratory failure.

There have been 22 reports since 1994. Seven cases were fatal. Most of the

cases involved lactic acidosis or symptomatic hyperlactatemia. In most instances, patients continued antiretroviral therapy in the presence of non-specific signs compatible with early symptomatic hyperlactatemia that preceded the development of neuromuscular signs and symptoms. Patients on stavudine who develop motor weakness should discontinue the drug.

Bristol-Myers Squibb is working with Health Canada to monitor reports of adverse reactions.

For additional information about stavudine, contact the Bristol-Myers Squibb Medical Information Department at 1-800-267-1088 ext. 2078.

Changes to diet of HIV+ inmates not enough

After a long advocacy campaign with BC Corrections Branch surrounding the inadequate nutrition of HIV-positive inmates, the BCPWA Society has succeeded in making some changes to the menu.

However, Jennifer Epp, Registered Dietitian with Vancouver Dietitians in AIDS Care, does not feel that the menus will always meet the nutritional needs of inmates diagnosed with HIV/AIDS. Symptoms associated with HIV, such as changes in taste, diarrhea, nausea and vomiting, are not reflected in these menu plans.

Menus need to be tailored to the individual needs of all HIV-positive inmates—one set will not meet all their nutritional requirements, Epp asserts.

Alternative meds may pose risk for surgery patients

Work by anesthesiologists is providing evidence that alternative medicines may pose a danger during surgery. At the recent American Society of Anesthesiologists annual meeting, researchers from MD



NEWSREEL

News from home and around the world

Anderson Cancer Centre in Houston described the case of a 37-year-old Chinese man who presented with bleeding after two operations, the first to remove a tumour in the neck and the second to restore vocal cord function. Doctors discovered that the patient's complications were triggered by long-term consumption of ginseng tea.

"When you mix herbs, anticoagulants or antiplatelets, an anesthetic, and a surgical field, you have a recipe for disaster," the researchers noted. They stressed the importance of anesthesiologists and surgeons eliciting complete information about the patient's consumption of drugs, herbs, vitamins, and other dietary supplements.

In the presentation, the researchers highlighted other broad types of potential complications, including the decreased effectiveness of HIV medications. St. John's Wort may significantly reduce the efficacy of protease inhibitors and contribute to drug resistance.

Source: The Medical Post

Regionalization of AIDS contracts

Provincial AIDS contracts for community-based organizations have now been transferred to one of the five Regional Health Authorities. The BCPWA Society, Positive Women's Network and the BC Coalition for Persons With Disabilities are among a small number of agencies with provincial mandates that have been transferred to the sixth Health Authority, called the Provincial Health Authority.

Prevention campaign targets HIV-infected

A controversial advertisement campaign in the San Francisco area directed at HIV-positive people has been influential in increasing condom use among the target audience, according to evaluations. Preliminary data showed that 40 percent of HIV-positive men were more likely to use condoms during intercourse after seeing the ads.

The campaign features HIV-positive spokesmodels in print ads and TV spots, on postcards, and on an interactive website. The campaign's message is that it takes a positive person to infect a negative person

with HIV. The ads sparked debate because they were the first to target HIV-positive people, and because local television stations refused to air the spots during certain hours. *Source: Bay Area Reporter*

Report highlights need for safe injection sites

The Canadian HIV/AIDS Legal Network recently released a report which called for a more effective response to harms related to drug use, saying that Canada has a legal and moral obligation to permit and fund trials of safe injection facilities.

The report, *Establishing Safe Injection Facilities in Canada: Legal and Ethical Issues*, describes the extent and severity of the injection drug use problem. In 1999, injection drug users accounted for 34 percent of the estimated 4,190 new HIV infections in Canada, and over 60 percent of the roughly 4,000 yearly new hepatitis C infections. In Vancouver's Downtown Eastside, HIV prevalence among injection drug users is estimated to be between 23 and 30 percent, while hepatitis C prevalence is estimated at 88 percent. ⊕

On March 23, the Lower Mainland Coalition for Social Justice held a rally against the BC Liberal government's cuts. Their theme was "Stand Together Against the Cuts." The demonstration of approximately 10,000 people from various local community groups walked through Vancouver's Downtown Eastside.



photo John Kozachenko



Can't pay for moving?

Do you need money to pay for the moving company?

Welfare may pay up to \$500 for a moving company. Welfare will not pay for your friends or family to help you move unless there are no moving or rental companies in your community.

You can apply to welfare for moving costs if:

- >You have been evicted.
- >There are medical reasons, such as being closer to your doctor or to a hospital for treatment.
- >The health department says your place is unfit or unsafe.
- >Your place has been destroyed by a fire or water leak, etc.
- >Your place is going to be torn down.
- >Your place has been sold and you have been given notice to move.
- >You are moving to start a job.
- >You are moving to another province so family or others can give you support that you can't get here.
- >You are moving to a much less expensive place.
- >Your family size has changed so you need a bigger or smaller place.
- >You are physically or mentally abused or are being threatened by the landlord or others.

There may be other reasons that you could ask an advocate about before talking to your welfare worker.

STEP 1

Get 2 or more written estimates of the costs of moving from movers. The estimates can be from:

- >Licensed moving companies
- >Licensed truck rental companies.
- >Check with welfare if you aren't sure.

STEP 2

Write a letter to your welfare worker about:

- >Why you are moving.
- >What the estimates say it will cost.
- >When you will need the money for the movers.

STEP 3

Drop the letter off at the welfare office.

- >You only need to give the letter to the reception desk.

STEP 4

Call your worker later that day and tell them:

- >You dropped off a letter today asking for moving expenses to be paid.
- >You will call back in 2 days for their answer.

STEP 5

Two days later call your worker.

- >Keep all moving company receipts.

STEP 6

If your worker says "NO", ask for an appeal kit and contact an advocate.

Second-class citizens

Study explores the vulnerabilities of HIV-positive women in Mexico

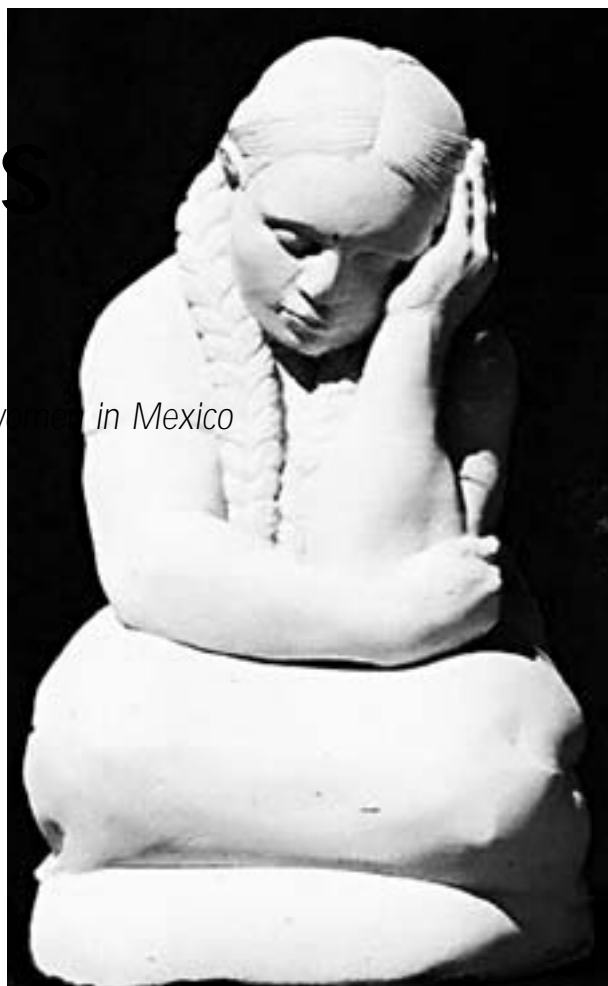
by *Tamil Kendall and Hilda Perez-Vasquez*

HIV+ Women in the Centre of Analysis and Response is a research and capacity-building project with the objective of increasing Mexican women's participation in treatment education, advocacy, prevention, and support in Mexico. This collaborative project receives technical support from the BCPWA Society and the Positive Women's Network. It is funded by the Canadian International Development Agency, Grupo Latinoamericano de Mujer y SIDA, and the Global Health Council. This article is a snapshot of some of the factors that contribute to HIV infection and determine the quality of HIV-positive women's lives in six Mexican communities.

Mexican and Canadian women face similar vulnerabilities to HIV infection and disease progression as women worldwide. Gender, class, and race disadvantage women in their personal and public lives. It makes them susceptible to infection and impedes access to social and medical services. Despite global similarities, the degree of vulnerability varies across and within national and international boundaries. The disproportionate number of new HIV infections among First Nations women in British Columbia is a case in point.

Vulnerability of Mexican women to HIV infection

Sexual transmission is the most common route of HIV infection in Mexico. Eighty-four percent of the women who participated in this study believed that they had been infected with HIV through sexual intercourse with a man. Women are vulnerable because they have little decision-making power with respect to sexual relationships. They do not believe they are at risk of HIV infection, in part because frequently their only risk behaviour is sex with a single partner to whom they are faithful. In stark contrast to the Mexican stereotype of the HIV-positive woman as a sex worker or "loose woman," 80% of the HIV-positive women had three or fewer lifetime sexual partners. Sixty-three percent had only had one sexual partner before finding out they were HIV-positive.



Although the Mexican epidemic is concentrated in the gay male population, male bisexuality is a key factor in the transmission of HIV to Mexican women. The stigmatization of homosexuality and bisexuality encourages women to ignore the potential for bisexual infidelity by their male sexual partners. The social constructs of HIV/AIDS as a disease that affects stigmatized and marginalized "risk groups" and of female fidelity in heterosexual relationships as protective increase women's vulnerability to HIV infection.

Even when women are aware of the sexual infidelity of their male partner, whether it is with women or men, their lack of power in sexual decision-making prevents them from effectively protecting themselves. "My husband was dogging around," said one woman. "I told him, 'You could infect me with something.'" Yet when her husband refused to use condoms, she continued to have unprotected sex with him.

Despite their lack of power in sexual decision-making, many women hold themselves and are held culturally responsible for the sexual behaviour of their male partners. "You have to please them," according to one woman, "because what they don't find at home, they look for in the street." The belief that women are responsible for the sexual infidelity of their spouses is not only internalized by women, but also expressed by authority figures. "The doctor asked me if I knew that my hus-

band had other partners,” noted another participant in the study. “I said, ‘Yes’, and he said, ‘Well, this [HIV infection] is what happens,’ as if he was putting the blame on me.”

Women’s perceived lack of power in sexual decision-making continues after receiving an HIV-diagnosis. Women feel that they would not be able to practice safer sex, or would only be able to do so by revealing their serostatus: “Men won’t accept [the condom]. They think that it doesn’t feel the same, that using a condom makes them less of a man.” Seventy percent of the women had not had a new sexual partner since being diagnosed with HIV. Gendered sexuality that disempowers women is a barrier to HIV prevention and to HIV-positive women fully enjoying their sexuality.

Vulnerability of women to HIV disease progression

Women tend to be diagnosed when HIV disease is advanced, either when they are experiencing symptoms of AIDS, during pregnancy, or when their husband is experiencing an AIDS-defining illness, frequently immediately before he dies. None of the women we interviewed reported independently requesting an HIV test because of a suspicion that she might be infected. In many cases, late diagnosis was attributed to medical negligence and ignorance.

Typically, women exhibited gynecological symptoms of AIDS for many years before being diagnosed with advanced AIDS.

HIV-positive test results continue to be delivered as death sentences. Many women in the study spoke of physicians who informed them of their serostatus by saying, “You have AIDS, and you are going to die. Tell your family.” This approach is inhumane, is medically inaccurate, and discourages people living with HIV/AIDS from seeking out ways to live as long and as well as possible.

The advent of highly active antiretroviral therapy (HAART) has greatly increased life expectancies among men and women with HIV/AIDS. In Mexico, 70% of PWAs have access to antiretroviral treatment. Similarly, in the study sample, 69% of the women had free access to antiretrovirals. By contrast, women without social security have few options for accessing antiretrovirals. Either they must cope with the paternalism and favouritism of healthcare providers who can provide or deny access to state-subsidized antiretroviral treatment, or they can begin treatment as part of a research protocol. However, access to medication will end when the protocol ends.

HIV-positive women with access to social security identified two major problems with the administration of antiretrovirals: medication shortages and improperly prescribed antiretrovirals. The majority of the prescribing physicians have not received specific training in HIV. Women commented that most

of the care available to them is generic rather than HIV-specific: “They [doctors] are used to normal people. If you have a cold they ask, ‘How do you feel?’ and look at your throat. But we need different care, specialized care, but it doesn’t exist. There are doctors, but they aren’t informed.”

In addition to resistance developing because of medication shortages, women reported stopping and starting therapy and abandoning treatment in response to side effects. Women did not disclose this behaviour to healthcare providers. They were not aware of strategies for managing side effects, and they did not know they could develop resistance to medications by stopping and starting treatment.

Treatment success requires more than antiretrovirals

The experiences of HIV-positive Mexican women underline the difficulties of providing high-quality HIV care, including antiretroviral treatment, in contexts where widespread discrimination and stigma against HIV-positive individuals persists. Mexico’s primary and secondary healthcare systems are relatively developed, and a large percentage of HIV-positive individuals are receiving antiretroviral treatment. However, providing antiretrovirals does not equate with treatment success.

Psychosocial issues and side effects must be addressed in order to support adherence and encourage positive, long-term outcomes. Through this research, women gained the skills to share their diagnosis with family members and children and increased their knowledge about antiretroviral treatment, nutrition, and preventive gynecological care as priorities.

The project built the capacity of women to respond to some of their self-identified needs through a 3-day workshop. We are continuing to support networking and leadership development and are sensitizing government, healthcare providers, and non-governmental organizations to the needs of HIV-positive women in Mexico. ⊕

Male bisexuality is a key factor in the transmission of HIV to Mexican women.

Tamil Kendall is a researcher and HIV/AIDS activist working in Mexico City with La Red Mexicana de Personas que Viven con VIH/SIDA. She was the coordinator of the BCPWA Society’s Complementary & Alternative Medicines Project.

Hilda Perez-Vasquez is a community health educator and activist who coordinates youth and women’s projects for Colectivo Sol.

Budget crunch affects BCPWA programs including Complementary Health Fund

A message from the Board of Directors

by Glen Hillson

In recent years, the monthly ceiling for Complementary Health Fund (CHF) reimbursement has fluctuated from \$35 to \$100. All net proceeds from the annual AIDS Walk go directly to the CHF, so the amount is dependant on the success of the AIDS Walk, as well as the number and dollar amount of applications for reimbursement.

Record AIDS Walk successes over the past three years have allowed us to increase the monthly ceiling to \$100. One of the effects of a higher ceiling is greater interest among BCPWA Society members to apply for reimbursement. That makes the monthly costs of the CHF go up. When the costs exceed the amount of money available, the CHF inevitably becomes a victim of its own success.

In the past year, the annual CHF payout has risen to \$320,000, which far exceeds the net revenues from the AIDS Walk. The amount continues to grow every month. As a result, we have been forced to make significant changes to sustain the CHF.

Fortunately, our successful six-year campaign to win monthly health allowances for PWAs receiving disability income assistance provides far more money for members to purchase health goods than the CHF could ever have achieved. Before the new monthly health benefit was enacted, our advocates had won about five hundred Schedule C monthly allowances, averaging almost \$500 per person. That works out to a whopping \$3 million per year. That's about fifteen times what the CHF pays out each year.

And there's more. The new Monthly Health Benefit of \$225 for nutritional supplements, vitamins, and bottled water will provide several million additional dollars each year to eligible PWAs on DB II who do not have Schedule C allowances. These successes will provide those in greatest need with more money to take charge of their health. It sets an example for other regions to fol-

low, and we can continue to advocate for increased Monthly Health Benefits that are more in line with actual health needs.

Paring back the CHF has been painful for the Board of Directors, and we know it will be painful for our members. At the same time, we have had to make a range of other cuts in our annual budget for the coming year to deal with a sizeable deficit from last year arising from overly optimistic revenue projections. We have trimmed spending in all departments and have undertaken staffing reductions to achieve some of the savings.

Fortunately, the people working for the Society—both staff and volunteers—are highly dedicated and skilled. They will continue to build on the BCPWA Society's mission of helping PWAs become empowered through mutual support and collective action to the very best of their abilities. ⊕

Changes to CHF

- The monthly ceiling will be set at \$45.00.
- Members will not be able to claim for any items for which they receive other funding (such as Schedule C or F, Monthly Health Benefit under DB II, or private insurance).
- Over-the-counter medicines for HIV-related conditions of the claimant will be eligible.
- Only members whose gross monthly income does not exceed \$3,000.00 will be eligible to access the CHF.



A S I A
Asian Society for the
Intervention of AIDS

210-119 West Pender Street
Vancouver BC V5K 1E9
T: 604-689-5567 asia.bc.ca

Providing support and
services to Positive Asians

為亞裔愛滋病毒帶菌者
提供資援和服務

Cung cấp dịch vụ và hỗ trợ cho
những người gốc châu Á.



A clash of cultures

PWAs in Vancouver contend with ignorance and prejudice within their community

by Ed Lee

Ten years ago, I left Toronto and moved to Vancouver, where there were more people with the same ethnic background as me. I was searching for a home that made me feel comfortable and accepted, for a community of diversity and inclusion. I found that in Vancouver. I love to see yellow and red-haired children enjoying

octopus at the Powell Street Festival. I love to see Caucasian families feasting on Chinese dishes and being able to correctly order them in Chinese. I also love to see tall young blond men holding hands with their equally buff Asian boyfriends. But these idyllic images of cultural diversity do not exist in all aspects of life.

Overall, there are few people of colour represented in mainstream AIDS organizations. Moreover, diversity needs to extend beyond representation, which merely plants the seeds for dialogue and helps to create authentic, safe spaces for HIV-positive Asians.

While it may seem more financially viable for the mainstream groups to provide services for the Asian communities during these days of cutbacks and belt tightening, they'd be hard-pressed to address their distinct cultural and language needs. It's also hard to imagine how they would be able to successfully reach out to Asian PWAs.

The challenges for support groups within the Asian community are language and the cultural sensitivity of not talking about "private" things.

The difficulty is not strictly one of language but one of cultural sensitivity. There are numerous Asian languages, each with their own writing. Education pieces targeted at the main Asian groups in Vancouver include Chinese, Japanese, Tagalog, and Vietnamese. Messages and images have to be tailored to each of these languages, to address the nuances of each language. Therefore, it is not just a simple task of just translation. Each distinct culture also has different way of dealing with homophobia, addiction, and recovery. In some Asian cultures, there are no words or phrases to describe these complex concepts.

Homophobia is a major issue in the Asian community. Homosexuality, AIDS, drug use, and addiction are all seen as "white" occurrences. Just as China refused until recently to accept that AIDS exists in China, many Asians do not accept that these issues affect many of their fellow country folk.

Given all these factors, imagine the overwhelming task that any AIDS organization faces trying to reach Asians. How do you create an awareness campaign about something that is not supposed to happen at all? Imagine the wide spectrum of the target population: young people who have just immigrated to Canada and their immediate families, long-time immigrant residents whose attitudes are built from their traditional Asian backgrounds, and transient students who come to study in Canadian schools. Now take that population and multiply it by the number of diverse Asian countries with different spoken and written languages.

Asians in Canada are not only diverse culturally but also in terms of when they immigrated. Some Chinese families in BC boast of nine or ten generations, while others have arrived recently—their respective languages, experiences, and attitudes are all very different. The older generation of parents and grandparents are the important nucleus of the family in many

Asian cultures. These people also need to be included in any HIV/AIDS outreach and messages, in order to influence and change attitudes or behaviour effectively.

What is really needed is an Asian PFLAG group. I know of a Chinese mother in Toronto who is trying to form a group, but I have yet to hear of one in British Columbia. A local Asian PFLAG group, or even an Asian PFLAG member, would be a giant step in combating homophobia and the first step in broader acceptance.

Once, in Toronto, I attended a gay Asian social where I noticed a large number of families, including children and older women, sitting close to the stage. I was told that they were the families of the Filipino drag queens who were performing at the social. I was quite taken aback but intrigued. Were the families truly supportive of their queer son, fabulously made up as a woman, or were they merely attending out of duty as good parents when their children perform on stage? The notion of seeing families at a queer event was jarring. While I am still not brave enough to take my oldest sister out to the local gay bar, my partner did attend my niece's wedding in New York City and was included in all the family wedding photos.

In my own search for community, I joined various organizations, including Gay Asians of Toronto. I met a great group of people but discovered that I was different and very much in the minority as a Canadian-born Asian. I was arrogant in my ignorance of what it meant to be from an Asian country. Slowly, I learned about the hardships that gays born in Asian countries had to endure compared to the relative ease of my own life.

When I arrived in Vancouver ten years ago, the Gay Asian Vancouver Area group was meeting in a living room to create an organization to provide AIDS education and services to the Asian population. Those meetings led to the creation of Asian Support for AIDS Project (AS-AP) in 1992.

In some Asian cultures, there are no words or phrases to describe homophobia, addiction, and recovery.

AS-AP became a part of the education department at AIDS Vancouver. The project took on a life of its own, which confirmed the need for a separate space and a distinct Asian-centric organization. This led to the eventual creation of the Asian Society for the Intervention of AIDS (ASIA).

ASIA needs to exist and continue to grow. Their mandate has grown from creating pamphlets in many different Asian languages to the support and care of at-risk Asian women and

intravenous drug users and their families. The programs that ASIA runs are not the same as the mainstream groups. The intent and, perhaps, the objectives are similar, but the philosophy and methodology of those programs require a lot more investigation to insure the success of those programs. The creation of a distinctly Asian space is critical to the success of ASIA's programs.

One example is support groups. It is widely accepted that a group of people in a similar crisis can come together and discuss their problems intimately and confidentially in a safe space. This notion is totally foreign, and it would not work for an Asian population.

The two main difficulties in creating and running support groups or for any program within the Asian community are language and the cultural sensitivity of not talking about "private" things. My parents raised me never to speak of anything that had to do with family in public since we had to maintain a good face. The preservation of face is a very strong cultural aspect that has played havoc with my personal life.

In addition to these barriers, the location of the support group is of utmost importance. Most HIV-positive support group meetings in downtown Vancouver are held either at St. Paul's Hospital, at the Pacific AIDS Resource Centre (PARC), or in the West End. Since these places are known as "AIDS spots," many Asians are fearful that they will automatically be labelled as having AIDS. Therefore, ASIA found a support group location that was both neutral and safe for all attendees.

The most successful Asian support groups to date are conducted in an Asian language and one where members attend a

dinner. Eating is very important in many cultures and more so in Asian cultures. Discussions over dinner have become far more intimate as the diners learn more about one another and newcomers quickly become welcome and begin to speak easily after one or two visits. The setting becomes quite family-like with a relaxed environment. Perhaps it has to do with the familiarity of the food that is served or the fact that it is at someone's home. It is this safe space where people feel comfortable enough to talk about their "private" selves and to share their experiences.

I am in awe of all those people who have or are now working or volunteering for ASIA. In particular, I feel that the volunteers are very courageous. I recall one woman telling me how she could not tell her family where she volunteered for fear of retribution. She had to sneak out of the house any time she went to work with ASIA.

I have learned much from my fellow Asians. I have seen their fears and have tried to look at their world through their eyes. I have lost my arrogance, and I am now humbled by their strength and courage. Diversity goes beyond the boundaries of ethno-cultural groups in Vancouver. It delves deeper into the wide diversity within each of those ethnic groups. These differences make it difficult to find the important common thread within all lives, but when found, it is extremely rewarding. ⊕



Ed Lee is Chair of the Vancouver AIDS Memorial Society.

WWW.CTAC.CA

The Canadian Treatment Action Council (CTAC) is pleased to announce the launch of its website!

An excellent resource for information about CTAC:

- > current and past issues of our newsletters
- > how to receive our newsletter electronically
- > position papers
- > press releases
- > current activities
- > how to get involved
- > links to other related sites
- > and much more



Become a CTAC member online!

Be sure to check out CTAC online at www.ctac.ca

A “liang” of prevention

Agency reaches out to marginalized Asian PWAs

by Cynthia Low

HIV/AIDS prevention is one of the most challenging health initiatives of our millennium. Vulnerability to HIV/AIDS is linked to our economic, emotional, social, cultural, physical, and intellectual capacity for overall wellness. At the Asian Society for the Intervention of AIDS (ASIA), we try to address these vulnerabilities using cultural, linguistic, and social norms of our communities. That means providing alternative HIV/AIDS prevention initiatives and community-based strategies.

For example, we use street outreach, online services, familial contacts, and intergenerational approaches to develop trust and eventually to provide referrals to services. That's because in many Asian cultures, families are the most important, if not the only, source of support. It may not be within the cultural norm to utilize a social service provider, particularly for a problem that may be related to shame and disgrace.

The recent McCreary reports on youth indicated several differences relating to Asian youth. They are more likely to engage in sexual activity later than their “British” counterparts; they have a higher level of ambivalence regarding sexual orientation, and they are less likely to seek help regarding sexual health. There are also circumstances surrounding immigration, language, generational and cultural conflicts that affect Asian youth. Strategies for prevention and education have to be able to address these conditions.

As the face of the epidemic has changes, ASIA has tried to take on a greater role as an organization to meet the diverse needs and concerns of our Asian communities. Not only do we provide support to the gay Asian community, we have also expanded our scope to reach out to youth, women, injection drug users, refugees, immigrants, and other marginalized individuals that come with unique barriers to HIV prevention. All our staff members are bilingual and some are trilingual. Currently we provide services in English, Cantonese, Vietnamese, and Mandarin, with a limited capacity for French, Taiwanese, and Bahasa Malaysia.

Today, we are proud to present many different education and prevention programs with a consciousness to the wide-ranging values, beliefs, and attitudes in our communities that contribute to HIV/AIDS and related issues.

MSM (Men who have Sex with Men) Program:

Offering support to gay, bisexual, and questioning Asian men through peer discussion groups, public outreach, Internet outreach, social gatherings, one-on-one counselling, and art therapy.

IDU (Injection Drug User) Reaching Out Project:

ASIA has been working with various agencies in the Downtown Eastside to help Asian IDUs access services and treatment.

P.A.D. (Positive Asians Dinner):

The Positive Asians' Dinner is a monthly dinner for Asians who are HIV-positive.

Education and Volunteer Program:

Volunteering at ASIA can mean anything from stuffing envelopes for a mail out and working in the office to doing outreach at public events, working on a web page, developing literature, and translating or interpreting. It can also mean being a member of the board of directors. The education component focuses on speaking at community events and schools and to service providers.

Women's Project:

The Women's Project is an exciting new project to develop an appropriate outreach program which privileges women's experiences and circumstances and validates their existing support networks and life skills, specifically focusing on sex-trade workers and prostituted women.

Youth Project:

ASIA is trying to reach out to Asian youth in a variety of different ways, including the Youth Health Action Team, which educates and engages youth in HIV/AIDS and community issues.

This is our tenth year and we strive forward proudly, making more contacts with more communities, building more foundations for the future, and giving voice to those who are marginalized in our communities. ⊕

Cynthia Low is the Executive Director of ASIA.

treatment

information

TREATMENT INFORMATION
PROGRAM MANDATE &
DISCLAIMER

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

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

HIV and diabetes: A First Nations perspective

by *Pamela Fergusson*

If you have been to Positive Outlook recently, you might have noticed something new. The HIV care, treatment, and support program at Vancouver Native Health is hosting a "Diabetes Drop-in" once a week. At the first meeting, a young aboriginal woman stepped in the door. "My doctor told me I am diabetic now," she said. "It was my HIV drugs that gave it to me." As the group sat and talked about how they felt about diabetes and HIV, one man said, "It's just another hill to climb."

Diabetes occurs when the pancreas

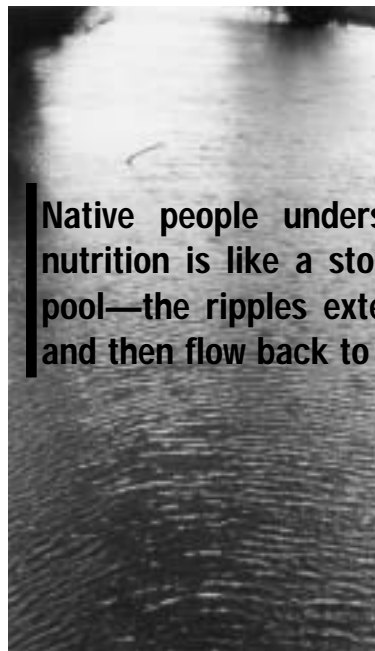
does not produce enough insulin or when the body does not effectively use the insulin that is produced. Over 90% of Canadians with diabetes have type 2 diabetes. Type 2 diabetes is associated with lifestyle factors.

Although diabetes and HIV know no cultural boundaries, incidences of both diseases are increasing in British Columbia's aboriginal population. As recently as the 1940s, diabetes was unknown among Canadian First Nations people. However, the prevalence of diabetes among aboriginal people is now triple the rate of the general population. An estimated 60,000 aboriginals have the disease, including undiagnosed cases. That is one in seven First Nations people. By contrast, 1997 Health Canada survey results

show that 1.2 to 1.4 million Canadians aged 12 and over have diabetes, including undiagnosed cases—roughly one in 20 Canadians.

HIV infection is also a growing problem in the aboriginal population, and the

aboriginal HIV-positive community has unique characteristics. According to Health Canada, the proportion of aboriginal AIDS cases increased from 1% before 1990 to 10.8% in 1999 and 8.5% in 2000. The proportion of aboriginal HIV and AIDS cases that are under 30 years



Native people understand that good nutrition is like a stone thrown into a pool—the ripples extend to the edges and then flow back to the centre.

continued on page 14

old, female, or attributed to injecting drug use is greater than the corresponding proportion among non-aboriginal cases.

For the First Nations people in Canada who have been struggling against these two diseases, the news that diabetes may be related to HIV is not welcome. In 1997, the US Food and Drug Administration issued a bulletin stating that protease inhibitors (PI) may increase blood glucose in HIV patients. A 2001 article entitled "HIV and Cardiovascular Risk Factors" in *The AIDS Reader* stated that:

- Impaired glucose tolerance and diabetes mellitus can occur in HIV patients receiving highly active antiretroviral therapy (HAART).
- The prevalence of insulin resistance in patients receiving PI therapy is estimated to be 25–62%.
- In an analysis of 782 patients treated with a PI-containing regimen, impaired glucose tolerance developed in 16% and diabetes was diagnosed in 2.4%.
- Of the patients who developed diabetes, 12 of 19 had developed central obesity by 6 months.

It is unclear why impaired glucose tolerance develops in some patients and not in others, but one study showed that diabetes was more likely to develop in older patients and in those with a family history of diabetes. This may indicate that aboriginal people, who have higher rates of diabetes than the general population, may be more susceptible to developing diabetes while taking PI therapy. (Still, for most people, the many benefits of HAART continue to outweigh the risks.)

People living with HIV/AIDS know about the role of nutrition in disease management and quality of life. One important difference with diabetes is that good nutrition is also a big part of prevention. Maintaining a healthy body weight through healthy eating and an active lifestyle can help prevent diabetes regardless of your HIV status.

Many of the nutrition recommendations for the management of HIV are complementary for the prevention and management of diabetes. The most important goal is to achieve and maintain a healthy body weight. Obesity, which seems to be occurring in greater fre-

quency in HIV-infected people, may lead to increased risk of developing heart disease and diabetes.

If you are overweight and central obesity is a problem for you, try to follow the Nutrition Recommendations for Canadians. Make fat no more than 30% of your total energy intake and saturated fat no more than 10%. Diabetes can lead to kidney disease; so, if you are eating extra protein, talk to your doctor to make sure your kidneys can handle it. These general recommendations can get you started, but see your dietitian to customize your own nutrition plan.

Native people, who have been practicing holistic medicine for centuries, understand that good nutrition is like a stone thrown into a pool—the ripples extend to the edges and then flow back to the centre. Similarly, nutrition is a part of health, a part of the individual, and a part of the community.

Many Native people are returning to traditional foods and traditional medicine to seek healing. In the Native Food Guide, published by Health Canada, these nutrient-dense, natural foods are organized into four food groups. The guide advises that we should:

- Choose different kinds of foods from within each group each day
- Balance energy intake from foods with energy output from activity
- Select and prepare foods with limited amounts of sugar and salt
- Use grease and oils in moderation.

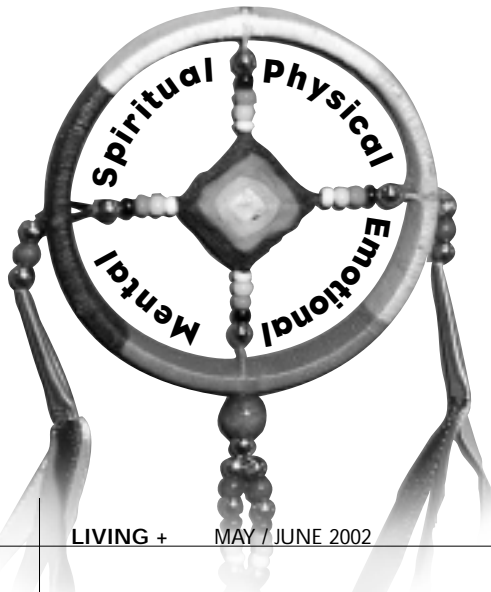
Frank Wesley, a First Nations Elder and diabetes educator says, "Eat foods from our Mother the Earth, exercise each day to build a strong healthy body, and smile to share your shine with everyone."

Living in balance is an important part of Native culture and teachings. The Medicine Wheel is an ancient symbol used by almost all aboriginal nations. It symbolizes the four directions, the four stages of life, and the four aspects of health: physical, mental, spiritual, and emotional. As we all seek to form connections and community with ever broadening ripples, the medicine wheel can be our guide. ☉



Pamela Fergusson is a dietitian working on ADAPT—a diabetes prevention project at Vancouver Native Health Society—and serves on the board at A Loving Spoonful.

The Medicine Wheel



Spiritual: The seven ways of healing are: <ul style="list-style-type: none"> • Talking • Crying • Laughing • Yelling • Dancing • Singing • Shaking 	Mental <ul style="list-style-type: none"> • Awareness • Acceptance • Knowledge • Understanding • Questions • Wisdom
Physical <ul style="list-style-type: none"> • Medications • Nutrition & traditional foods • Activity & traditional ways • Safe and supportive housing 	Emotional: The seven teachings are: <ul style="list-style-type: none"> • Sharing • Caring • Kindness • Humility • Trust • Honesty • Love

Down but not out

Depression among PWAs is commonplace

by R. Paul Kerston

Maybe lately you've noticed you're regularly getting too little—or too much—sleep. Or maybe you have no interest in daily activities, in your appearance, or in food. These and a host of other symptoms may indicate depression. Often missed by physicians, depression can strike anyone. Doctors need a keen attunement toward their patients and need to ask the right questions to diagnose it.

Depression is common in persons living with HIV/AIDS, with as many as 22–45% of PWAs experiencing it. According to an article entitled “Management of Depression and Related Neuropsychiatric Symptoms Associated with HIV/AIDS and Antiretroviral Therapy” in a recent issue of *The Canadian Journal of Infectious Diseases*, depressed mood is the most common neuropsychiatric complaint in persons with HIV/AIDS seeking psychiatric evaluation. It affects our quality of life, which affects our overall health. It can negatively affect major daily decisions, including health choices from food to medication intake and drug adherence.

In essence, depression is the inability to deal with stress. The causes range from basic fears of the unknown to having too

many issues to cope with. The feeling that things seem hopeless may prompt some to slide into depression, sometimes without realizing it. Doctors have noted that people without a support network of friends or family may have unrecognized depression, partly because stress may be dealt with, at times, by talking things over with somebody. Therefore, treatment for depression may include both drug therapies and speaking with a therapist or doctor.

For PWAs, drug side effects are a major cause of depression. Insomnia and depressed mood are among the side effects reported with antiretroviral medications such as efavirenz, lamivudine, and zidovudine.

Depression has different levels of severity. Table 1 lists specific markers of a major depressive episode. Many of these markers individually represent problems that we all face from time to time—they usually don't signify depression. However, if these symptoms occur in combination, it is cause for concern.

The good news is that depression can be treated in many instances. The two main methods of treating depression are drugs and counselling. Tricyclic antidepressants and serotonin reuptake inhibitors are two classes of drugs that

have proven effective. It can take 4–6 weeks to respond to treatment, though improvement is often seen in one week. Don't stop treatment early.

Mild to moderate depression can be treated with psychotherapy, without the use of drugs. However, a combination of drug therapy and counselling may reduce the possibility of relapse. Drug burdens are not something we want to increase more than necessary. Certain blood tests—including complete blood count and liver function—are necessary before beginning drug therapy, and monitoring is important to prevent drug interactions with antiretrovirals. In many cases, drug treatments for depression are short-lived.

Living with depression is not really living at all. Try addressing the challenge of diagnosis and treatment. Working closely with your healthcare practitioner is perhaps the most important strategy. ⊕



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

Table 1: Criteria for a major depressive episode

Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning. At least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

- Depressed mood most of the day, nearly every day.
- Markedly diminished interest or pleasure in all, or almost all, activities.
- Significant weight loss or weight gain, or decrease or increase in appetite

nearly every day.

- Insomnia or hypersomnia nearly every day.
- Psychomotor agitation or retardation nearly every day (observable).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness, or excessive or inappropriate guilt (may be delusional) nearly every day.
- Diminished ability to think or concentrate, or indecisiveness.
- Recurrent thoughts of death, recurrent suicidal ideation without specific plan,

a suicide attempt, or a specific plan for committing suicide.

The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

The symptoms are not due to the direct psychological effects of a substance or a general medical condition (hypothyroidism).

Source: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.*

Full steam ahead

Carnitine fuels the body's energy production

by Gordon Waselnuik

L-carnitine is a natural substance found in many foods. It is made from essential amino acids called lysine and methionine. Our bodies use L-carnitine for several functions. It can be absorbed quickly in the small intestine and made in the liver and kidneys where vitamins C, B6, and niacin are required for its production. L-carnitine works mostly in the muscle cells and is the molecule that transports long chain-fatty acids across the membrane of the mitochondria. Those essential fatty acids are transformed into fuel for the body by the cellular mitochondria.

Mitochondria are the power cells of the human body that convert essential fatty acids and sugars into energy. The amount of L-carnitine available determines the ability of the mitochondria to burn calories and give the body energy.

Carnitine has been likened to the engineer of a steam locomotive who shovels coal in the boiler. The faster and harder he shovels, the faster the train will go. Some people feel it is the body's premier energizer. Therefore, L-carnitine is necessary to stimulate energy production. Heart and skeletal muscles depend upon fatty acids as a major source of energy.

The blood test for measuring levels of L-carnitine is not considered very reliable, so an assessment of symptoms is probably the best guide to knowing whether a person may be L-carnitine deficient.

Symptoms of L-carnitine deficiency

Symptoms of low L-carnitine levels include muscle weakness and loss, confusion, angina (heart pain), peripheral nerve pain, severe shortness of breath, and fatigue.

People living with HIV/AIDS are likely at higher risk for L-carnitine deficiency resulting from nutritional deficiency, gastrointestinal disturbances, and loss of kidney function or shifts in metabolic pathways. Individuals with depleted muscle mass

are limited in the amount of L-carnitine their bodies can store. Loss of mass in some of the larger muscles like the buttocks and legs is common in people with HIV disease.

Supplementation

Many people with illnesses and other medical conditions may not be able to get enough L-carnitine from their food. They can potentially benefit from supplementing their L-carnitine intake. Two forms of supplementation are manufactured, namely L-carnitine and L-acetyl carnitine. The acetyl formulation is recommended when used for treatment of peripheral neuropathy and for people over forty years of age. The acetyl form is easier for the body to metabolize, but it is also more expensive to buy.

L-carnitine is thought to have synergy with co-enzyme Q10 and alpha lipoic acid. Therefore, taking these three products in combination should enhance the benefit.

L-carnitine supplements are available in pill or capsule form, either through prescription or over the counter. They are very expensive and the quality can vary. It is probably better to buy prescription grade to better ensure you are getting your money's worth. In Canada, L-carnitine can only be sold by prescription, but in other countries such as the United States, it can be obtained over the counter.

Uses for L-carnitine

Supplementation may be helpful in addressing several conditions related to HIV/AIDS, including elevated tryglyceride levels, mitochondrial toxicity from nucleoside HIV drugs, peripheral neuropathy, and loss of energy and weight.

Many people with muscular dystrophy and post-polio syndrome also use L-carnitine supplementation. People with heart, liver, or kidney problems, as well as those suffering from

Alzheimer's disease, may also benefit from L-carnitine supplementation.

Other benefits possibly derived from L-carnitine are improved immunity, slowed aging, prevention of heart attacks, increased melatonin production, improved memory and learning ability, and enhanced liver function.

Symptoms of low L-Carnitine include muscle weakness, confusion, heart pain, peripheral nerve pain, shortness of breath, and fatigue.

Dosage and side effects

The optimal dosage for L-carnitine is far from an exact science but seems to vary somewhere from 500mg to 3000mg daily. It is considered safe at any level with no serious side effects. Nausea, vomiting, and stomach cramps may occur when starting treatment, and most proponents suggest starting at a low dose and increasing gradually.

The evidence

L-carnitine is generally considered a form of complementary or alternative medicine (CAM), except in the treatment of end-stage renal disease or liver failure. Like many CAMs, the evidence for its benefits and safety is often anecdotal and requires further research in randomized clinical tri-

als. One clinical trial currently taking place in Canada is evaluating the use of L-carnitine as an intervention for antiretroviral drug-related neuropathy. Peripheral neuropathy is commonly associated with ddI and d4T but is also caused by HIV.

To find out more about L-carnitine research, visit the PubMed website at <http://www.ncbi.nlm.nih.gov/PubMed/>.

Where to get it

L-carnitine can only be sold by prescription in Canada. In Vancouver, most community pharmacies do not carry it. Finlandia Pharmacy is the only outlet in Vancouver that sells it. All prices quoted below are for 100 capsules.

L-carnitine: 250mg, \$62; 500mg, \$90.

L-acetyl carnitine: 250mg, \$78; 500mg, \$147.

Based on these figures, the monthly cost can vary from \$27/month for 500mg daily of L-carnitine to \$265/month for 3000mg daily of L-acetyl carnitine. ⊕

[Please see accompanying article on page 27 about a new test developed by the BC Centre for Excellence in HIV/AIDS to detect mitochondrial toxicity.]

Gordon Waselnuk is a treatment counsellor with the BCPWA's Treatment Information Program.

Carnitine content in various foods

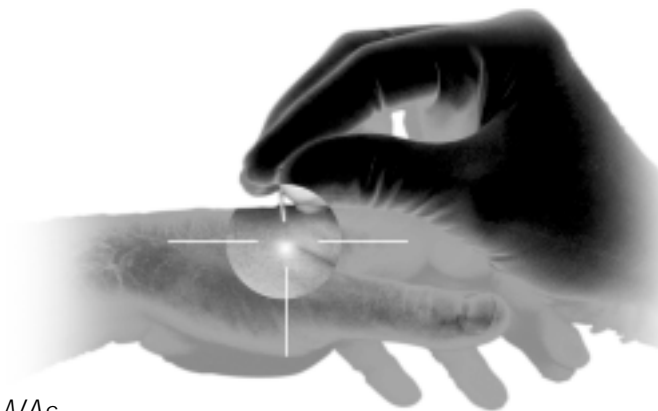
Product	Quantity	Carnitine
Cheddar cheese	3.5 oz	3.7mg
Ice cream	3.5 fl. oz	3.7mg
Whole milk	3.5 fl. oz	3.3mg
Cottage cheese	3.5 fl. oz	1.1mg
Beef steak	3.5 oz	95mg
Ground beef	3.5 oz	94mg
Pork	3.5 oz	27.7mg
Bacon	3.5 oz	23.3mg
Codfish	3.5 oz	5.6mg
Chicken breast	3.5 oz	3.9mg
Eggs	3.5 oz	0.0121mg
Whole wheat bread	3.5 oz	0.36mg
White bread	3.5 oz	0.147mg
Macaroni	3.5 oz	0.126mg
Rice (cooked)	3.5 oz	0.0449mg
Asparagus	3.5 oz	0.195mg
Orange juice	3.5 fl. oz	0.0019mg
Peanut butter	3.5 oz	0.083mg

Chart by Marcy Fenton, M.S., R.D., & Ernie Rodriguez. From Positive Living, February 1998, a magazine for people with HIV/AIDS published by AIDS Project Los Angeles.



L-carnitine supplements

Pinpointing the problem



The ancient Chinese practice of acupuncture can help PWAs

by Sunny Lee

Looking back at what the famous Chinese medicine doctor Zhang Zhong-Jing said hundreds of years ago, we find that diseases similar to AIDS might have occurred in China at that time. “During the first ten years of the Qian An Era (196 AD), two-thirds of my relatives (more than 200) succumbed to disease, seven-tenths of which were due to an epidemic fever,” Zhang stated. Today, AIDS can still be classified as a type of feverish disease based on traditional Chinese medicine (TCM) theories.

Acupuncture is a branch of TCM healing modality based on “chinglo”, or body meridians and collaterals. The fundamental TCM principle is harmony for good health, which is attained by the flow of *qi*, the vital energy or life force, through the body meridians. The insertion of hair-thin needles, with or without moxa, just below the skin at specific points along the meridians helps to encourage the flow of *qi* where it may be blocked, sluggish, or overstimulated, which is believed to cause illnesses. Moxibustion is the burning of moxa, a Chinese herb, as an adjunct to the needle in stimulating the meridians.

The function of the meridians and collaterals are key to the health of the individual. The ancient Chinese medical document *Miraculous Pivot* states, “The meridians and collaterals transport blood and *qi* to adjust yin and yang, nourish tendons and bones, and improve joint function.” The condition of the meridians can help resist pathogens as well as to show the symptoms and signs of diseases of the related internal organ.

Acupuncture is effective for a variety of ailments, including arthritis, asthma, bursitis, headache, hemorrhoids, indigestion, and sinusitis. Aside from the great analgesic function for pain relief, it can improve circulation, stimulate lipolysis, reduce hypersensitivity of skin and mucous membrane as well as increase immune response or reduce bacterial infections. Needling the acupoints serves to regulate blood flow to the affected area and to attract white blood cells, which are effective in treating inflammation. Acupuncture can directly and indirectly affect the function of the autonomic nervous system and could increase the number of blood cells (red, white and platelets) and the production of antibodies, which is vital for the immune system.

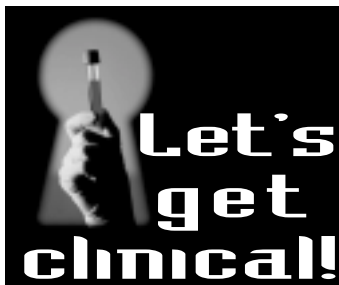
Acupuncture treatment has shown steady positive results for people with HIV/AIDS, thus supporting claims to treating infectious diseases and leading to the theory that there is a possible “interferon” production by cells in the presence of certain viral infections. A definite increase in the serum concentration of the gamma globulin, which could be an index of the production of specific antibodies to viral and bacterial antigens, could inhibit the activities of HIV.

Through my 14 years of practice and accumulated experience, I developed a series of methods in treating different stages of AIDS with acupuncture and Chinese herbology.

The following are common symptoms and signs of HIV-related illnesses.

- Deficiency of lung-kidney yin, manifested by febleness, aching at the waist, weakness of the legs, shortness of breath, dry mouth and throat, flushing, hectic fever, nights sweat, tinnitus, deafness, dry coughs with phlegm, reddened tongue, and a thready and rapid pulse. These are common symptoms in PWAs.
- Accumulation of internal wetness-turbidity (Chinese diagnostic terms) indicated by high fever, sticky perspiration, heavy head- edness with headache, anorexia, foul and smelly stool with pain at the rectum, greasy white tongue, and a rapid, weak and floating pulse. These are common symptoms of opportunistic infections affecting HIV patients.
- Invasion of heat into *ying* and blood system indicated by high fever (aggravated at night), mucocutaneous haemorrhage, vex- ation, reddened tongue, convulsion or dementia in severe cases, as well as thready and rapid pulse. These symptoms are common in AIDS patients suffering from opportunistic infec- tions or Kaposi's Sarcoma.

Sunny Lee, R.Ac. PhD, practices at the Can-Integrated Healing Centre in Vancouver. He is president of the B.C. Qualified Acupuncturists and TCM Practitioner Association, and president of the S.T.A.U.N.C.H. Foundation (Society for Therapeutic Alternatives Using Complementary Healing).



Canadian trials examine interleukin-2 immune-booster

by Jim Boothroyd

No fewer than three of the eight clinical trials now enrolling at the Canadian HIV Trials Network are looking at the potential uses of an immune-boosting agent called interleukin, or IL-2.

The largest of the trials is ESPRIT, also known as CTN 110. (The others, CTN 145 and CTN 124, are listed elsewhere on this page). This major study aims to recruit 4,000 participants in 22 countries to evaluate the effects of giving recombinant interleukin-2 (rIL-2) to HIV-infected people 18 years old or older with CD4 cell counts of at least 300/mm3.

The goal is to compare the effectiveness of rIL-2 plus anti-HIV therapy versus anti-HIV therapy alone on numbers and severity of AIDS-related illnesses and deaths over a five-year period. Produced by certain white blood cells, IL-2 is a protein that stimulates the growth of CD4 cells, one of the body's natural infection fighters.

Participants are randomly assigned to receive or not receive rIL-2 at a dose of 7.5 MIU twice daily for five consecutive days, every eight weeks. This routine is repeated

twice. Thereafter, the frequency of receiving rIL-2 is tailored to individual needs.

As of March 12, Canadian sites had enrolled 109 of the total 150 recruits that they need. Principal investigator Dr. Jean-Pierre Routy of Montreal Chest Hospital reported no unexpected adverse events among participants, and he said that the trial's data and safety management board had recently reviewed the trial and approved its continuation.

Preliminary findings from the first eight months of the ESPRIT study were presented at the 9th Conference on Retroviruses and Opportunistic Infections in Seattle in February. The findings indicate that the median increase in CD4 counts in participants after three cycles of rIL-2 is 389 cells/mm3 (see conference abstract at <http://63.126.3.84/2002/Abstract/12627.htm>).

Sabrina Mastroprimiano, a CTN nurse and trial coordinator at the Montreal Chest Hospital, has also presented early findings drawn from fourteen ESPRIT

participants, eight of whom are on the rIL-2 arm. Three of the eight had received three cycles of rIL-2 at the time of her small study. She says that the symptoms experienced by participants who had completed one week of rIL-2 were most severe on days three to five. Symptoms included fevers, fatigue, malaise, perspiration, and chills that can make participants feel ill and "unable to do much."

Mastroprimiano says, however, that the severity of symptoms is largely "dose-related" and that, through education and planning, nurses are able work with participants to effectively manage symptoms.

The British Columbia ESPRIT trial site is the Cool Aid Community Health Centre in Victoria. ⊕



Jim Boothroyd is Communications Manager at the Canadian HIV Trials Network.

Other CTN trials enrolling

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

145 (SILCAAT), Recombinant IL-2 to Slow Progression of HIV. BC site: Providence-St. Paul's Hospital in Vancouver.

148, Gender Differences in Lipodystrophy Syndrome. Four sites in Quebec and Ontario—no BC site.

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

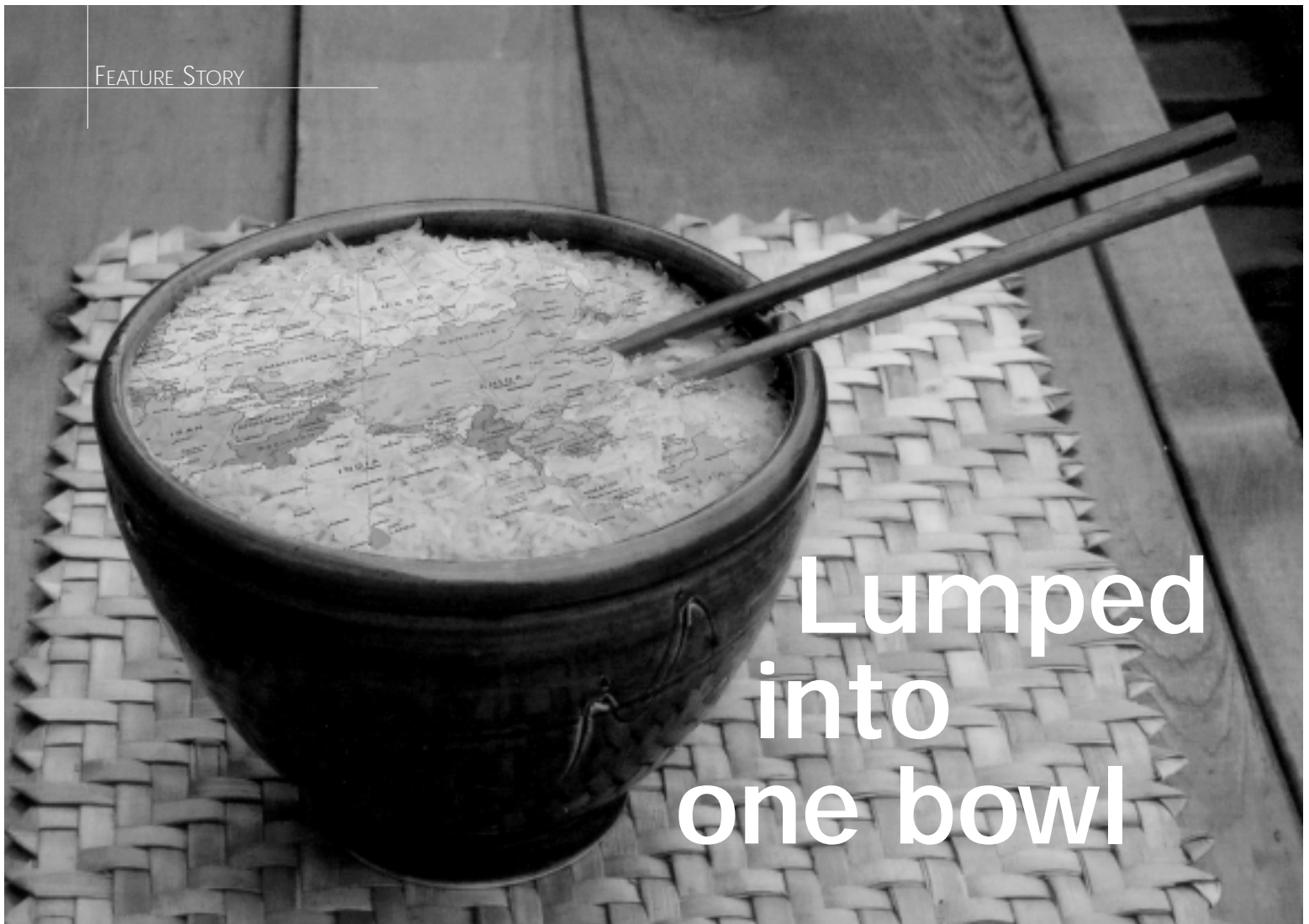
Aid Community Health Centre in Victoria.

164 (STI), Structured Treatment Interruptions. BC sites: Downtown IDC in Vancouver and Cool Aid Community Health Centre in Victoria.

167 (OPTIMA), Options in Management of Antiretrovirals. BC sites: Providence-St. Paul's and Downtown IDC in Vancouver; Cool Aid Community Health Centre in Victoria.

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

For more information about CTN trials, please visit the CTN website: www.hivnet.ubc.ca/ctn.html or call 1-800-661-4664.



Lumped into one bowl

Asian Pacific Islanders' cultural diversity poses a challenge for healthcare providers

by Ippei Yasuda

Well-educated and well-off, the popular image of Asian and Pacific Islanders (APIs) is that of the “model minority.” In the US, forty-four percent of APIs age 25 and over have a bachelor’s degree or an advanced degree, compared to 14% among other ethnic minorities. The poverty rate among APIs is 10.7%, compared to 23.4% among other ethnic minorities. In fact, 42% of API married-couple households have an income of \$75,000 or more, almost double that of other ethnic minorities. Yet, when it comes to healthcare, their educational and economic status doesn’t guarantee access. That is only possible if people have the right attitudes, behaviour, and skills to utilize the healthcare system.

Diversity within the API population

Like other ethnic minorities, APIs are not just one cluster of

people. Migrating all over Asia, ethnic Chinese have formed their own cultures in the countries where they live. They have established their own societies, adjusting to historical, political, and regional conditions.

In the US, APIs comprise 49 ethnic groups, speaking over 100 languages and dialects. Although there are some basic cultural similarities, APIs come from different cultural, historical, political, regional, and religious backgrounds. Each API group has established its own society and culture. Each society is comprised of different generations and classes and is shaped by such factors as being American-born versus being a recent immigrant. APIs don’t possess one common identity; their identities are varied and unique to each group.

The APIs’ rich cultural diversity poses its own challenges in utilizing the healthcare system. This diversity also makes healthcare service delivery perplexing for service providers.

Everyone who works in the health education or healthcare field probably agrees upon the necessity of a culturally and linguistically sensitive health education and healthcare system. Since APIs comprise only four percent of the US population, the API population has historically been perceived and categorized as a single population. The US government's large-scale funds for healthcare are usually allocated to the API community as a whole, not to specific sub-communities.

Culturally and linguistically sensitive services

Tailoring a program to a specific target population in the API community is time-consuming and expensive. Unfortunately, for the small ethnic Asian group, culturally and linguistically sensitive comprehensive HIV/STI (sexually transmitted infections) services are virtually non-existent. Recruiting and training people to be health workers who can deliver health education and care to the community can be extremely difficult if the community's population is small and limited sources are available to recruit such personnel. Especially in HIV/STI education and care services, the misconception and social stigma surrounding HIV/STI and their association with homosexuality may discourage people from working in the field. In reality, however, peer-based HIV/STI prevention work is crucial both

Lack of funds and human resources forces agencies to prioritize ethnic groups within the API population, depending on HIV prevalence.

for education about HIV/STI and in order to support behavioural changes that will allow a client to improve her or his health and to reduce the risk of infection.

In major cities such as Los Angeles, New York, and San Francisco, API-targeted HIV/STI prevention and care service agencies have been providing culturally and linguistically sensitive services. The service provision area of each agency, however, is restricted within specific boundaries because the government allocation of funds allows each agency to serve only residents in their jurisdiction. An API individual who lives outside of a major metropolitan area may have to receive services from a local agency, where no one speaks her or his language.

In San Francisco, which has one of the largest concentrations of APIs in the world outside of Asia, more than fourteen Asian and Pacific Islander ethnic groups contribute to the city's cosmopolitanism. Yet, even though various HIV/STI agencies began there, it is a challenge for service providers to deliver comprehensive services to all of the API ethnic groups. Lack of monetary and human resources force agencies to prioritize ethnic groups within the API population depending on the

HIV/STI prevalence and incident rate in each ethnic group. Thus, there are always underserved ethnic groups.

HIV and psychosocial issues

HIV/STI prevention and care services are not only about health education and medical services but also about psychosocial issues. People with HIV often have multiple issues, such as mental health, substance use, low income, housing problems, family issues, and domestic violence, which interfere with their opportunity and willingness to access HIV care.

In order to maximize service delivery and to help an individual to opt for positive life changes, referrals need to be made to an appropriate service provider; but not all referral agencies have the language capacity and cultural sensitivity to deal with API clients. In such cases, the individual may not be able to access medical care because of unsolved immediate problems such as lack of funds for food and/or housing. For API newcomers who haven't assimilated to American culture, HIV treatment can still be unavailable or ineffective for these reasons.

Cultural barriers to getting optimal healthcare

Although each API ethnic group has a distinct and unique culture, understanding some cultural similarities may offer insight to service providers when they begin to analyze attitudes and behaviours related to HIV/STI prevention and care. Danny Yu, MSW, former psychotherapist of the Asian & Pacific Islander Wellness Center in San Francisco, has identified nine cultural amplifiers, which intensify difficulties experienced by APIs living with HIV in terms of accessing better social and medical services.

1. Family role over individual identity

"Each member in family has a specific role based on age and gender. Asian and Pacific Islanders may prioritize their family role (son, mother, father, etc.) over their individual identity."

For instance, in Chinese culture, an unmarried son usually stays with his parents to take care of them. Thus, filial piety or obligation to his parents may cause the HIV-positive man to feel shame for not being able to be a good son because of his HIV status. As a result, he may hide his HIV diagnosis from his parents and relatives. The situation may interfere with his adherence level to HIV medications and with his ability to access social services.

2. Indirect communication

"In Western cultures, indirect communication can be seen as passive-aggressive behaviour. In Asian and Pacific Islander cultures, indirect communication avoids drawing attention to another's mistakes or oversights. Value is placed on awareness of the needs of the group or the needs of those other than oneself."

continued on next page

In Japanese culture, asserting one's needs to others is considered impudent; instead, one should expect others to know one's needs. Many Japanese clients expect their case managers to be aware of their needs and to offer help before they verbalize their needs.

3 Deference to authority

"Deference is a form of respect. Most Asian and Pacific Islander cultures value deference to authority, values often reinforced by hierarchical structures in their societies and histories of colonization."

In general, physicians play an authoritative role in patient care. Many Asians tend to hesitate to ask their physicians questions or to express their opinions about HIV treatment because they feel that they have a lower status than their physician, especially when the doctor is Caucasian. Instead, Asian patients smile or nod. The physician may perceive the gesture as understanding and agreement.

For small ethnic Asian groups, culturally and linguistically sensitive comprehensive HIV services are virtually non-existent.

4. Language

"Language barriers can isolate a patient from life-saving and life-enhancing services and information."

API patients sometimes bring their friends or relatives to medical appointments for interpretation. The friends and relatives, however, may have their own cultural biases and may reject dealing with sensitive issues such as sexuality. At the same time, patients may not want to discuss sensitive matters in front of their friends or relatives. In this case, providers are not able to detect flaws in interpretation and the patient may not be able to exchange accurate information with service providers.

5. Shame

"Shame is used in Asian and Pacific Islander cultures to remind individuals of their obligation to their families and their communities."

The ashes of a Korean gay man were refused storage in the family's cemetery by his father because of his AIDS diagnosis. The father wanted to save the family's face. In his mind, the gay son had disgraced his family. Shame may make APIs living with HIV feel unworthy of receiving treatment and support services because they have disappointed their family.

6. Taboo subjects

"Issues such as sex and sexuality, homosexuality, illness, and death are considered taboo in many Asian and Pacific Islander cultures. Discussion of these issues is thought to

bring bad luck or the irresolution of these problems."

For instance, Vietnamese and Japanese cultures have no affirming words for homosexuality. In Asian families, even though parents recognize their child's homosexuality, they avoid dealing with it. Asian gay men, consequently, tend to isolate themselves from their families. Such isolation can interfere with their care-seeking and support-seeking behaviour and lead them to depression and alienation.

7. Avoiding direct expression of feelings

"Many Asian and Pacific Islander cultures discourage the direct communication of feelings. Talking about one's feelings is often viewed as a sign of an inability to handle one's own problems."

In general, APIs hesitate to seek psychotherapy. They often resist disclosing their problems and feelings because of shame at their inability to solve their own problems. They view themselves as disgraceful and vacillating.

8. Health beliefs and fatalism

"Illness and death may be attributed to bad luck. Outcomes of an individual's disease may be seen fatalistically."

Some Asian cultural beliefs such as karmic retribution can lead to fatalism. One HIV-positive Thai male says that he is destined to die young due to his promiscuity.

This belief makes him passive in his HIV care and prevents him from being proactive.

9. Traditional healing

"Patients report physical relief as well as an overall increase in their sense of well-being from healing practice such as acupuncture, Ayurvedic medicine, qi gong, shamanistic healing, and energy balancing."

In the Pacific Islander community, a deep connection with nature shapes the view of human nature. They place value on holistic healing. Physicians' overemphasis on Western medicine can be perceived as disregard of the spiritual aspects of healing by Pacific Islanders. Many Western medical practitioners do view holistic healing as being of dubious value.

The emphasis on family values and shame in API culture often leads to a strong concern with saving face not only for oneself, but for one's family and those with whom one deals. This is crucial to both cultural identity and to one's place in society. Such cultural characteristics need to be carefully analyzed by service providers to determine the obstacles and challenges facing APIs in terms of accessibility to healthcare. ⊕

Ippeiyasuda is a Treatment Advocate at the Asian & Pacific Islander Wellness Center in San Francisco.

Treating HIV-positive Asians in Vancouver

by Dr. Brian Conway

I was called to the emergency room to see John (not his real name), a 29-year-old Chinese man who had a seizure at home. He had a fever. The CT scan of his head showed a brain abscess. When I examined him, he was not moving the left side of his body very well. In addition, he had oral thrush.

His parents told me he was quiet and still living at home. Recently, he had become more withdrawn; he picked at his food and didn't always seem to understand their questions.

I didn't bring up the issue of HIV infection.

The next day, his sister asked to speak with me privately. She informed me that her brother was gay, but that their parents didn't know. "Please don't tell them, it would kill them to find out," she said. Family honour—especially if he had AIDS. By then, I knew his CD4 count was 20. He had toxoplasmosis, and despite aggressive treatment, he died of the complications of his disease over the next two weeks. His parents were told he had brain cancer.

In my work with the Ministerial Advisory Committee on HIV/AIDS, I became aware of how the mainstream Asian community viewed HIV infection. In 2000–01, only 43 cases of HIV infection were diagnosed in individuals identifying themselves as Asian. This represents 6.6% of the reported infections in British Columbia, despite the fact that Asians constitute 25% of the population of the Lower Mainland. Further, of 886,317 HIV antibody tests requested in British Columbia from 1996–2001, only 4% were conducted for self-identified Asian adults.

The silver lining may be that almost 58% individuals having a test are of "unknown" ethnicity. It may well be that a number of Asians are coming forward but refusing to state their ethnicity.

Being married to a Chinese-Canadian woman for the past 14 years (and living in Vancouver since 1994), I have come to appreciate the richness and diversity of Asian cultures, and how culture may impact on our ability to diagnose and care for HIV infection. A person may feel shame about having HIV and a sense they may have disappointed their family. Issues of sexuality (especially homosexuality), illness, and death are considered taboo in many Asian cultures. Further, talking about one's feelings may be

viewed as a lack of maturity or, worse, an inability to handle one's own problems. Illness may also be attributed to bad luck, and its outcome viewed fatalistically, a situation at odds with the active participation in care that has served us well in the HIV field.

Locally, the Asian Society for the Intervention of AIDS (ASIA) has worked tirelessly to champion the cause of HIV education and care in diverse Asian communities. It has gone a long way towards accomplishing its mission of providing culturally and linguistically appropriate support, outreach, advocacy, and education on HIV/AIDS and related issues. However, its programs have not yet reached mainstream Asian community groups. This takes time—and funding. Witness the efforts of the

In 2000-2001, only 6.6% of reported HIV infections in BC were among Asians— even though Asians constitute 25% of the population in the Lower Mainland.

San Francisco-based Asian & Pacific Islander Coalition on HIV/AIDS and its mainstream "Physician's Guide to Working with Asians and Pacific Islanders Living with HIV."

In New York, the Chinese American Planning Council, one of the largest providers of social services to Asians in the United States, has a well-developed HIV/AIDS services program, including a series of comic books—yes, comic books—drawing on the stories of the pig and the monkey king to teach children about HIV.

It would be easy to develop similar programs in Vancouver. All that is required is time. And money. ASIA is showing us the way, but they need help. Let us band together to ensure that I am never called to the emergency room to see people like "John" ever again. ⊕



Dr. Brian Conway, MD, FRCPC, is Assistant Professor in the Department of Pharmacology & Therapeutics at the University of British Columbia.

Sensing Danger

Innate immune system provides early defense against infection

by Ken Rosenthal and Paula Braitstein

Although disease-causing germs surround us, we rarely get sick. We are generally protected against infections by our body's immune system, which has two main arms: innate immunity, the part of our immune system that reacts automatically no matter what is facing it, and adaptive immunity, the part of the immune system that develops specific weapons against germs.

Our innate immune system is the first line of defense against invading disease-causing germs (pathogens). It provides early defense against infection and alerts the adaptive immune system that pathogen invasion has begun. Innate immunity is particularly important in warding off bacterial, viral, and parasitic infections at mucosal surfaces of our body, such as our lungs, guts, and genital tracts, where most germs enter and start their infections.

Although long-ignored and thought to be non-specific, the innate

immunity acts almost immediately to protect us. Indeed, our innate immune response usually keeps disease-causing germs at bay while our adaptive immune system gets ready.

By contrast, the adaptive immune system is highly specific and requires more time to get going following exposure or immunization. Adaptive immunity is carried out by antibodies and/or T-cells that specifically recognize one agent and do not act on different agents. The adaptive immune system also has a specific memory that permits it to respond more rapidly to re-exposure to pathogens. However, even with specific memory, adaptive responses require days or weeks to get going.

Understanding how the innate immune system responds to infections could help develop improved vaccines and lead to the prevention of infections.

immune system, as recent studies show, uses an ancient family of receptor molecules to recognize pathogens and plays an important role in directing adaptive immune responses. After nearly two decades of trying to trigger adaptive or specific immune responses to HIV, no successful immune therapies or vaccines have been developed. In light of this failure, attention is increasingly turning to understanding how the innate immune system recognizes and responds to infections. Perhaps this knowledge will help in the development of improved therapies and vaccines and lead to the prevention of infections.

Innate versus adaptive immune responses

Innate immunity is present at all times in all normal individuals. It is an evolutionary ancient form of defense found in most organisms, from fruit flies to whales. It does not require prior exposure to an infection to be effective, and it treats different infections the same way every time an individual is exposed. Most importantly, innate

The cast of the innate immune system

Innate defense against infection can be broken down into defenses that are always present (constitutive) and those that are very rapidly turned on (inducible). Innate immunity is carried out by physical barriers, secreted products from various cells, and inflammatory white blood cells. The epithelial surfaces of our body—intact skin and mucous membranes that line our lungs, gut, and genital tract—provide a physical barrier to infection. Individuals who have bad burns or ulcers, such as genital ulcers that cause breaks in the barrier, are more susceptible to infections.

Most infections enter our bodies and start infections at the mucous membranes. It is amazing to think that in many places in our bodies, such as our intestine, only a single layer of cells separates our insides from the infections present in the outside world. These body surfaces get support defending us against infections from products that are always produced and secreted





by these surface epithelial cells, such as mucus and anti-microbial peptides. The layer of mucus helps defend us by blocking the attachment of microbes to epithelial cells and assisting in their expulsion from the body. In addition, acids secreted in our stomach, enzymes (such as lysozyme in tears), and substances in the blood are toxic to potential invaders.

Unfortunately, physical barriers are not sufficient to protect us. They are subject to damage. The inducible innate responses provide an additional defense through a variety of cells, including epithelial cells, various white blood cells, and secreted factors, such as cytokines, chemokines, reactive oxygen, and anti-microbial peptides.

Triggering inducible innate defenses requires recognition of infection. It is now clear that our innate immune system can recognize danger signals. It does so by recognizing molecular differences between disease-causing germs or pathogens and their hosts. The molecular patterns in disease-causing germs that trigger innate immune responses are called pathogen-

A recent discovery uncovered receptors that have existed for millions of years and are the foundation of host defense in all organisms except bacteria.

associated molecular patterns (PAMPs). These PAMPs are seen by pattern recognition receptors (PRRs) found on innate immune cells. Molecular patterns recognized by the innate immune system are shared by large groups of microbes and include molecules that make up bacterial cell walls, such as lipopolysaccharides (LPS), bacterial DNA, and double-stranded RNA, which is made when certain viruses replicate.

Once PRRs on innate immune cells recognize PAMPs or danger, they trigger a series of anti-microbial responses. While these innate immune responses play an important role in the early control of infection, they also play an active role in directing and shaping the subsequent adaptive immune response.

Sensing danger: toll-like receptors

Receptors are proteins on the surface of cells that can have a variety of different functions. The innate immune system uses PRRs that see repeating patterns of shared molecules on the surfaces of disease-causing germs, detect invasion, and alert the immune system. Some of these receptors are found on white blood cells called macrophages that recognize, bind, and eat foreign invaders. These are called phagocytic receptors. Eating one's enemies, digesting them, and destroying their genetic material is a very primitive and effective means of host defense.

Amazingly, though, a recent discovery uncovered a family of receptors that have existed for millions of years and are the foundation of host defense in all organisms except bacteria. Plants, insects, and animals share this ancient system of recognizing

pathogens. It predates the adaptive immune system, which is only found in vertebrates, and provides early defense against infection. These molecules, called toll receptors, were first discovered in fruit flies where they were shown to be important in defending the flies against fungal infection.

We now know that mice and humans also have toll-like receptors (TLRs). So far, 10 toll-like receptors have been identified in humans and each TLR recognizes a unique danger signal shared by a class of pathogens.

For example, toll-like receptor 4 (TLR4) sees Gram-negative bacteria by recognizing lipopolysaccharides that make up the bacterial cell wall. Once TLRs recognize infecting pathogens, they signal for activation of induced innate responses. These induced innate immune responses include local inflammation. The redness, heat, swelling, and pain of local inflammation are signs of the increased flow of blood, blood cells, and molecules to the site of infection. Induced innate immune responses also serve to activate adaptive immune responses.

Conclusions

The innate immune system provides early defense against infection and alerts the adaptive immune system to pathogen invasion. These two functions act through an evolutionarily ancient receptor system, called toll receptors, that is shared by

plants, insects, and animals. Innate immunity acts immediately and often succeeds in preventing an infection from being established. If not, it is reinforced by recruitment and increased mobilization of white blood cells and molecules to the site of infection by the induced innate response. If this barrier is overcome, cells of the innate response help to initiate and direct adaptive or specific immune responses.

Increased understanding of how the innate immune system recognizes and responds to infection will contribute to development of improved immune-based therapies and vaccines and may lead to better prevention of infections. ⊕

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 rosenthk@mcmaster.ca.



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



Staying on track

Adhering to your treatment regimen can help prevent drug resistance

by Nicole Gutfrucht

People taking highly active antiretroviral therapy (HAART) must contend with numerous complications and issues, from nausea and fatigue to how much water should be consumed with a pill and whether or not it is taken with food. While it may be tempting to simply take a break and miss a dose or two, most doctors don't believe that's a good idea.

Like other viruses, HIV is constantly making copies of itself. Sometimes during this replication, mistakes are made in the genetic code of the virus. These mistakes are called mutations. While some mutations are harmful to the HIV, or have no noticeable effects on it, other mutations can help the virus build up resistance to certain drugs. This happens when mutations occur in the specific enzymes (reverse transcriptase and protease) that are targeted by HIV drugs.

When the virus becomes resistant to a drug, the medication's positive effects on viral suppression will no longer occur. This is true for the particular medication being used, and for any drugs that rely on the same enzyme to attack

HIV cells. This cross-resistance can cause someone to become resistant to a medication he or she has never used before. It is also possible to pass on a strain of HIV that is resistant to a drug. This means that people who have never taken HAART before may find some drugs don't work for them.

So how can drug resistance be prevented? Adherence. To help stop resistance from occurring, it's important to keep an adequate level of drug in the blood at all times. Dosing schedules are designed to do just that. If a dose of medication is missed, the drug level drops, making it possible for HIV to replicate more quickly. The more quickly the virus replicates, the more chances there are for mutations.

Dosing schedules will make sure that the next dosage is taken before the drug levels drop off too much. In addition, some medications are absorbed better if they're taken with food, while others need to be taken on an empty stomach. This, too, will contribute to how much drug is in the blood.

With all the possible side effects and the complexity of some dosing schedules, following a treatment plan can be difficult. According to an article entitled "Adherence: Keeping Up with Your Meds" in Project Inform's *The Body*, "To find a treatment regimen you can live with, it's necessary to settle two sets of requirements—yours and the drugs."

Before deciding to start antiretroviral therapy, it's important to look at your own schedule and lifestyle. This can help determine whether you're ready to start HAART, as well as what kind of schedule will work best. People who find that they don't have much structure in their day—that they're not eating, sleeping, or waking at set times—may find it easier to adhere to a schedule that involves once or twice daily dosing, with few restrictions on when meals need to be eaten.

Another factor to consider before starting treatment is the possible side effects of the medications. It's often easier and less frightening to deal with expected side effects than something that blindsides you.

Storage issues are another consideration, especially for people without a stable living situation. Some medications, such as ritonavir, need to be refrigerated. Making sure that prescriptions are always in supply is another important part of adherence.

All these considerations can make it easier to follow a set dosage schedule, which is a vital part of making sure a treatment plan continues to work. ⊕

If a dose of medication is missed, the drug level drops, making it possible for HIV to replicate more quickly.



Nicole Gutfrucht is a Researcher with the BCPWA Society's Treatment Information Program.

BCCFE at the forefront

New test under development for early detection of mitochondrial toxicity

by *Glen Hillson*

In an article published in the March 14, 2002, issue of the *New England Journal of Medicine* (NEJM), Dr. Julio Montaner of the BC Centre for Excellence in HIV/AIDS (BCCFE) outlines a new test being developed for the early detection of a common but potentially life-threatening side effect of antiretroviral therapy. The test, currently being evaluated in several research protocols at the BCCFE, offers hope for better management of drug treatment.

Since the advent of highly active antiretroviral therapy (HAART), many problems have been noticed in large numbers of people taking combination drug therapy. Frequently these problems occur in people whose HIV disease appears to be under control—they have normalized their CD4 counts and their viral loads are less than 50 copies/ml of blood. The large and growing list of complications includes changes in body shape, redistribution of body fat, muscle/weight loss, bone degeneration, peripheral neuropathy, extreme fatigue, shortness of breath, rapid heart beat, kidney and liver deterioration/failure, diabetes, and pancreatitis. Many, if not all, of these occurrences may be related to the same root cause—mitochondrial toxicity.

Mitochondria are the powerhouse of human cells and can affect virtually any body system: muscles, nerves, organs, and brain. Mitochondria turn cell waste into energy for the body. In normal cellular activity, the mitochondria operate as part of a finely tuned



Dr. Julio Montaner

symbiotic relationship, converting glucose into energy, and breaking down cell waste such as lactic and pyruvic acids in the process.

Research has shown that mitochondrial toxicity is more common with certain drugs in the nucleoside class, most notably ddI and d4T, and possibly AZT.

“Presently the most reliable test for the diagnosis of nucleoside-related mitochondrial toxic effects is muscle or liver biopsy; however, biopsy is not practical for routine screening and monitoring” according to the NEJM article. The new test is a novel polymer chain reaction (PCR) assay for mitochondrial DNA performed on a blood sample. (PCR tests are also used for viral load tests for HIV and hepatitis C.) The results of the research so far show that hyperlactatemia was associated with low levels of mitochondrial DNA. Hyperlactatemia is an overaccumulation of lactate (a waste product) in the body and is a common manifestation of mitochondrial toxicity.

This test may offer the advantage of enabling care providers to identify lower levels of mitochondrial DNA before side effects develop. This early detection would allow them to change or adjust therapy proactively before the effects become clinically apparent.

“The challenge remains to keep ahead of emerging toxicity,” said Dr. Montaner. “Ultimately we hope that this test will allow us to continue to maximize the impact of currently available therapies.” ⊕

Glen Hillson is a community representative on the Advisory Committee for Drug Evaluation and Therapy at the BC Centre for Excellence.

Looking for volunteer director, writers, cast and crew to take us through the 2002 Fringe run. We have the Fringe space, a small budget and now we need the talent. You do not need to be HIV+ to be a part of this unique theatre troupe.

BCPWA

**THEATRE
POSITIVE**

Contact:

Jackie Haywood at **604.893.2259**



Theatre experience a definite asset.
Willingness to jump in
and be creative an attribute.

Weighing the evidence

The science of making recommendations for specific nutritional supplements

by *Diana Peabody*

Evidence-based medicine provides the framework for decisions around clinical practice and treatment guidelines in HIV disease. Dietitians are facing growing pressure to make nutrition recommendations, especially concerning micronutrient supplementation—vitamins, minerals, and amino acids—using this rigorous method of evaluating the evidence.

The available research is evaluated on the type, amount, and quality of evidence. The gold standard is the randomized clinical trial, usually a double-blinded, placebo-controlled intervention study, because it decreases bias and gives the most objective results. Expert opinion is considered the weakest evidence. The results of this evaluation determine the strength of a recommendation, from “should always be offered” to “should never be offered.”

In nutrition, the lack of clinical trials makes it difficult to find proof of benefit or proof of cause and effect. We often rely on *in vitro* (test tube) studies, epidemiological evidence (study of a population), animal studies, and anecdotal evidence (case reports and hearsay). As a result, we sometimes have to use expert opinion to guide our decisions.

Numerous factors in studying nutrient levels

Nutrients are hard to study with the usual scientific method, especially in HIV disease, because the interactions between nutrients, the gut, the immune system, and the viral replication process are complex. The studies that do exist usually report mildly deficient serum (blood) levels, which are sub-clinical, meaning there are no symptoms. Laboratories and researchers may use different norms or techniques to define a deficiency, which makes it hard to compare studies.

Moreover, it is still unclear whether norms used for a healthy population should be used for people with HIV, although this issue has not been investigated.

If an HIV-infected person does have low serum vitamins or minerals, it could mean that they really have nutrient deficiency with more generalized malnutrition, or it could reflect altered metabolism of the nutrient. During periods of systemic infection, the body develops an acute phase response, which alters the metabolism of many micronutrients. The liver

sequesters (collects) nutrients to make infection-fighting substances, which lowers blood levels of these nutrients. It is unclear whether HIV infection induces an acute phase response, and if it does, at what stage of the disease. Perhaps this response, which protects the body, causes the deficient nutrient levels, making it difficult to know whether supplementation is required or even beneficial.

Nutrient deficiencies could also be the result of a drug-nutrient interaction or even an error at the laboratory. The difficulty in sorting out these variables has resulted in a lack of consensus in the scientific community and a reluctance to make recommendations for specific micronutrient supplements.

The challenge of determining zinc doses

Zinc is an example of a nutrient for which no agreement exists about the recommended intake for HIV-positive people. A belief that high doses of zinc would stimulate and maintain a healthy immune system resulted from the general recognition that zinc is an important factor in immune system function.

A number of studies raised concerns by reporting that zinc deficiency is common and that it is associated with faster HIV disease progression and increased risk of dying. It is not clear whether zinc deficiency caused the disease to progress faster, or whether the disease was progressing and causing the deficiency,

In nutrition, the lack of clinical trials makes it difficult to find proof of benefit or proof of cause and effect.

perhaps via the acute phase response. It is also hard to measure and interpret zinc status because serum levels are affected by the time of day, food, stress, and infections.

If you compare the results of three different, frequently quoted studies, the strength of a recommendation would likely be “should sometimes be offered.” In 1993, Tang reported that zinc intakes greater than 20mg per day resulted in faster HIV disease progression than lower intakes. Then in 1998, Baum reported that serum zinc was positively associated with CD4 counts, that

low serum levels were associated with advanced disease, and that low dietary zinc intake (less than 9.34mg/day) was associated with an increased risk of mortality. In 1984, Chandra reported that very high doses of zinc (300mg/day) in healthy HIV-negative men actually suppressed immune function.

All of these studies have limitations. One could argue that Tang did not look at serum levels or higher intakes of zinc (over 50mg/day). The results of the Baum study could indicate that zinc intake and serum levels were lowered by advanced disease in her study population. In addition, her population consisted of HIV-infected subjects who were actively using injection drugs, which introduces other nutritional and medical complications. Both the Tang and Baum studies report on dietary intake, which is very difficult to measure. The Chandra study was very small and used extremely high doses.

The results of these studies do not help us determine what zinc dose, if any, people with HIV should take. The Baum study suggests that it is prudent to make sure that everyone is at least meeting their basic requirements and to supplement if serum levels are measured and found to be low. However, the Tang and Chandra studies indicate that dosing should be modest and that more is not always better.

Determining HIV requirements

Nutrient recommendations for daily intake have been developed to prevent deficiencies in the healthy population. The requirements for a disease state, such as HIV, are unknown. We still don't completely understand the actions of vitamins and minerals, and the long-term consequences of pharmacological doses (very high doses) are not known. If we use evidence-based medicine to make recommendations for nutrient supplements, it becomes apparent that little scientific proof exists to

show that supplementation will positively influence disease progression or death in HIV disease.

The critics of evidence-based medicine argue that it is too standardized and that it does not include concepts such as the relationship between healthcare provider and patient, being comfortable with uncertainty, or the use of evidence other than clinical trials. Because so much nutrition information and mis-

Nutrients are hard to study with the usual scientific method, especially in HIV disease, because there are complex interactions.

information is available, this process of evaluating the evidence can be *one* tool to help make good nutrition decisions.


A balanced approach

The first principle in supplementing should be to do no harm. Certainly, staying well-nourished with a generous intake of nutrients from foods and taking positive action towards health will be enormously beneficial. A thoughtful, well-planned supplementation regimen may also help, but we really don't know which supplements or what doses will give the best results. Given the evolving nature of nutritional science, using different methods, including evidence-based medicine and expert opinion, may be the best way to make decisions. ⊕



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


For the record...



A **survey**

BCPWA Survey Number 5 takes time to fill out and when you do this, you are a volunteer and an advocate. Please only fill out one survey.

only for persons with HIV disease.







If it ain't broke ...

Presentation to the Reference Drug Program Panel

by Glen Hillson

Under the Reference Drug Program (RDP), Pharmacare creates groupings of drugs that treat the same condition and sets its coverage level for each group at the price of the most cost-effective drug, which is called the "reference drug." Patients eligible for Pharmacare benefits receive full coverage for the reference drug, or may choose a more expensive drug and pay the difference. Patients can obtain special authorization for full coverage of a more expensive drug if their doctor presents medical reasons.

Last year, BC Minister of Health Planning Sindi Hawkins announced the formation of a consultation panel to find an alternative to the Reference Drug Program. Glen Hillson recently made the following presentation to the panel.

People living with HIV/AIDS rely heavily on prescription drugs to slow disease progression, maintain health, and extend life. The therapeutic class of drugs known as anti-retrovirals—drugs whose mechanism of action is to slow or halt HIV replication—accounts for 5% of the total Pharmacare budget. As well, many of us use a variety of other drugs to manage the effects of our illness—effects such as symptoms, side effects, and opportunistic infections arising from compromised immunity.

The classes of drugs currently included in the RDP are not widely used by people with AIDS, at least not for conditions related to their HIV infection. However, we do rely heavily on a strong, rational, publicly funded system of drug distribution that ensures equality of access. For such a system to effectively meet the needs of all residents of BC, its design must be evidence-based, it must be cost effective, and it must complement other facets of the overall healthcare system to ensure delivery of comprehensive, quality care.

When the RDP was first introduced in 1995, it was very controversial and, in many cases, public opinion cut across traditional lines of support and affiliation. Among healthcare consumers, there was uncertainty and concern about how RDP would affect them. A full range of opinion was reflected among consumer advocacy groups. For this reason, the RDP has been subjected to unprecedented evaluation and scrutiny to assess its effects. Different impacts of the program have been evaluated by at least four different research groups from Harvard, University of Washington, University of British Columbia, and McMaster University. Although funded by the BC government, this evaluation work was conducted independently and was encouraged by a

range of stakeholders, including the drug industry, which is the most vociferous opponent of RDP.

I would like to talk briefly about the context of RDP in the greater scheme of healthcare delivery in BC and the rest of Canada because that context is the subject of one of the most wide ranging and important public discourses on healthcare in our history, and because a meaningful assessment of RDP in relation to possible alternatives must include a broader discussion of cost containment options.

The current public discourse places a large emphasis on assertions of rising costs of healthcare in general and drug programs in particular. Some stakeholders call current systems unsustainable. Regrettably, strategies that are marketed by governments as intended to contain costs are little more than manoeuvres to shift costs.

BC has the lowest per capita total drug expenditure in Canada, even though BC's population has the highest percentage of seniors. What troubles the current government is that BC's public purse funds a greater proportion of these costs than other provinces. And in order to alleviate that circumstance and pave the way for tax cuts and redirected spending, they propose to shift drug costs to individuals, to private insurance plans, and to employers.

Bulk purchasing by Pharmacare and RDP has proven to be the most effective tool currently at our disposal for containing drug costs without adversely impacting health outcomes. Recently, the Canadian premiers talked of the creation of a national crown corporation for the bulk purchase of drugs. This, combined with greater price competition, has the potential to help keep costs down.

However, the present reality is that drug price regulation in Canada by the PMPRB (Patented Medicine Prices Review Board) has proven to be relatively ineffective. Exceedingly generous patent protection for research drug companies leaves very little room for competition. This has made the drug industry the most profitable industry in the world. The RDP has had the greatest effect in stimulating price competition here and in countries such as Germany and New Zealand. In many instances, drug companies have reduced prices as a means of competing for market share with the reference drugs.

I would like to discuss some of the benefits and myths about the RDP. According to Pharmacare estimates, the RDP has saved Pharmacare \$161 million since it was introduced in 1995. In

1999, the estimated saving was \$44 million. Opponents of the program have argued that higher costs result elsewhere in the health system because of the RDP, due to increased doctor visits and discarded drugs. This argument appears to have been ideology-based, having little evidence to support it. The RDP works because the program is evidence-based. Since its inception, intensive independent evaluation has demonstrated that the RDP reduces the overall cost of healthcare.

Some argue that the RDP substitutes cheap healthcare for optimal healthcare. Evaluation of the program reveals that it has

In order to pave the way for tax cuts and redirected spending, Pharmacare plans to shift drug costs to individuals, to private insurance plans, and to employers.

had no adverse impacts in terms of hospitalizations, morbidity, mortality, or other patient outcomes. In fact, the cost-shifting strategies that are being set in motion can and do place life-saving drugs out of reach for some people, resulting in poorer population health outcomes. This is what occurred in the province of Quebec when drug costs were shifted to the poor.

The drug industry has threatened that the RDP creates an unfriendly commercial environment for them. From 1988 to 1999, Rx&D (Canada's Research-Based Drug Companies) reported that industry investment in BC increased 398% so that argument seems specious. And although BC represents 13.3% of Canada's population, it only receives 3.3% of the national pharmaceutical research and development spending, an amount that has not changed in percentage terms since 1988.

The drug industry waves the flag for innovation and for research and development investment every time there is a

potential threat to profits. In truth, the eleven Fortune 500 drug companies spend 12% of revenue on research and development and 2.5 times that amount on administration and marketing. As for innovation, a recent study of drugs approved in the US between 1982 and 1991 revealed that 53% of the newly discovered drugs had "little or no therapeutic gain" compared to drugs already marketed. The RDP helps to avoid paying premium prices for newer "me too" drugs that offer no improvement over the reference drug.

Industry devoted a large portion of its massive profits to opposing the RDP through full-page newspaper advertisements and a court challenge. In doing so, they inflicted additional waste on the public purse. When assessing industry arguments on RDP, it is crucial to remember that drug companies are exclusively accountable to their shareholders and are motivated entirely by profit.

The RDP in BC has worked very well, and BC should look at other therapeutic areas to achieve additional cost savings. Residents of BC have come to appreciate and support the program because it has not adversely impacted health outcomes, it helps make the Pharmacare program more sustainable and rational, and it limits profit gouging by corporations. Doctors have also come to realize the long-term benefits of the RDP in terms of their patients having sustainable, long-term access to quality care. ⊕



Glen Hillson is the Chair of the BCPWA Society.



To our wonderful BCPWA Volunteers!
This is *your* recognition event.
Please join us on May 9th, 2002 at 6 pm
for a spectacular evening of fun, great food, games and prizes at our
WILD WEST CASINO
RSVP by invitation only



Trizivir

by Cristhofer Cuadros

Trizivir (ABC + 3TC + AZT) es una sola píldora que está compuesta de tres nucleósidos inhibidores de la transcriptasa reversa (NTR). Esto simplifica la cantidad de píldoras que el paciente tomaría diariamente si su tratamiento contra el VIH comprende los tres componentes del Trizivir.

Trizivir está indicado para el tratamiento de la infección por el Virus de la Inmunodeficiencia Humana (VIH) en

sibilidad aparecerán fiebre y/o erupción como parte del síndrome. Otros signos y síntomas pueden incluir síntomas respiratorios, dolor de garganta o tos, síntomas gastro intestinales como náuseas, vómitos, diarrea o dolor de estómago. Otros síntomas frecuentemente observados de la reacción de hipersensibilidad pueden incluir letargo o malestar y síntomas musculoesqueléticos.

Los síntomas relacionados con esta reacción de hipersensibilidad empeoran al continuar el tratamiento y pueden poner en riesgo la vida del paciente. Generalmente, estos síntomas se resuelven al suspender la administración de abacavir. Los síntomas de la reacción de hipersensibilidad aparecen normalmente en las primeras seis semanas del tratamiento, aunque estas reacciones pueden ocurrir en cualquier momento durante el tratamiento. Se debe controlar estrechamente a los pacientes, especialmente los dos primeros meses del tratamiento con Trizivir. Los diagnosticados con reacción de hipersensibilidad estando en tratamiento deben interrumpir Trizivir inmediatamente. Nunca se debe reiniciar el tratamiento con Trizivir o con otro medicamento que contenga abacavir (Ziagen) en pacientes que lo han interrumpido a causa de una reacción de hipersensibilidad. El reinicio del tratamiento después de una reacción de hipersensibilidad conduce a que en cuestión de horas, vuelvan a aparecer los síntomas, siendo esta recurrencia normalmente más grave y desenlace de muerte. ⊕

Si usted tienen una reacción de hipersensibilidad, cuando este tomando trizivir, deje de tomar trizivir inmediatamente y llame a su medico.

adultos. Esta combinación sustituye a los tres componentes (abacavir, lamivudina y zidovudina) utilizados por separado en dosis similares. La demostración del beneficio del Trizivir se basa principalmente en los resultados de estudios realizados en pacientes con enfermedad no avanzada, que no hayan sido tratados previamente o tratados durante un tiempo moderado con medicinas antirretrovirales.

La terapia deberá iniciarse por un médico con experiencia en el tratamiento de la infección por el VIH. La dosis recomendada de Trizivir en adultos (>18 años) es de un comprimido dos veces al día. Trizivir puede tomarse con o sin alimentos. En las investigaciones clínicas, aproximadamente el 4% de los individuos que reciben abacavir - desarrollan una reacción de hipersensibilidad (alergia). En casi todas las reacciones de hipersen-

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 Miércoles 10:00AM a 5:00PM.

Visítenos 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

Información sobre tratamientos anti VIH vía correo electrónico nuestro email es treatment@parc.org

Cristhofer Cuadros is a Researcher with the BCPWA Society's Treatment Information Program.

Volunteering at BCPWA

Profile of a volunteer:



"Kath possesses a natural ability to relate with people of diverse backgrounds. Her endless flow of energy helps to inspire both TIP staff and fellow volunteers."

Angela Guglielmucci

Kath Webster

Volunteer History

I started in 1999 with BCPWA's Treatment Information Program (TIP), where I currently volunteer. I coordinated the Complementary Health Tent at the AIDS Walk for the past two years. I also spent a year on the Retreat Team.

Why pick BCPWA?

My involvement with TIP enables me to stay on top of the ever-changing treatment issues, which helps me to be actively involved in my health care. For me, this is one of the keys to managing this disease.

Why have you stayed?

Since my diagnosis, BCPWA has been a valuable part of my overall support system. The connections I have made with both members and staff are very important to me.

Rating BCPWA

Excellent. I think BCPWA is truly committed to serving the needs of the very diverse population of people with HIV/AIDS.

Strongest point of BCPWA

Naturally, I am biased due to my involvement. Therefore, I think TIP is invaluable, specifically the ABCs program which focuses on HIV/AIDS treatment education around the province. The Retreat Program also ROCKS.

Favourite memory

When I was very sick and had a CD4 count of only five, I was at a healing retreat with about 20 other members, and all of us were dancing wildly to "I Will Survive". It worked for me! That was when I decided to become a volunteer.

Future vision for BCPWA

That, despite the nasty political climate in the province, we can maintain our funding and continue with this important work.

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, Tuesday 3PM-7PM, 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 for appointment 604.893.2223.

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).

GAYPOZGROUP: Exploring the impact of HIV on Life expectations and Self-care. Meeting Tuesdays, 7PM BCPWA Lounge. Register at info desk (604.646.5323) For info contact Steve at 604.687.4062

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.

POSITIVE WOMEN'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 Wednesday 2PM-3PM. Call Sangam 604.692.3006 for more info.

Thursday

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. 8:00PM to 9:30PM. 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 PM- 4:00 PM at St. Paul's Hospital in Room 2C-209 (2nd Floor, Burrard Building). For information call Mary Petty at 604.806.8223.

POSITIVE WOMEN'S NETWORK:

>Sharing Circle for HIV+ women from 1PM-3PM. This is a time to share stories and support each other. Call Stacie 604.692.3005 for more info.
>"Taking a break" group for HIV-Positive women. Thursday 6PM-8PM: 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

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.

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.

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.

OPPOSITES ATTRACT:

A support group for HIV- gay men with HIV+ partners is designed to help partners develop and enhance their coping skills while building a mutual support network. The group meets the 1st & 3rd Wednesday of each month from 6:30pm - 8pm at St. Paul's Hospital. Please call Mary Petty 604.806.8223.

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).

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 persons

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: lucybarney@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 (JMOJA):

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.

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 store-front 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 McNeill 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.island-net.com/~varcs/homepage.htm.

VICTORIA PERSONS WITH AIDS SOCIETY:

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

THOMPSON-OKANAGAN

HEALTH

OUTREACH HEALTH SERVICES:

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

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

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

AIDS GROUPS & PROGRAMS

AIDS RESOURCE CENTRE - OKANAGAN & REGION:

Information, referral, advocacy, peer support, social & 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@silk.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 call Gail Orr at 397.2717.

QUESNEL SUPPORT GROUP:

For PWA/HIV and their families. For information call Jill at 1.250.992.4366.

Upcoming BCPWA Society Board Meetings

Date	Time	Location	Reports to be presented
May 1, 2002	3:00pm	PARC Training Room	Director of Fund Development Presentation /Written Departmental Reports
May 15, 2002	3:00pm	PARC Training Room	Executive Committee /Written Executive Director Report
May 29, 2002	3:00pm	PARC Training Room	Standing Committee /Written Departmental Reports
June 12, 2002	3:00pm	PARC Training Room	Director of Communications Presentation / Written Executive Director Report
June 26, 2002	3:00pm	PARC Board Room	Executive Committee / Written Departmental Reports
July 10, 2002	3:00pm	PARC Training Room	Standing Committee /Written Executive Director Report
July 24, 2002	3:00pm	PARC Training Room	Director of Treatment Info Presentation / 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

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.

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

Nurses with big... noses

by *Glen Hillson*

Some folks are too nosy. Even if they have the noblest intentions, it still constitutes prying. And when it comes to health issues, this can be tiring and stressful—their inquisitiveness often reveals information that I would have preferred to remain blissfully ignorant about for a while longer.

It seems as if a week doesn't pass without some well-intentioned Florence Nightingale leaning forward and asking in a solemn tone, "How are you—are you feeling okay?" Each time I brace myself for what is certain to follow: some rendition of "You look like reheated Kraft dinner." Often I reply, "I was feeling pretty good until hearing that the very sight of me makes you want to reach for a barf bag." I have now warned all my friends to tell me I look vibrant and gorgeous or keep yer damn opinions to yerself!

Healthcare professionals are among the worst offenders. Ask them to check something out and before you know it, they're poking around where they weren't invited. Just the other day, I had an 8:00 a.m. appointment for my semi-annual liver ultrasound. It seems that I am at high risk for liver cancer. For whatever reason, the medical profession thinks they should have the maximum advance notice of my impending demise, so they closely monitor me.

It may have been tolerable if it stopped there. But I knew I was in for a long day when the receptionist asked me if I had drunk lots of water to fill my bladder. Why this sudden interest in my bladder? Aside from having to go to the bathroom hourly all night long, my bladder

seems to be functioning better than other parts of my body.

My adventure was about to start careening out of control. First, they dressed me up in a sad-sack nightie, which they promptly yanked up to expose my torso without even a hint of foreplay. Then the stern lady at the controls contracted her fist around a bottle of KY until it emitted a loud farting sound and deposited a large blob of cold, sticky Jell-O onto my belly. For the next half hour, she explored the entire region with her one-eyed wand while instructing me to turn this way and that, breathe, hold, and so on. When it was all over, I happily learned that there were no apparent tumours in my liver.

Then the other shoe dropped. "You have a single, fairly large gallstone," the nurse announced with far too much enthusiasm. Aw jeez, why did she have to go snooping around looking at my gallbladder, I thought to myself. I didn't recall ever inviting her to perform an exploratory procedure. I guess she just couldn't help herself.

Did I really need to know about my gallstone? I don't think so. If it started to act up, wouldn't that be soon enough? Besides, I'm not eligible for gallstones. Fat, fair, and forty are the membership requirements for joining that club. Nowhere does it say grey, grumpy, and fifty.

I wonder what will be next. I could go for a physical exam. Maybe my doctor will look in my ear and announce that my brain has atrophied to the size of a pea. Worse yet, the inside of my skull may have given



way to a tumour as big as a grapefruit. When my doctor bangs my knee with his little hammer to check reflexes and the entire joint turns to dust, will he tell me my drug regimen has caused osteonecrosis? What if he tries to listen to my heartbeat and decides to call the paramedics?

I suppose medical science would be at a standstill if it weren't for inquiring minds. And I can hardly blame my friends for their curiosity about the large black bags perched lazily atop my cheekbones. It's comforting to know that people are genuinely concerned, and for most health problems, early detection is good medicine. But sometimes I wish folks would just mind their own business now and then. ⊕

Glen Hillson abandoned any illusion of privacy years ago.