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BRITISH COLUMBIA
PERSONS WITH AIDS
SOCIETY



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

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

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think +

opinion and editorial

Taking charge of our health through advocacy

by Glen Hillson

In this issue of *Living+*, we focus on the importance of advocacy to people living with HIV/AIDS.

For at least a decade, we have known that a hugely disproportionate share of the devastation of HIV has been occurring in poor countries south of the equator. It wasn't until the World AIDS Conference was held in South Africa two years ago that the challenges of responding to the epidemic in poor countries became the topic of global advocacy and discussion at even the highest levels. We have taken our first baby steps to intervene in a disaster that has already reached unprecedented magnitude.

Closer to home, advocacy has helped achieve tremendous progress for PWAs. The BCPWA Society was formed in 1986 largely in response to the imperative for an organization controlled by PWAs that speaks and advocates for our rights and needs. Compassionate access to experimental medicines, our entitlement to meaningful consultation with other stakeholders, and more ethical clinical research are some of the advances. One of the more important accomplishments of the BCPWA Society has been to win monthly health allowances that enable PWAs on disability income assistance to access health goods and services not funded by the health system. Payout of these allowances is likely to reach \$10 million yearly. That is 20 times what our Complementary Health Fund provides!

In light of recent cuts to Pharmacare, the BCPWA Society has successfully lob-

bied the BC government for reinstatement of coverage for topical antifungal preparations and hormone replacement therapies that combat wasting. We helped convince the federal government Standing Committee on Justice and Human Rights to shelve a plan for mandatory HIV testing of individuals involved in dust-ups with police and fire fighters. And it looks like our interventions may contribute to saving the provincial Reference Drug Program. These are just some examples of how advocacy has helped PWAs.

Canadian tax law disallows charitable status to organizations that spend more than 10% of their budgets on lobbying government. This rule effectively muzzles Canada's 80,000 registered charities. AIDS organizations in both Canada and the US have also been required by federal funders to remove the word "advocacy" from their names as a condition of receiving future contributions. Charitable organizations are welcome to do the yeoman's share of the work needed to help people cope with health and social issues. Yet, governments prevent those same organizations from having a voice in the discussion of how to more effectively prevent and solve the same problems.

A core value of the BCPWA Society's mission statement, which is to promote empowerment through collective action, is likely to come under attack. It is important to the future well being of PWAs that we strengthen our voices and preserve our right to advocate. ☺

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

False rapid test results

The B.C. Centre for Disease Control says people who took a certain type of rapid blood test for HIV may have been given false results. The test was given to more than 3,000 people at four Vancouver clinics.

The "rapid" test involved pricking a finger and testing for a reaction with a chemically treated strip of paper. The test usually gave results within an hour.

The test has now been shown to be unreliable, sometimes giving false negative results. It has been discontinued.

Health Canada is advising anyone who received a negative result on an HIV rapid blood test since March 2000 as their sole HIV test, to contact the clinic or health care professional for further testing, using the longer method. That means sending a vial of blood to a laboratory and waiting several weeks for results.

Nevirapine can make you crazy

Researchers in London have reported three cases of neuropsychiatric complications from nevirapine treatment in patients with HIV infection but no history of mental illness. All cases were resolved when treatment was stopped.

In one case, a man developed low mood, cognitive impairment, and clouding of consciousness within two weeks of starting nevirapine. A woman experienced delusions of persecution and infestation within two weeks of starting nevirapine treatment, ultimately leading to an impulsive suicide attempt. A third patient developed persecutory delusions and depressive thoughts ten days after starting nevirapine.

Nevirapine is a non-nucleoside reverse transcriptase inhibitor (NNRTI) used to reduce the viral load in HIV infection. Its side effects include hepatotoxicity, gastrointestinal symptoms, and dermatological reaction. Efavirenz, another NNRTI, can



Photography: Angus Praught

On May 15, the AIDS Memorial Society of Vancouver officially broke ground at Sunset Beach West. In attendance (l. to r.): Allan Rock, Federal Industry Minister; Stephen Owen, MP, Vancouver-Quadra; Ed Lee, chair; Hedy Fry, MP, Vancouver Centre; David McCann, owner, Creekhouse Gallery; Allan De Genova, vice-chair, Vancouver Parks Board.

cause insomnia and psychotic reactions.

Source: *British Medical Journal*

Reimbursement for topical antifungals

Topical antifungal creams were among the many product categories that were delisted from the BC Pharmacare formulary last year. The delisting consisted of only covering prescriptions under Pharmacare's special authority process; however, applications from doctors on behalf of PWAs were being routinely turned down.

The BCPWA Society recently intervened and topical antifungal special authority applications will now be approved for persons with HIV and for transplant patients. If your application was previously denied, your doctor can now resubmit it.

Measles suppress HIV

A study in Africa found that viral load was apparently reduced by almost two logs during acute measles infection in

children. After they recovered from measles, the HIV viral load came back.

Interpretation was complicated by the fact that no baseline viral loads were available for the children before they came down with the measles. Instead, researchers measured viral load in children who had been hospitalized with measles, and found it surprisingly low.

This reduction was particularly remarkable because an illness such as measles would be expected to raise the viral load, due to increased immune activation.

Source: *AIDS Treatment News*

Committee report on reference drug program

The Select Standing Committee on Health recently issued a report in which it recommended that Pharmacare should retain and potentially expand the reference drug program (RDP) and explore solutions to streamline the special authority process.

In its report, *Patients First: Renewal*

NEWSREEL

News from home and around the world

and Reform of British Columbia's Health Care System, the committee noted that pharmacists, physicians, and government should negotiate a more effective special-authority process, including whether local pharmacists could take on the task.

Under the RDP, Pharmacare creates groupings of drugs that treat the same condition and sets its coverage level for each group at the price of the least expensive drug.

Since BC introduced the program in October 1995, it has been the subject of much debate. Pharmaceutical manufacturers condemn it because they lose profits, manufacturers of generic drugs support it, and physicians have become accustomed to it but remain critical of the slow, cumbersome process of faxing in special authority requests.

Tenofovir tested as topical microbicide

Gilead Sciences, the manufacturers of Viread (tenofovir DM), will collaborate with the US National Institute of Health on a study to evaluate the effects of tenofovir when used as a topical gel for prevention of HIV through sexual transmission. Tenofovir is the newest antiretroviral drug, currently licensed in the US and Europe to be used orally in combination with other antiretrovirals.

Prevention of HIV transmission remains one of the greatest challenges of the epidemic. Condom use and education programs have only been somewhat effective in reducing HIV transmissions. It is estimated that 15,000 new infections occur daily, most of them through heterosexual contact. In some areas such as Africa, men refuse to use condoms and women have little or no power to negotiate safer sex. An effective topical microbicide, a gel applied locally, could empower more people to take precautions against infection.

Presently there is no microbicide available that impairs transmission of HIV.

WHO launches global strategy on CAM

The World Health Organization recently released the first global strategy on alternative and traditional medicine. Both health practitioners and consumers have raised concerns about safety, policy, regulation, evidence, biodiversity, and the preservation and protection of traditional knowledge in connection with the use of alternative medicine.

According to the U.N. agency, the strategy provides a policy framework that will assist countries in regulating traditional or alternative medicine so that it is safer and more accessible to those who want to use it, especially in developing countries, where more than one-third of the population lacks access to essential medicines.

There is growing concern that some new users of alternative medicines may use these therapies incorrectly or use medicines that have not been proven safe.

Drug ads can convince people they're sick

Advertising prescription drugs is a form of disease-mongering that encourages healthy people to believe they need medical attention, according to Barbara Mintzes, a researcher at the Centre for Health Services and Policy Research at the University of British Columbia.

In an article in the *British Medical Journal*, Mintzes claims that drug advertising campaigns in the U.S. "medicalize normal human experience." For example, during a year-long ad campaign in the U.S. for Propecia, a drug that treats hair loss, physician visits for baldness were up 79 per cent from the previous year, proof that advertising shifts health-care usage patterns.

Direct-to-consumer drug advertising is

not allowed in Canada, although drug makers and media groups are pushing to have that ban dropped.

Source: Globe and Mail

New director for Theatre Positive

Theatre Positive, the BCPWA Society's peer-driven theatre group for people infected or affected by HIV disease, has a new director. Terry Costa, founder of A Queer Theatre (aqt-vancouver), is active in both the AIDS and queer communities. He has received many awards, including the 1999 Mississauga Arts Council Emerging Theatre Artist Award.

Costa will direct Theatre Positive's *Dancing With My Dead Lover and Other Stories* at the Vancouver Fringe Festival in September. It is a creative quilt of original music, dance and stories, based on a concept by Costa and company manager Jake Thomas. Writers include John Kozachenko, Jake Thomas, and Jackie Haywood, with music by Dwight Gabriel. ⊕



Terry Costa

Photography: John Kozachenko

Self-Advocacy:



get your just desserts

Enjoy the summer fun: Free camping at provincial parks

ALERT: The BC Parks Disabled Access Pass is invalid. The provincial government has changed the system for accessing free camping at provincial parks. But don't despair. The eligibility criteria have not changed for disabled persons living with HIV/AIDS.

If you receive a disability allowance from welfare, you are eligible to camp for free in BC provincial parks. To gain free access, you must follow these steps:

•Step 1

Go to your welfare worker and ask for a Release of Information form for free camping. Your worker will fill this form out with you.

•Step 2

Make sure the worker stamps the form.

•Step 3

Keep the form with you. When you arrive at a provincial campsite, show the campground operator your Release of Information form and one piece of ID. If you had a BC Parks Disabled Access Pass, it will not be accepted.

For more information about BC's provincial parks, call 1-800-689-9025 (604-689-9025 in Vancouver) or visit the website <http://wlapwww.gov.bc.ca/bcparks>.

Federal parks

No exemption from paying park fees is available for people with disabilities in federal parks. However, a federal park pass is only \$38 for one year. For more information about federal parks, call 1-888-773-8888 (604-513-4777 in Fort Langley) or visit the website <http://parkscanada.pch.gc.ca>.

Community centre passes and discounts

The City of Vancouver provides a special pass, the Leisure Access Card, for people living on low incomes. With this

pass, you can access Park Board swimming pools and ice-skating rinks for free, plus you can receive a 50% discount of fees for community fitness centres. If you live outside of Vancouver, contact your local community centre to see if your city offers similar passes.

Who is eligible:

- anyone receiving welfare
- any person or family whose total yearly income is equal to, or below, the following levels:

1-person:	\$18,400
2-person family:	\$23,000
3-person family:	\$28,600
4-person family:	\$34,600
5-person family:	\$38,650
6-person family:	\$42,700
7 or more:	\$46,800

To prove your yearly income, you will need to provide your Notice of Assessment from the Canada Customs and Revenue Agency. This notice is mailed to you each year after you file your income tax form.

How to apply

If you are receiving welfare, go to your local community centre and give them a copy of a current income assistance cheque stub or a current ministry transit pass. Remember to bring photo ID. A card will be issued to you for one year.

If you meet the low-income guidelines, go to your local community centre and ask for an application form for the Leisure Access Card. Remember to bring your most recent Notice of Assessment. A card will be issued for 3-12 months, depending on eligibility. ⊕

We're staying put!

1107 Seymour

An important update on what's happening at the BCPWA Society

by Ross Harvey

The BCPWA Society isn't moving after all. But it might have been.

For the last couple of years, the BCPWA Society and AIDS Vancouver had been searching for new shared accommodation, knowing the 10-year lease at the Pacific AIDS Resource Centre (PARC) would expire on September 30, 2002. Both agencies were concerned their PARC costs were too high and were convinced they could do better elsewhere. By late last year, the search was rapidly narrowing down to a funky two-story property on Hornby Street near Drake.

Then, on February 18, AIDS Vancouver announced that it was pulling out of the PARC partnership and was going "to relocate its programs within the communities it serves". PARC was dead, and AIDS Vancouver was gone.

This decision compelled the BCPWA Society to quickly change gears and start urgently seeking its own space and programming solutions. There were less than seven-and-one-half months to go.

The very first initiative was a survey of the membership. The survey, called "What Now? The Future of Your Services", was distributed through the Information Desk at the BCPWA Society and sent to all members in the March/April issue of *Living+*. The 161 respondents made it clear they wanted the BCPWA Society to try to stay at the current PARC site (49%) or in the neighbourhood (30%) and to keep all its programs in one place. Also, 45% indicated

they liked the idea of some kind of ongoing partnership with AIDS Vancouver.

Armed with this information, the BCPWA Society simultaneously sought negotiations for a new lease with the owners of the PARC building, Brenco Investments Ltd., and began looking at alternative properties in the general area. As well, detailed information sharing with the leadership of AIDS Vancouver gave them a different perspective on the costs and benefits of maintaining their client services, including the grocery, the library, and case management services, at the PARC site.

Simultaneously, the BCPWA Society board of directors struck a Working Group on the Future (WGF). Consisting of the board's executive committee and four senior staff persons, the WGF was charged with two major tasks. First, it was to find a home for the agency. Second, it was to conduct a thorough review of the BCPWA Society's programs and services with an eye to achieving new efficiencies, recommending where members might benefit from dropping outmoded activities and the implementation of new ones.

Then, in late April, the BCPWA Society received word that AIDS Vancouver had decided it would like to keep its client services located at the same venue as the BCPWA Society after all. On this basis, we commenced vigorous new negotiations with Brenco for a new lease on the PARC site, with the BCPWA Society as the sole lessee on the understanding that AIDS Vancouver would sub-lease the space it required from

the BCPWA Society.

On May 28, Brenco accepted the BCPWA Society's offer to lease. Among its other features, the new lease will see the BCPWA Society paying a per-square-foot annual rent ten years from now that will be in excess of \$2.00 less than it is paying today!

The BCPWA Society plans to move all its operations to the second floor of the PARC building. AIDS Vancouver will continue to locate its client services (case managers, library, and grocery) where they are currently located on the first floor. The BCPWA Society will try to sub-lease other first floor space to an agency or agencies engaged in activities compatible with and supportive of its membership.

The WGF is still examining the questions of how best to deliver the programs and services provided by the BCPWA Society, whether some ought to be discontinued, and whether other new ones should be instituted. As always, your concerns and suggestions as a BCPWA Society member are welcome; please contact any member of the board of directors or the executive director. ☺

Ross Harvey is executive director of the BCPWA Society. He has considerably more grey hairs now than he did a year ago.



Campbell's cuts

After a year under the new Liberal regime, BC has seen extensive changes in many important areas, including healthcare and income assistance.

The government originally announced that they would not reduce the budget for healthcare. However, the government agreed that, additional expenses such as addiction services and other increased healthcare costs due to population growth, escalating drug costs, and wage increases resulted in a province-wide healthcare funding crisis. The government transferred the costs to the consumer through the following measures:

- A 50% increase in the premiums of the Medical Services Plan (MSP). This increase will have a large impact on low-paid working PWAs by significantly reducing their monthly income. The monthly MSP premium for a single person is now \$54. Only individuals earning less than \$16,000 per year or people on income assistance qualify for an exemption from paying MSP.
- A simultaneous decrease in coverage of services under MSP. Services that are no longer covered include massage, chiropractic services, podiatry, eye exams, and physiotherapy. Many of these services are actively used by PWAs as an alternative to traditional treatment options. Eye exams may be covered every 12 months for people living with HIV; however, in order to access this service, the optometrist must be aware of the person's HIV status.

A brief analysis of how provincial cuts will affect PWAs

by Naomi Brunemeyer

- The delisting of medications from Pharmacare. Although some advocacy successes have resulted in access to testosterone and topical antifungal creams, some drugs that are used by people coinfecting with HIV and hepatitis C are not covered under Pharmacare.
- The announcement of hospital closures, which means a lack of access to primary healthcare for many rural PWAs.
- The transfer of all provincial responsibility to the regional health authorities, the elimination of the HIV/AIDS Division within the Ministry of Health Services, and the elimination of the Minister's Advisory Committee on HIV/AIDS. No longer is there any concerted provincial response to HIV/AIDS in BC.

While the government protected higher wage earners by offering tax reductions, significant cuts were made to the incomes of marginalized people. Decreased income results in increased poverty for PWAs.

- The Liberal government increased the provincial sales tax by 0.5%. Poor people pay a higher proportion of their income in sales tax than do wealthy people.
- The training wage was reduced to \$6.00 for the first 500 hours on the job. This affects many PWAs returning to low-paid

jobs or those released from institutions such as recovery houses or prisons.

- Shelter rates were lowered for people living in rural areas on disability assistance. Previously, the higher shelter allowance covered increased heating expenses during harsh winters. Now, many PWAs will have to use part of their support allowance to cover these expenses.
- Crisis grants now have restrictive monthly limits. Crisis grants are an option of last resort. Now, PWAs that face unforeseen financial expenses will have decreased opportunity to access this additional income support.
- PWAs will also have their access to justice significantly reduced by the cuts to Legal Aid and the Human Rights Commission and by the closure of court houses.

Many of the changes made within the first year of this Liberal government will have a significant impact on people living with AIDS, and the future seems to hold more of the same. Proposed changes in housing and income disability assistance will further affect people living with AIDS. The BCPWA Society will continue to follow in its tradition of collective advocacy on behalf of our members. ☺



Naomi Brunemeyer is the director of communications and marketing at the BCPWA Society.



New disability legislation

How it will impact PWAs

by Naomi Brunemeyer

On April 15, the BC legislature introduced two new acts that will replace the existing income assistance or welfare legislation. The legislation was passed on May 29th.

A separate act will provide benefits for people with disabilities, but it will no longer be called DB2.

Much of the following information comes from government fact sheets. Because the legislation was introduced without regulations, many unanswered questions remain. We will keep BCPWA Society members updated as more information becomes available.

What is the new definition of disability?

A person will be designated as belonging to a group of “persons with disabilities” if the person is at least 19 years old and has a severe mental or physical condition that

- 1) in the opinion of a doctor will last at least 2 years, *and*
- 2) in the opinion of a health professional will significantly restrict the person’s ability to perform daily living activities either continuously or periodically for extended periods, *and*
- 3) requires the person to have help to perform daily living activities.

Daily activities will be defined in upcoming regulations.

An amendment to the disability legislation proposes to reduce the age to 18. In a public document dated April 17, the Minister of Human Resources referred to 18 year olds as meeting the criteria for eligibility.

Will people with HIV/AIDS still qualify for disability assistance?

A person will need to meet the definition of disability in order to qualify for disability assistance. Although the government has given some assurances that people living with HIV/AIDS may not be greatly affected, the BCPWA Society is concerned about how the regulations may restrict PWAs from qualifying.

Will I need to be reassessed?

The ministry will review all current disability files. Many existing DB2 recipients will not have to reapply if there is sufficient information in their files to confirm that they meet the criteria.

Is my disability designation permanent?

No. Your disability designation is not permanent. A person must continue to meet the definition of disability in order to maintain the designation. A designation can only be cancelled as a result of a review. The ministry expects to review all files once every five years, but a review may not result in the need to reapply.

Are there time limits to receiving disability benefits?

Time limits do not apply to people with disabilities. There is no maximum length of time that you may receive disability benefits. If you continue to meet the disability definition, you will continue to receive income assistance.

If I qualify for disability assistance, will I be forced to go back to work?

Persons with disabilities may be assessed to determine their employability. You may be required to participate in an employment training program as a part of this assessment while continuing to receive disability assistance.

What if I go back to work, but I am unable to continue working?

You will not have to reapply for your disability designation. You will maintain your disability designation and enhanced medical benefits for an unspecified length of time after returning to work.

Will I lose my Schedule C benefits?

Grandparented tribunal awards such as Schedule C benefits will be maintained under the new legislation. However, the BCPWA Society and other community groups are concerned that while the intention may be to continue to provide Schedule C health allowances, the legislation can be interpreted to suggest that Schedule C may be eliminated at the discretion of the Minister of Human Resources.

Will I lose my Monthly Nutritional Supplement Benefit?

This benefit (\$225) will be maintained under the new legislation.

Will I lose my bus pass?

Additional information may be contained in the regulations. If you maintain your disability designation, you should maintain your bus pass.

Will I lose my enhanced medical benefits?

If you maintain your disability designation, you will continue to receive enhanced medical benefits.

The BCPWA Society is concerned about the potential impact these changes to assistance will have on people living with HIV/AIDS. We will continue to work with community groups and government to ensure that our concerns are considered in the development of the regulations. ☺



Cross-Canada checkup

A snapshot of community activism across the country

by Shari Margolese

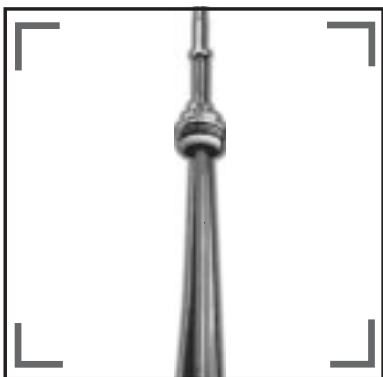
At a recent press conference, a reporter asked Louise Binder, chair of the Canadian Treatment Action Council (CTAC), when AIDS would be considered an epidemic. "It already is," Binder said. "I mean in Canada," the reporter replied. To which Binder repeated, "It already is!"

The AIDS epidemic has hit Canada hard. By the end of 1999, an estimated 49,800 Canadians were living with HIV/AIDS. Yet, many Canadians are unaware that the AIDS epidemic is occurring in their own backyard, and many believe that AIDS is over.

Activists and advocates for people with HIV/AIDS have battled to end such misconceptions. They have taken on many challenges, from funding and access to treatment, to human rights. Toronto, Vancouver, and Montreal—traditionally Canada's hardest hit cities—have had rough and ready grassroots AIDS movements responding with fervor to issues affecting PWAs. The HIV epidemic has continued to grow and evolve since communities began organizing a Canadian response twenty years ago. As the face of the epidemic has changed, so has the advocacy movement.

A shift in focus in Ontario

According to the AIDS Committee of Toronto (ACT), Toronto ranked worse than the national average for rate of HIV infections. By the end of 1999, over 20,000 people had been diagnosed with HIV in Ontario, with 65% of them living in Toronto. Men who have sex with men account for 76% of all cases in Toronto. Despite being home to such a large number of PWAs, the Toronto activist scene is dwindling.



As Toronto began to lose its original activists to AIDS, injustice and anger fueled the fight.

“Toronto had a dynamic activist community,” says Toronto-based advocate Tony DiPede. “The first wave of infections in Toronto was white, upper middle-class, gay men. We were experiencing such a mosaic of pain ... friends, colleagues, communities. We had to mobilize.” DiPede admits that the AIDS movement in Toronto would not have happened without the gay community. He says that as Toronto began to lose its original activists to AIDS, injustice and anger fueled the fight.

For a while, traditional activist tactics such as protests were successful. Then, Mike Harris’ government made changes without consultation. In effect, they said that people could make as much noise as they wanted, but the government was not changing its policies. DiPede says these types of disappointments and frustrations do not help to recruit new activists. Although a core of activists remains, fewer troops are enlisting to fill the ranks.

Many essential activists have taken their skills to where they believe they *can* make a difference to the federal level. DiPede’s theory is backed by the emergence of groups such as CTAC, the Canadian HIV/AIDS Legal Network, and the Canadian Aboriginal AIDS Network (CAAN). Steve Maguire et al. of McGill University in Montreal provide a comprehensive analysis of this evolution in *When “Silence = Death”, Keep Talking: Trust, Control and the Discursive Construction of Identity in the Canadian HIV/AIDS Treatment Domain*. “The activist movement is changing,” says DiPede. “Screaming and yelling do not work any more.”

The more sophisticated public policy discussions that are slowly working do not attract recruits to the movement, according to DiPede. “They don’t allow the average person to get involved.” Other Toronto-based activists believe that part of the reason activism has cooled off in Toronto and the rest of Ontario could be a general feeling that the social safety net has been gutted. For many AIDS service organizations, keeping the doors open and the lights on have become priorities.

Meanwhile, the current provincial government has left no shortage of issues to challenge. “There has been no new housing for PWAs in Ontario in the past seven years,” says Ruthann Tucker, executive director of the Fife House Foundation and a member of the Task Force for Secure and Affordable Housing for People Living with HIV/AIDS. Unfortunately, very little data and research exist in Canada or the US to support the task force’s bids for more money.

Tucker blames the abolishment of rent control for intensifying the housing crisis in Toronto. “Shelters are available but generally unsafe for PWAs as they have active TB and drug use.” She says that Fife House sees a trend towards more injection drug users, transgendered people, women looking for supportive housing, and other people from endemic areas. For the first time in its six-year history, its women’s housing program has a waiting list.

Kim Johnson, coordinator of Voices of Positive Women (Voices) Peer Network, says that they are definitely seeing more women come into the Toronto office over the past few months. “There is a huge level of anxiety among women who come into the office. It is as if they have already decided that they’re not going to get what they need. Women feel unreachable.”

Binder, who also serves as VOICES chairperson, suspects that the front-line trend of more women looking for services signals a shift. “Usually more HIV infection in women is indicative of an increase in the injection drug use and endemic populations.”

Complacency in Quebec

In Quebec, the AIDS epidemic came in three primary waves of infection. The first wave began in 1978 among people from HIV-endemic countries. Until 1984, these people constituted the majority of AIDS cases reported in Quebec. Since then, they have represented approximately 10% of newly diagnosed AIDS cases. Many PWAs without immigration status do not have access to treatment in Canada.

The second wave of HIV infection, in 1983, affected men who have sex with other men. The rate of infection increased rapidly among this group. Since 1984, homosexual/bisexual men have constituted the majority of diagnosed AIDS cases. At the end of 1999, they represented over 60% of all HIV-infected people in Quebec.

The third major wave of infection began around 1985 among injection drug users. Currently, HIV is spreading more rapidly among injection drug users than any other population. According to Health Canada, close to 16,500 people were living with HIV infection in Quebec at the end of 1999. Montreal-based PWA



advocate Jose Sousa notes that Quebec's aboriginal populations have also seen a steady increase in infection.

Currently, little activism occurs in Quebec, according to Sousa, who notes that some formulary-related treatment access issues require advocacy, but that "no one is getting real excited about them." A recent move by the Quebec government to make HIV a reportable disease has been virtually unchallenged by the community.

From a service provider's perspective, Sousa believes that people in Quebec have become complacent and (like Ontarians) may have shifted from issues to operations. As a community member, Sousa believes that the predominantly gay HIV-positive population has become more stable on drug regimens and, therefore, fewer people are attending groups to get treatment information. That makes it more difficult to find new advocates to mentor.

The people who have been doing advocacy work in Montreal have been at it for many years and are burned out. Sousa has been volunteering since 1989. "We just want a break, but there is no one to take our place," he says.

"People would like to have lives," says Ron Rosenes, a CTAC board member and past chair of ACT. "There are a few die-hard activists, but many people are working and getting on with their lives." Rosenes believes that many gay men who were diagnosed when triple regimens were available have managed to stay at work and not make AIDS the entire focus of their lives.

British Columbia activists crank up the heat

Vancouver has developed a reputation as the injection drug capital of the north. So much so that *POZ Magazine* recently took note of Vancouver's "dirty little secret: one of the highest rates of HIV infection in the developed world." Yet, advocates and activists from across the country agree that Vancouver currently has the most dynamic of all the community-based AIDS movements. VANDU, a community-based group that advocates for Vancouver's drug-using population, is the first of its kind in the nation.

Vancouver has become the hotbed for hot issues. The HIV community is calling for federally funded "safe injection facilities" and challenging a recent move by government health officials to initiate "partner notification" practices. Fighting these issues has created a rare troop of activists that includes care providers, consumers, and researchers as partners on the battlefield.

Glen Hillson, the chair of the BCPWA Society and vice-chair of CTAC, has been on the front lines in Vancouver since 1996. "The large presence of community really has been inspirational," he says, adding that one of the unique aspects of the Vancouver epidemic is that diversity around social identity is a reality and not just theoretical. He notes that there are large populations of HIV-positive gay men, injection drug users, women, Asians, and aboriginal people.

Hillson believes that Vancouver's highly acclaimed grassroots response developed out of necessity in the 1980s when the right-

wing shift in government was not AIDS- or gay-friendly. Organizations were created for social and emotional support and to help fight the stigma of HIV/AIDS. Hillson is "very proud" of the big impact the British Columbian AIDS movement has had on how society views healthcare in the province.

Advocates across the country agree that Vancouver currently has the most dynamic community-based AIDS movement.



However, Hillson believes that the evolution of the movement is not over. The next step will be to get past the "my disease versus your disease" mentality of some interest groups in order to integrate care and action with other similarly minded Canadian consumers.

Relative to the rest of Canada, BC has enjoyed a high level of HIV care. No one pays for healthcare or drugs. Still, there are tradeoffs relative to cities south of the border. Although Canada has more equality of access, it also has larger waiting lists, whereas in the US you can get better service if you can afford it. However, relative to the developing world, Hillson concedes that British Columbians are "pretty lucky."

Toronto advocate DiPede has immense respect for Vancouver activists. "We have to learn from BC," he says. "They have kept (AIDS issues) hot. They have a tradition of activism which is strong and powerful." However, he echoes the concerns of many other activists across the country: "What will happen when their version of Mike Harris is finished hacking up the province?"

Activists still have a lot of work to do before the public realizes that AIDS has not gone away. But their comments show that the fire continues to burn hot in Vancouver. They provide motivation and inspiration to the movement, sparking the embers that lie just below the surface of those cities where disillusionment and complacency have become commonplace. ⊕



Shari Margolese has been a PWA advocate for nine years and is currently the national women's representative on the Canadian Treatment Action Council.

PWAs finally at the table

Report on direction setting meeting for the Canadian Strategy for HIV/AIDS

by Jeff Anderson

Consumer-driven organizations such as the BCPWA Society and Comité des Personnes Atteintes du VIH du Québec recently joined researchers, governments, and other AIDS stakeholders in a three-day meeting to determine the focus of Health Canada's Canadian Strategy on HIV/AIDS (CSHA). The six goals of the strategy were determined in 1998. They were expanded into 10 "directions" in the fall of 2000 at a meeting in Grey Rocks, Quebec, where stakeholders also produced 292 commitments to action.

This year's meetings in April marked the first time Health Canada included PWA organizations in consultations to review those commitments and the strategy as a whole. Recognition by Health Canada that PWAs should self-select peers to represent our viewpoints and present our issues was acknowledged as an important contribution to Health Canada's response to the epidemic and a critical component in any successful national strategy.

At the April meetings in Montreal, participants reviewed current progress and identified key approaches to advance these 10 directions:

- Mobilize integrated action on HIV/AIDS.
- Build unique approaches for aboriginal peoples within the CSHA.

- Build a broad information strategy.
- Get public commitment, political leadership, and funding.
- Build a strategic approach to prevention.
- Build a strategic approach to care, treatment, and support.
- Renew and develop human resources.
- Engage vulnerable Canadians.
- Move to a social justice framework.
- Develop a five-year operational/strategic plan.

Montreal participants identified needed activities, and summaries are being drafted by Health Canada. Volunteers will be matched with various proposed projects and outcomes for each of the directions. Those of us who volunteered to advance the outcomes will be notified shortly about the timelines and strategies appropriate to the activities.

Overarching the CSHA is direction 10—developing a five-year operational/strategic plan. The introduction to this strategy states that Health Canada will be working with identified stakeholders and people with AIDS to devise the operational plan and each of its components. This, too, represents a first. Health Canada now recognizes PWA organizations as a critical component in a national response to the HIV/AIDS epidemic.

The challenge for PWAs and PWA-driven organizations will be to create a coordi-

nated national voice and to collaborate with Health Canada and others to shape these directions into meaningful, measurable, attainable outcomes. Key HIV/AIDS consumer groups across Canada have been developing such an initiative for the past eighteen months. This initiative is the logical starting point toward achieving this goal.

The Government of Canada has not increased funding in a decade, although the number of people with AIDS in Canada has risen nearly 40% since the \$42 million was originally committed in 1992. Under these circumstances, the absence of Minister of Health Anne McLellan from these discussions may indicate that Health Canada might not consider AIDS among its highest priorities. The speed, vigour, and determination with which Health Canada approaches the outcomes of these strategy meetings and the support they offer to national partners, such as PWA consumer organizations, will provide the answer to our communities. ⊕

Jeff Anderson is the treasurer of the BCPWA Society's board of directors and the Society's representative to the Pacific AIDS Network.



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information

Experimental drugs:

what's in the pike

by *Glen Hillson*



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.

At this year's 9th Conference on Retroviruses and Opportunistic Infections, which took place in Seattle in February, an oral session was devoted to experimental anti-HIV drugs. In recent years, this part of the scientific program has tended more toward compounds close to market release and has been geared toward building pre-launch hype. This year, however, more attention was paid to new classes and compounds.

Reverse transcriptase inhibitors

There was an update on recent data from clinical trials involving tenofovir DF (TDF; Viread), a single tablet, once-daily nucleotide reverse transcriptase inhibitor (RTI) with potent activity against wild-type and nucleoside-resistant HIV. Adding tenofovir DF once daily to an existing regimen showed significant and durable HIV RNA reductions in patients with M184V or multiple mutations. Authors of a large 48-week study involving 550 patients concluded, "Tenofovir DF has a safety profile which remains similar to placebo." Tenofovir is also a highly potent inhibitor of HBV, which causes hepatitis B.

Non-nucleoside RTIs

Resistance to drugs in this class can develop very quickly with the evolutionary selection of just one or two mutations. Development of new NNRTI compounds is pointed toward finding drugs that are more durable.

One of the more promising new drugs discussed was TMC125. In a phase II study of patients whose virus was resistant to both efavirenz and nevirapine, TMC125 was substituted for seven days to assess antiviral response in NNRTI-experienced patients. Across dosing groups, average viral load reduction among the twelve patients over a seven-day period was 0.9 log. In a separate five-day monotherapy study of treatment-naïve patients, the rate of decline in viral load was similar to five-drug combinations. Rate of decline is generally considered a reliable indicator of potency. Rash seems to be the most common side effect. This has also been the case with other NNRTIs.

Several abstracts were presented on DPC 083. In an eight-week study of 51 patients whose virus is resistant to efavirenz or nevirapine, 57% achieved viral loads below 400 copies when treated with DPC 083 and two nucleosides.

continued on page 14

Protease inhibitors

One of the largest drawbacks of protease inhibitor (PI) therapy is its potential to elevate cholesterol and triglyceride levels, leading to coronary disease and other complications.

Authors of one study further evaluated the safety of atazanavir (BMS 232632), which was previously reported to have less impact on blood lipids than other PIs. In subjects who have failed a prior regimen, atazanavir/saquinavir once daily was safe and well tolerated, and it rapidly and durably suppressed HIV RNA and increased CD4 counts. Atazanavir/saquinavir once daily lowered total cholesterol, LDH, and triglyceride levels compared to ritonavir/saquinavir twice daily, which produced prompt, marked, and sustained increases. The ability to improve lipid profiles in treatment-experienced subjects suggests that atazanavir may reduce the risk of cardiovascular events. Atazanavir has a long half-life, which means it is suitable for once-daily dosing. Expanded access programs are expected this summer in North America.

Tipranavir (TPV) is in early phase III clinical trials. Of all protease inhibitors down the pike, tipranavir appears to have the greatest ability to overcome strains of HIV that have become resistant to multiple protease inhibitors. TPV

plasma concentrations were significantly enhanced in the presence of 100 or 200mg of ritonavir.

Entry inhibitors

Fusion inhibitor T20 is the entry inhibitor in the most advanced stage of development. Although it requires twice-daily subcutaneous injections, recent data show it can provide roughly 2 log reductions of HIV in protease inhibitor experienced patients. T20 is a very promising agent for

Development of new NNRTIs is pointed toward finding more durable drugs.

salvage therapy in heavily treatment-experienced patients. A small number of patients in North America (about ten in Canada) currently receive T20 through expanded access.

Other entry inhibitors, including antagonists of CD4 co-receptors CXCR4, and CCR5, are early in development. T20 is a very large molecule, which poses significant manufacturing challenges. One goal for future research is to find smaller molecules with similar antiviral effect. ☺

For the record...

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.

A

survey

only for persons with HIV disease.



Power plants

The yin and yang of Chinese herbs

by Sunny Lee

Nowadays, herbal medicines can be found in health food stores and even in drug stores. Herbal medicines are generally prepared from plant materials, such as leaves, stems, bark, and roots. They are also prepared from flowers, fruits, seeds, twigs, and even exudates (exuded matter) such as sap. Throughout history, biologically active ingredients from different plants have been helping people around the world to treat mild, severe, chronic, and acute diseases.

In Western culture, medicinal herbs are grouped into more than 20 categories according to the body systems they affect. For instance, ginkgo is used to strengthen blood vessels and St. John's wort is used to treat the nervous system. By contrast, traditional Ayurvedic herbal treatment uses medicinal herbs to obtain a person's *prakriti*, the ultimate balance of the three *doshas*—body, peace, and balance.

Chinese medicine is one of the oldest medical systems in the world. It is a unique system based on the belief that disease is the result of disturbances of the body energy (*qi* or *Ch'i*) and the imbalance of yin/yang energy. Chinese herbal treatment is part of a larger system of healing that includes acupuncture, Tuina/massage, qigong, and bone setting. This healing system can help the body correct the energy imbalance.

Traditional Chinese medicine (TCM) views the human body as a whole. TCM diagnoses and treatments are based on an overall analysis of symptoms and signs, including the nature, cause, and location of the illness and the patient's physical condition. TCM principles emphasize the nature, properties, and flavours of Chinese herbs.

The four properties of herbs are hot,

cold, warm, and cool. Heat symptoms such as fever and other heat-related conditions are treated with cool or cold herbs.

The five flavours (tastes) of herbs are sweet, sour, bitter, pungent, and salty. The Chinese have found that the flavours of herbs nourish different visceral organs in the following manner: sweet herbs for the spleen, sour for the liver, bitter for the heart, pungent for the lungs, and salty for the kidneys. This herbal interaction with specific ener-

Chinese herbal treatment is part of a larger system of healing, which can help the body correct the energy imbalance.

gy channels or meridians is called *qujing*.

Chinese herbs also have directional properties—ascending, descending, floating, and sinking—that affect specific areas of the body. Ascending herbs, for example, are used for the head or upper chest. Chinese herbal prescriptions (called herbal decoctions) usually contain several herbs, perhaps as many as a dozen. These combinations are chosen not only for their effect on specific illnesses but also for their ability to balance potential toxic side effects.

In recent years, Health Canada has begun to regulate Chinese herbs and remedies as natural health products and has

prohibited some products for sale because of their alleged toxicity. However, the toxicity of Chinese herbs is strictly governed by Chinese Materia Medica documentation. A qualified TCM practitioner is able to use correct dosages and knows how to use herbal combinations to balance any side effects. Chinese herbs are safe to use and effective in treating many illnesses.

For HIV patients, I have been suggesting Radix astragali (*huang qi*) as a tonic for *qi* and to optimize the

immune system; Radix ginseng (*ren shen*) as a tonic for *qi*; Fructus jujubae (*da zao*) as a tonic for the spleen and stomach; and Radix glycyrrhiae (*gan cao*) for improving the health of spleen, heart, and lungs. Patented Chinese herbs that I recommend for HIV patients as a prophylaxis are Pill for Invigorating the Spleen (*jian pi wan*), Pill for Invigorating Kidney Qi (*shen qi wan*), and Pill of Rehmanniae (*liu wei di huang wan*). Although I encourage the use of Chinese herbs to assist the body systems, I also caution patients to pay attention at all times to drug-herb-supplement interactions. ⊕

Sunny Lee, R.Ac. PhD, practices at the Can-Integrated Healing Centre in Vancouver. He is president of the BC 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).



The niacin flush

It gives you hot flashes plus regulates cholesterol levels

by Nicole Gutfrucht

Niacin, or vitamin B3, is from the B complex family. It is found in grains, chicken, and fish. The human body uses it to break down sugar and convert fat into a form that can be used to give energy to the cells.

A few different forms of niacin are available, niacinamide being the most common because of its less frequent side effects and lower cost. However, the Life Extensions Foundation states that it is not as effective at lowering cholesterol and triglyceride levels.

The Stockholm Ischemic Heart Study was a randomized study in which some of the 555 participants received 1g of niacin three times a day and 1g of clofibrate twice a daily. All participants were survivors of heart attack. The study found that the niacin-clofibrate combination reduced cholesterol levels by 13% and baseline triglyceride levels by 19%. The mortality rate was also decreased by 26%.

In the Coronary Drug Project, 8,341 men who had previously had a heart attack participated in a six year randomized study. Some of the men were given niacin at a dose of 1g three times daily and others were given a placebo. The group taking niacin showed cholesterol levels that were decreased by 10%, triglyceride levels down by 26%, and the number of people who had recurrent nonfatal heart attacks was reduced by 26%.

Some doctors recommend niacin for people with HIV to treat dyslipidemia, a problem sometimes associated with highly active antiretroviral therapy (HAART). A disorder of lipoprotein metabolism, including lipoprotein overproduction or deficiency, it is thought by many to cause high levels of triglycerides and LDL (bad cholesterol) and low levels of HDL (good cholesterol). This leads to an increased risk of stroke or heart

attack. Because of the way niacin affects the fats and sugars that we take in, it can help get these levels back to normal.

The standard adult dose for niacin supplements is 2-3g a day, but you should discuss dosing with your doctor first.

Like other medications and supplements, niacin can cause some problems. The most common side effect of niacin is a red, itchy rash, particularly on the face and upper body. A Canadian AIDS Treatment Information Exchange (CATIE) fact sheet says that "taking an aspirin or ibuprofen 30 minutes before your morning dose may help reduce this symptom, but is not advisable for people with stomach ulcers or low platelets."

Like other vitamins, you should always take niacin (and aspirin) with food. This will help reduce gastrointestinal side effects, such as nausea, diarrhea, stomach pain, flatulence, and heart burn. As niacin can cause elevated blood sugar levels, it is not recommended for people with type-2 diabetes. Niacin is metabolized in the liver and therefore can be hard on people with liver damage. While taking niacin, you should have your liver enzyme levels checked often for elevation.

Niacin is also not recommended for people who have gout, peptic ulcers, or high blood pressure. If nausea, abdominal pain, vomiting, diarrhea, faintness, jaundice, or headache occur while taking niacin, it's important to see a doctor since these side effects can be signs of low blood pressure or liver problems. ☺

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



Why We Ask for Your Card Number:

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

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

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

Liver “wurst”



Taking milk thistle for liver problems may do more harm than good

by Ron Rosenes

Living your liver is no easier than leaving your lover when you are HIV-positive and have liver problems, perhaps even viral hepatitis (such as hepatitis B or C) co-infection. I could tell you to consider taking a load off your liver by drinking less alcohol, cutting down on Big Macs, doing fewer party-ceuticals, quitting your job, winning the lottery, and going to live in seclusion in Fiji with a staff of twelve. Instead, let's do a reality check.

Many people are using milk thistle (MT) to protect the liver from the onslaught of drugs and daily living. But how much do we really know about silymarin, the active ingredient in milk thistle? Many studies of the effect of this herb in people with liver disease have been conducted, and they suggest that it appears to have desirable anti-inflammatory, anti-carcinogenic, and anti-fibrotic properties. Anti-fibrotic means it has been shown to reduce scarring of liver tissue common in people with liver disease.

Unfortunately, that does not necessarily mean it is effective in preventing liver damage in people with HIV who are taking medications in conjunction with different herbs, vitamins, and other complementary therapies. In fact, we need a lot more research before we can say MT is suitable to be taken under these circumstances.

The good news is that scientists such as Dr. Brian Foster are beginning to study drug-herb interactions. According to Dr. Foster, a researcher at Health Canada, evidence shows that MT, when used on an occasional basis, may inhibit or slow some of the pathways used by the liver to clear HIV drugs. Dr. Foster is conducting studies to determine if continuous use of MT leads to increased levels of these drugs in the blood, which would create the potential for greater side effects and toxicities. Data published in November 2000 in the *Journal of Drug Metabolism and Disposition* suggest that, in fact, milk thistle may reduce the amount of antiretroviral drugs in the blood. However, human studies are still needed to know how important this interaction may be.

Most of us who are on antiretroviral therapy for life (hope and a prison sentence in the same word) have become adept at monitoring our CD4 cell counts and viral loads. But when was the last time you looked at the results of your liver function tests (LFTs)? How many times has your doctor told you that you scored “high”

on one of your liver tests and you took it as a compliment?

LFTs include several markers that can help determine liver health. Certain medications, alcohol, fried foods, and even vitamins and herbs can cause the elevation of liver enzymes with names that can make your eyes glaze over when you read your lab reports: ALT, AST, LDH, GGT, alkaline phosphatase, and bilirubin. Liver disease caused by hepatitis can also cause these markers to be elevated. It is more important than ever to ask your GP for a referral to a specialist to sort out the potential causes of elevated liver enzymes. The

There is evidence that milk thistle may inhibit or slow down some of the pathways used by the liver to clear HIV drugs.

specialist may be a clinical pharmacologist who will analyze everything you are taking for possible interactions or a hepatologist (liver specialist) trained to look for underlying liver disease.

In the meantime, use MT with caution. The usual dose of 200mg standardized to 70% silymarin can be taken three times a day before meals or on an empty stomach. Many practitioners recommend the use of MT in cycles of one month on, one month off, although the length of the cycle may vary for each individual. Pay attention to your liver function tests and talk to your doctor about their clinical relevance. Keep all your healthcare providers informed about all the therapies you are taking.

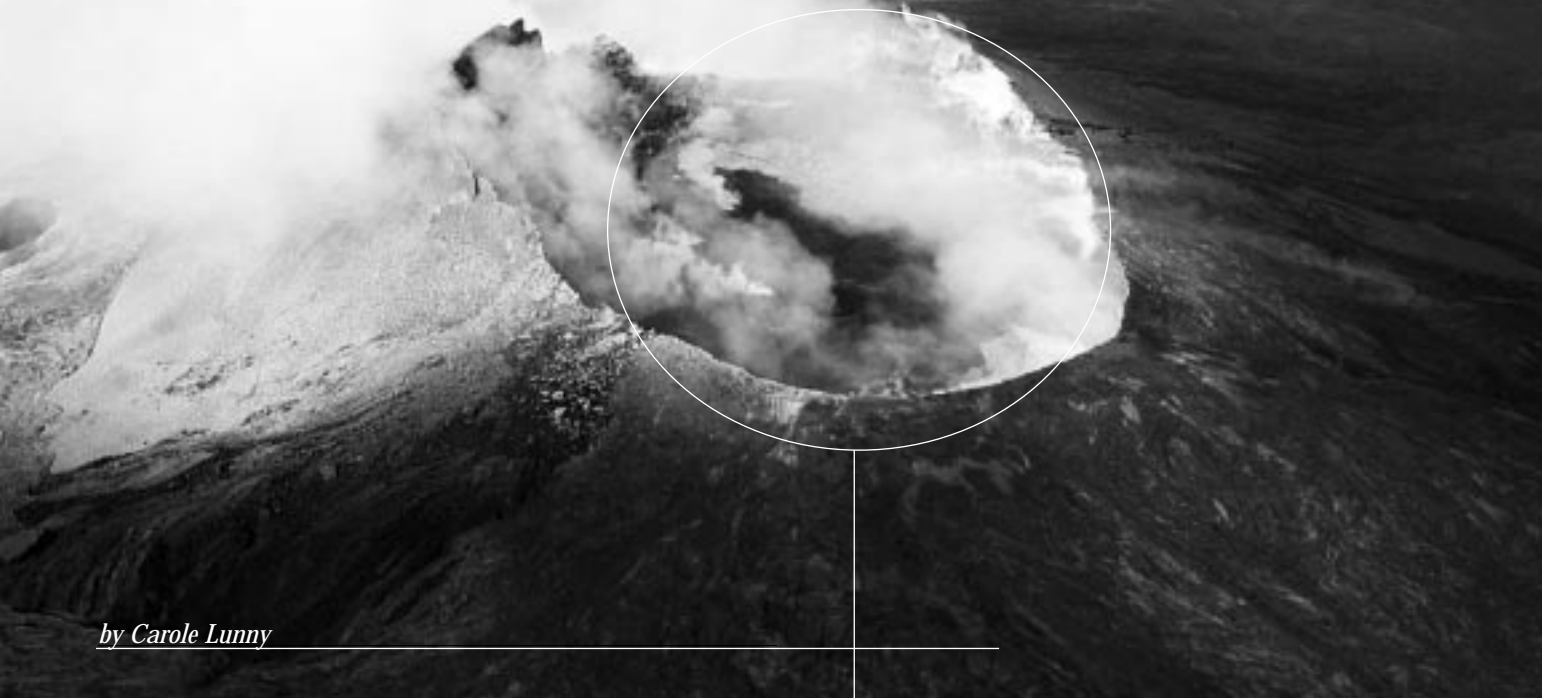
This issue has really hit home for me. It seems that one particular enzyme, my GGT, is elevated, and we don't know why. It could be my drugs. It could be drugs and the MT, which I have been taking for the past three months. The specialists are looking into it. Stay tuned for a full report. ☺

Ron Rosenes is a member of the boards of the new Sherbourne Health Centre in Toronto, the Canadian Treatment Action Council, and AIDS Action Now and an honorary director of the AIDS Committee of Toronto.



Trouble down below

Cervical growths common among HIV-positive women



by Carole Lunny

Cervical growths are a common problem among women with HIV. Dysplasia, squamous intraepithelial lesions, and cervical intraepithelial neoplasia are screening terms describing abnormal cell development or growth in the cervix. Women who are more severely immune suppressed appear to be at a higher risk for dysplasia and neoplasia.

Dysplasia is classified as low grade (less likely to progress to cancer) or high grade (more likely to progress to cancer) if not treated. Statistically, mild dysplasia is more likely to go away without any treatment. Severe dysplasia has a higher probability of becoming invasive cancer over time if not treated. Atypia means that the cells of the cervix look funny (of unknown significance) and may or may not be cervical dysplasia. See Table 1 for more details.

Prevalence

Studies have found that the prevalence of dysplasia among HIV-infected women ranges 31–63%, and HIV-positive women are almost five times more likely to have dysplasia than their HIV-negative counterparts. In addition to having a higher prevalence of cervical dysplasia, women with HIV tend to have larger lesions, more advanced dysplasia, and more vulvovaginal lesions than do HIV-negative women. Dysplasias can be persistent, progressive, recurrent, and difficult to treat in women with HIV.

Almost all cervical cancers occur in association with specific types of a sexually transmitted DNA tumor virus called human papilloma virus (HPV). While HPV infections are quite common, only a small portion of women infected with high-risk types of HPV will develop cervical cancer. In addition, recent research suggests that vitamin A deficiency may play a role in the development of squamous intraepithelial lesions (SIL) in HIV-positive women. Risk factors for dysplasia and neoplasia include cigarette smoking, a low CD4 cell count, African-American descent, youth, multiple sex partners, and low dietary intake of vitamin C.

Diagnosis

Abnormal cells in the cervix are detected through routine Pap smears that can prevent cervical cancers before they develop. If the doctor finds atypia or dysplasia, a colposcopy or a biopsy will be performed.

Colposcopy is a diagnostic tool to determine the cause of abnormalities found in Pap smears. A colposcopy is a visual examination of the cervix—a relatively simple and painless procedure, usually performed in out-patient clinics at hospitals. The actual procedure lasts approximately ten to fifteen minutes.

A colposcopy seems much like a Pap smear, but there are a few important differences. As with a Pap smear, you are positioned

Table 1: Abnormal GYN screening terms

Term	Definition	Smear grading	Colposcopy grading
Atypia	Cells show minimal changes. May be "atypical" due to vaginal infection, the use of oral contraceptives, or because the person doing the Pap smear may not have handled the cells properly.	Borderline	Low grade
Dysplasia	Means abnormal development. Dysplasia is pre-cancerous. Dysplasia is described by using CIN 1-3 and CIS to represent the extent of the problem.	Mild	Low grade
SIL	Squamous intraepithelial lesions are another way to describe dysplasia by identifying lesions in the thin cellular layers of the vaginal tract. It suggests a pre-cancerous condition.	Mild	Low grade
CIN 1	Cervical intraepithelial neoplasia is abnormal growth or tumor in the tissue covering or surrounding the cervix. CIN 1 means that one third of the sample has dysplasia or pre-cancer.	Mild	Low grade
CIN 2	CIN 2 means that two thirds of the sample has dysplasia.	Moderate	High grade
CIN 3	CIN 3 means that the entire sample has dysplasia.	Severe	High grade
CIS	Carcinoma-in-situ on a Pap smear means the same as CIN 3 but does not show any signs of invasive cancer.	Severe	High grade

From www.projinf.org/fs/gyn.html

on the examination table, but acetic acid (such as common table vinegar) is placed on the cervix, which causes the cervical cells to fill with water so that light will not pass through them. Another difference that you will notice is that your physician uses a colposcope to view your cervix.

A colposcope is a large, electric microscope that is positioned approximately 30cm from your vagina. A bright light on the end of the colposcope makes it possible for your physician to visualize your cervix. Your physician focuses on the areas where no light passes through. Abnormal cervical changes are seen as white areas: the whiter the area, the worse the dysplasia. Abnormal blood vessel changes are also apparent through the colposcope. If your physician is able to view the entire abnormal area through the colposcope, a tissue sample or biopsy is taken from the whitest abnormal areas and sent to the lab for further evaluation.

Treatment

Once the tissue is examined and the type of abnormality is determined, treatment may or may not be needed.

A cone biopsy can be used to identify abnormal cell tissue as well as remove it. A small core of tissue from the middle of the cervix, the transformation zone, is removed. The transformation zone is where two cell types meet in the middle area of the cervix. A cone biopsy is usually performed in the doctor's office under a local anesthetic.

Two main methods are used to perform cone biopsy. The loop electrosurgical excision procedure (LEEP, also called large loop excision of the transformation zone, or LLETZ) removes the tissue by using a wire that is heated by an electrical current. Patients are given local anesthesia, and the procedure can be performed quickly in a physician's office.

Another method of cone biopsy involves using a surgical scalpel or laser to remove the tissue. This procedure typically requires general anesthesia and may be performed in a hospital or outpatient facility. An overnight hospital stay is not usually required.

The most common side effects of cone biopsy include cramping and discomfort, as well as moderate or mild bleeding for a few weeks after the procedure. Patients should avoid sexual inter-

course, tampons, and douching until the incision is completely healed, which may take several weeks. Patients should also discuss other possible side effects of cone biopsy before the procedure.

The advantages of cone biopsy are that it provides a large sample of tissue for analysis, and it can sometimes completely remove the cancer so the patient does not need additional surgery. However, due to the possibility of complications from cone biopsy, women should discuss all aspects of the procedure with their physician before undergoing biopsy.

Abnormal cells in the cervix are detected through routine pap smears that can prevent cervical cancers before they develop.

A new treatment for cervical, anal, or genital neoplasia caused by the human papilloma virus (HPV) is called 5-fluorouracil. It is a cream and an approved anti-cancer drug that works by preventing normal cell division. Side effects of the cream include burning, inflammation, and discoloration of the skin.

If cervical dysplasia is untreated, it can develop into cervical cancer. Features of cervical cancer include vaginal discharge, which is often foul smelling and usually bloodstained. Treatment is by irradiation or surgery or a combination of both, and cytotoxic drugs may also be used. Development of cervical cancer can and should be caught by regular six-month Pap smear tests. Visit your doctor regularly. ⊕



Carole Lunny is the outreach coordinator for the BCPWA Society's Treatment Information Program.

Medicare on life support

A special two-part feature on the national health care debate and its implications for PWAs

by Glen Hillson

For some time now, Canadians have been increasingly immersed in an escalating debate over the future of health care in this country. Tensions mount from the steady erosion of access to quality care and the resources necessary for its provision. Long waiting lists for care, the desire of investors to access lucrative markets, the need for investment in a healthier population through prevention and health promotion, and the tug of war for political and economic power have all punctuated a discussion of fundamental questions. What do we value in our health system? What do we expect of it? How do we define and express our humanity?

People living with HIV/AIDS and the community-based organizations they have formed have much at stake in this debate. Some of the key principles embodied in the 1984 Canada Health Act, such as universality and accessibility, help form the foundation of social equality in our country. That foundation could crumble from the challenges to these principles. Many costs of the system would be transferred to those least able to pay: the sick and the poor. The factors that make people vulnerable to loss of health will thrive, and people will suffer. Residents who can afford to pay for quality care will be at the front of the line. The impact on the HIV/AIDS epidemic could well be increases in numbers of HIV infections and greater barriers to accessing quality care.

Most of what we have come to understand and take for granted about our health system is the product of several decades of public examination of values and policy that contribute to our present realities. The health care debate often seems a great deal more complicated than it really is. Even a cursory understanding of the evolution of health care policy in Canada over the past several decades does much to demystify the debate. It is no accident that the discussion is often cast in forms that are confusing and misleading. It's much easier to lead people by the nose if they are lost and unsure where they are headed.



The beginning of Medicare

A pivotal breakthrough occurred in Saskatchewan in 1959 when Premier Tommy Douglas created Medicare, the first health care system in Canada funded by tax revenue. The name Medicare still endures. Douglas' achievement "proved public health was economically feasible, as well as essential in a civilized country," according to an essay by Vanessa Vella. "Universal health care has also decreased social and economic inequality. It took nearly twenty years after the birth of Medicare in Saskatchewan for the federal government to fully implement a similar program nationally."

"Our proudest achievement in the well-being of Canadians has been in asserting that illness is burden enough in itself. Financial ruin must not compound it. That is why Medicare has been called a sacred trust and we must not allow that trust to be betrayed." – Justice Emmet Hall

In a 1974 working document entitled "A New Perspective on the Health of Canadians", Minister of National Health and Welfare Marc Lalonde declared that "the goal of the Government of Canada will continue to be not only to add years to our lives but life to our years, so that all can enjoy the opportunities offered by increased economic and social justice."

Lalonde gave special attention to what he called "ominous counter-forces at work that constitute the dark side of economic progress." He cited environmental pollution, city living, habits of indolence, abuse of alcohol, tobacco and drugs, and eating patterns, which put the pleasing of the senses above the needs of the human body.

The Canada Health Act

When the *Canada Health Act* became law in 1984, it declared that "the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

The Act sets out five principles to reflect the expectations of Canadians, to define roles and responsibilities, to guide public policy development, and to provide certain guarantees for Canadian residents. Two of the Act's principles that are of key interest to health care consumers are those of universality and accessibility. To satisfy those principles, the Act provides as follows:

"In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred percent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions."

"In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province must provide for insured health services on uniform terms and conditions and on a basis that does not impose or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons."

The debate

Several key figures have emerged in the course of the recent debate on the future of the health system in Canada. Former Saskatchewan Premier Roy Romanow, former Mulroney cabinet minister Don Mazankowski, and Senator Michael Kirby are among several politicians commissioned by the federal and provincial governments to report on the state and future of the system.

Among anguished, frightening cries of "the system is in crisis and no longer sustainable" and "it costs more than we can afford," the supporting rhetoric is frequently confusing and the messages become garbled. Those who seek to insert profit opportunities into the mix often do so in the name of putting patients first.

The expressed desire to build greater efficiency into the system is frequently a thin disguise for cutting services and transferring costs to individuals—usually those with the least ability to pay—through higher premiums and user fees. Access to quality care will become easier for the wealthy. Scratch below the surface of the lip service paid by profiteers to health promotion and prevention to reveal plans for a system that penalizes people for getting sick and impoverishes those who are ill. For instance, "placing greater emphasis on individual responsibility," when laid bare, consists of instituting user fees, delisting products and services from universal coverage, and telling people to stop smoking and to exercise more. The latter may be sound advice but hardly resembles a serious commitment to investing in improved public health outcomes.

"How is it that we feel obliged to use economic arguments to justify global inequities." – Stan Houston, M.D., Roundtable on Society and Health, University of Calgary, March 6, 2002

Alberta's counterattack

In 2001, the Alberta government commissioned Mazankowski to pre-empt the findings of Roy Romanow and assert greater control over the agenda for the debate. Although Mazankowski is a board member of Great-West Life Insurance Company, in his report, "A Framework for Reform," he didn't hesitate to recommend that many medical services be delisted. One obvious impact of those delistings is that in many instances private insurance would pick up the ball dropped by government payers.

"Our approach is built on the fundamental assumption that all Albertans should have fair and equitable access to health service," Mazankowski states at the beginning of his report. "No one should be denied access to essential health services because they are unable to pay." Masses of Canadians breathed audible sighs of relief. They thought that powerful Alberta Premier Ralph Klein was poised to let us keep Medicare. Many media commentators—champions of the sound bite—stopped reading. In a critique that called the Mazankowski Report "A Health Care Trojan Horse," the Canadian Union of Public Employees (CUPE) said most health care commentators were so busy admiring the craftsmanship of the report's language they forgot to look inside.

What was inside the report was much more ominous. Provincial

governments headed by Klein, former Ontario Premier Mike Harris, and BC Premier Gordon Campbell seem to have designed their strategies to trigger questions about the interpretation of terms such as universal, comprehensive, and need. CUPE says that Mazankowski has attempted to move the debate away from the collective right of Canadians to health care as a basic human right, toward individual responsibility for health care choices and funding.

Many Canadians have been brainwashed by a media industry controlled by big business into thinking that cuts to public health care, while a bitter pill, are also fiscal good medicine, even though evidence-based analysis of economic and health outcome indicators leads to the opposite conclusion.

“The good news is that the plight of the world’s poor is being discussed at the highest levels. The bad news is that the cure emanating from these discussions too often resembles the disease.” – Marc Lee, BC economist, Canadian Centre for Policy Alternatives

The federal role

Meanwhile, at the federal level, Senator Kirby, chair of the Standing Senate Committee on Social Affairs, Science, and Technology, has issued several “interim reports”—and he’s not done yet. Kirby was assigned the task last year in a move that Maclean’s magazine called a “crafty stratagem to deflect criticism from the federal Liberal’s appalling inaction on a looming health care crisis.” In a compilation of recent surveys and polls, Kirby reports that roughly 90% of Canadians consider universality a very important principle of the *Canada Health Act* and that 80% support accessibility.

“I need to understand the values underpinning Canadian’s perceptions of public health care.” – Roy Romanow

Romanow’s interim report in February 2002 says that almost all Canadians he has heard from so far want to ensure that the poor-

est in our society have access to health care and should not be bankrupted by the costs of acquiring needed health care services.

He also tackles the question of Canadian values. This approach was eschewed by Mazankowski, who preferred to focus on issues of cost and funding sources, while avoiding the entire question of how citizens define their rights. Romanow points out, “Always, there are significant value judgements lying behind people’s views on which options are acceptable and which are not.”

Romanow discusses the matter of interpreting the *Canada Health Act* in what he refers to as “coming to grips with the language of the debate.” This is a challenging task regardless of where you sit. For Romanow, it means flirting with strategies that will weaken the principles of universality and accessibility. People often interpret or understand key terms in fundamentally different ways. For example, who defines need—the individual, the expert provider, or objective evidence-based assessments? Does “fair” mean equality of opportunity, equality of income, or even merit in terms of deserving or not deserving the service? What does access mean in terms of timeliness and wait lists?

When the Toronto Star reported that Romanow might be headed toward user fees and medical savings accounts, the Canadian Treatment Action Council (CTAC) responded with a news release. “These measures would be very detrimental to people living with serious chronic illnesses such as HIV/AIDS,” said Louise Binder, chair of CTAC. “User fees and medical savings accounts would not reduce health care costs. Instead, they would transfer those costs to people, who as a result of illness, have the least ability to pay. Long-term illness impacts income levels and commonly drives those afflicted into poverty.” ⊕

Part Two will appear in the September/October issue of Living+ magazine. Glen Hillson will examine some of the themes that have emerged in the debate, including reactions from the AIDS community.



Glen Hillson is chair of the BCPWA Society.

AIDS Vancouver The Helpline

Provides anonymous and confidential information and referrals to anyone with questions about HIV and AIDS.

Tel: 604-893-2222

Email: helpline@parc.org

Helpline Online

AIDS Vancouver’s newest service! An interactive forum that allows people to post questions about HIV/AIDS and have them answered by “experts” in the field, trained volunteers and community members.

LOG-IN: www.aidsvancouver.ca

British Columbia Persons With AIDS Society

Notice of Annual General Meeting

WHEN: October 26, 2002 at 11:00 AM

WHERE: Parkhill Hotel, 1160 Davie Street, Vancouver

REGISTRATION: 10:00 AM - 11:00 AM

MEETING BEGINS AT: 11:00 AM (Sharp)



The membership will meet to receive the Annual Report of the Directors, consider amendments to the by-laws of the Society, elect the Board of Directors of the Society for 2002/2003, and conduct other such business as is deemed necessary in accordance with the constitution and bylaws of the Society.

Members wishing to have business placed on the agenda for the Annual General Meeting should submit it prior to July 30, 2002. A letter to the Secretary of the Society containing

- 1) a brief paragraph describing the specific intent of the business, and,
- 2) a properly worded motion pertaining to the business

should be sent to the Society's registered office at 1107 Seymour Street, Vancouver, BC, V6B 5S8.

Important Dates to Remember:

Resolutions from the Members to be Submitted to the Secretary, BCPWA by . . . July 30, 2002

Mailout of AGM packages August 22, 2002

For individuals who do not receive mail, AGM Packages will be ready for

pick up from Member and Volunteer Services Info Desk on August 26, 2002

Last day Proxies are Mailed October 15, 2002

Last Day Proxies May be Requested for Picked Up October 21, 2002

If you have any questions or would like to receive a copy of the Society's Annual Report please call Joel N.C. Leung, Secretary, at 604-893-2263 and leave a confidential message. To ensure accuracy please spell your last name slowly in the voice message and leave a contact phone number.

A lunch will be served.

Upcoming BCPWA Society Board Meetings

Date	Time	Location	Reports to be presented
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
August 7, 2002	3:00pm	PARC Training Room	Executive Committee / Written Executive Director Report
August 21, 2002	3:00pm	PARC Training Room	Standing Committee / Written Departmental Reports
September 4, 2002	3:00pm	PARC Training Room	Director of Individual Advocacy Presentation / Written Executive Director Report
September 18, 2002	3:00pm	PARC Training Room	Executive Committee / Written Departmental Reports

The Pacific AIDS Resource Centre (PARC) is located at 1107 Seymour St., Vancouver.

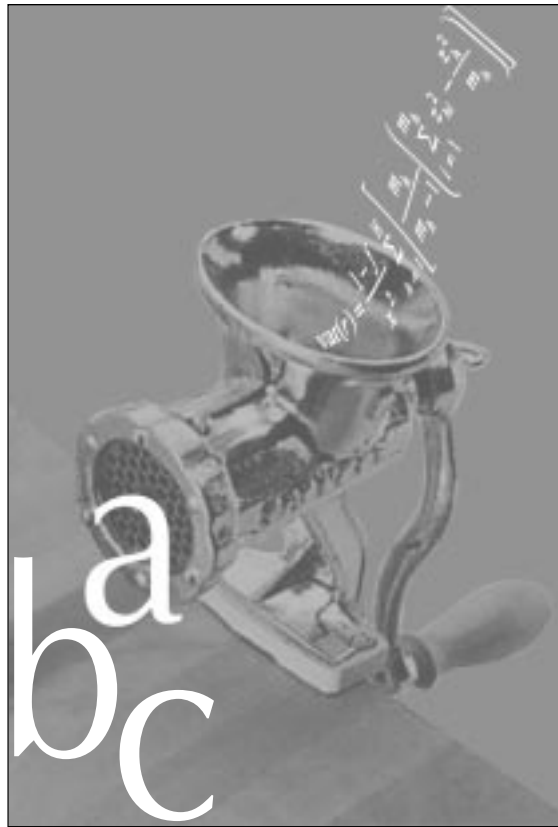
For more information, contact:

Katharine McEachern, Manager, Executive Operations

Direct: 604-893-2292

Email: katharin@parc.org

SCIENCE MADE SIMPLE



A primer on types of research designs

by Paula Braitstein

Sometimes it may seem that, like a rose, research is research is research—in other words, that all research uses the same methods. It may seem as if the type of study design is secondary, or even superfluous, to answering a particular research question. In fact, once a clear research question exists, researchers have many tools at their disposal for answering it. Usually, whether an answer is achieved and whether that answer is reliable or interpretable depends on the research design.

The most common types of research designs can be categorized into three main groups: descriptive, analytic, and interventional.

Descriptive studies

Descriptive studies describe the distribution of a disease: who, where, and when. These studies do not try to establish causation. Rather, they are usually preliminary descriptions of a new disease or symptom. Examples of descriptive studies are case reports (reporting on one case of a disease) and case series (reporting on several cases). The first reports of PCP and Kaposi's sarcoma in gay men in the early 1980s are excellent examples of the importance of case reports and case series. These early reports sounded the alarm for what was to become one of the worst epidemics in world history.

Another type of descriptive study is a cross-sectional study. A cross-sectional study is like taking a snapshot of a situation at a particular moment in time. It is good for seeing if associations or correlations exist between two variables, but it is impossible to know whether the presumed effect happened before or after the cause.

To better understand what a cross-sectional study is, think of salami. Suppose we want to know how much fat is in a whole salami. We could cut the salami somewhere in the middle and count the number of fat globs in that cross-section. From that, we could generalize about how much fat is in the salami as a whole.

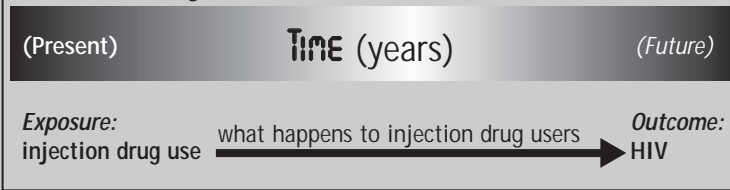
Analytic studies

In analytic studies, researchers actually try to test a hypothesis about a relationship between an exposure and a disease. Common types of analytic studies are cohort and case-control studies.

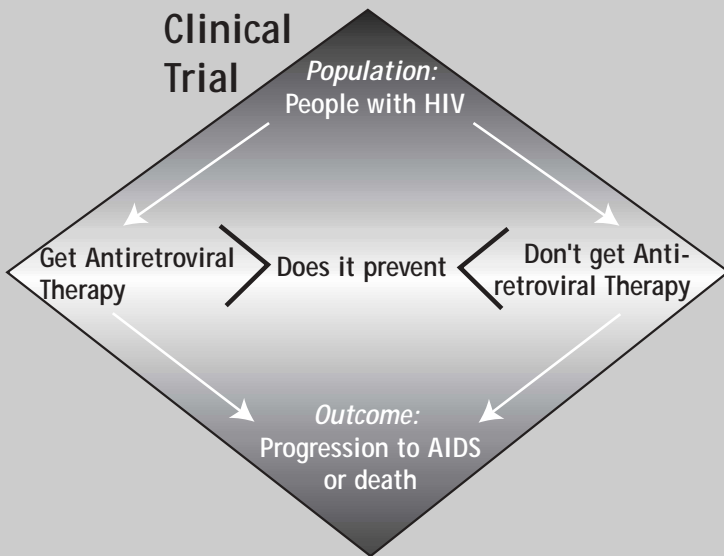
Cohort studies hypothesize that a particular exposure will be associated with a particular outcome. They follow a (usually large) group of people with a particular exposure over an extended period of time to observe whether an exposure is associated with an outcome.

Many people are familiar with the Vancouver Injection Drug Users Study (VIDUS). This cohort study involves people whose expo-

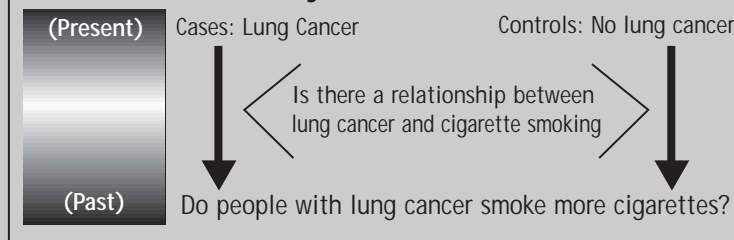
Cohort Study



Clinical Trial



Case-Control Study



sure was defined as having injected drugs within the previous month. These individuals have now been followed for several years, and the rates of HIV and hepatitis C infection—the key outcomes of interest—have been well documented among this community.

Cohort studies are very important for understanding the development of disease and its relationship to a given exposure. Since they involve large groups of people over a long period of time, cohort studies are very expensive, which is the main disadvantage of this kind of research.

Case-control studies take a group of people with a particular disease (the “cases”) and compare them to a group of people without the disease (the “controls”). The entire group is then analyzed to see if the cases have more of a particular exposure than the controls.

For example, to test the hypothesis that smoking cigarettes causes lung cancer, we might take a group of people with lung cancer and compare them to a group of people without cancer to find out whether more of the cases smoke cigarettes than the controls.

Case-control studies are useful for examining rare diseases because you just use whomever you can find with the disease (and, of course, who give their consent to participate). A drawback to this type of study is that they are usually retrospective, meaning the disease has already occurred, and the research participants are asked to look into the past to consider their exposures. This leaves the research open to a variety of biases that can potentially skew the results. It also doesn't help the people who already have the disease.

Interventional studies

The last major type of research design is interventional. The major type of interventional research is the clinical trial, the study of a new drug, test, program, or other kind of intervention. Most clinical trials are comparative in some way, meaning they compare a group that received the experimental drug (or whatever is under study) and a group that did not receive it.

The best kind of clinical trial is one that is “controlled” in some way to prevent possible bias from entering into the study. A comparison trial is one method of controlling for bias. For example, if everyone receives the experimental drug, the researcher can't tell if the positive effects are a placebo effect or if the experimental drug is actually working. By including a group of people who don't receive the experimental drug, the researcher can compare the effects between the two groups. Check future issues of *Living+* for more information on how to control for bias.

These are three of the different types of research designs. The kind of design used depends on the question being asked, the nature of the disease and/or exposure, and the financial and other kinds of resources, such as time, that researchers have available to them. ⊕



Paula Braitstein is the director of treatment information for the BCPWA Society.



Adherence to antiretrovirals: How much is enough?

by Evan Wood

In 1996, the wide availability of protease inhibitors offered real hope to people living with HIV. Not only did these new drug therapies reduce viral replication, increase CD4 cell counts, and improve health, but some scientists thought that long-term suppression of viral replication would enable the eventual eradication of the virus from people's bodies. With this goal in mind, treatment guidelines recommended that people "hit early and hit hard" with a combination of three drugs, even if they felt they were in good health.

A recent study demonstrated the importance of adherence for the most important outcome—development of AIDS and survival.

Although the combination of at least three drugs did prove to be the most effective strategy for preventing HIV disease progression, scientists no longer believe that HIV can be eradicated from the body with the current arsenal of antiretroviral treatments. Experience has also shown that the benefits of anti-HIV treatments must be weighed against the unintended effects of the

medications. Numerous side effects, such as diarrhea and nausea, can seriously reduce quality of life. Long-term complications such as lipid abnormalities can be life threatening.

As a result, HIV treatment guidelines were revised to recommend delaying therapy until a patient's CD4 cell count drops below 350. Recent evidence suggests that people may safely delay treatment until the CD4 count drops to 200. The relevance of the amount of virus people have in their blood, or plasma viral load, may be of secondary importance in terms of when treatment is best initiated. This strategy of delaying treatment aims to avoid the side effects of antiretrovirals, while preserving the benefits of treatment until such time that taking HIV therapy becomes absolutely necessary.

The barriers to taking antiretrovirals

Deciding when to start HIV treatment is a big decision, but it may be among the smallest challenges of taking antiretrovirals. A recent study among healthcare workers further underscored the impact and importance of side effects, noted by patients for years. The study monitored workers who took post-exposure treatment to prevent HIV infection after being exposed occupationally to HIV. Thirty-eight percent of them discontinued their medications before the end of the recommended one-

month treatment period because of side effects.

In addition to side effects, many other factors contribute to people not taking all of their drugs all of the time. Pill fatigue (that is, being sick and tired of taking pills), forgetfulness, and dietary restrictions are just a few of the many challenges of HIV treatment.

In light of these challenges to medication adherence, a critical question that people face is how much adherence is enough? This question has been the focus of much study over the last several years. The evidence is overwhelmingly clear—and it's not pretty. People need to take at least 95% of their pills at least 95% of the time, in order not to develop drug resistance. In other words, you need to take at least 9½ pills out of 10 on time and as prescribed (with or without food) if you want the pills to keep on working. This is extremely difficult to achieve.

The consequences of missing a dose

The problem with missed doses—"evenings" or "days" off from treatment—is that some of the anti-HIV drugs remain in your system for several hours or days after your last dose. This small amount of medication is not enough to stop the virus from replicating, but it is enough to allow the virus to become resistant to whatever drugs are still kicking around in the blood. Over time, your virus will become resistant to the drugs, so they will no longer work.

More bad news is that (with a few exceptions) if you become resistant to a particular drug, you will become resistant to all (or most of) the drugs in that class. That means if you develop resistance to one protease inhibitor, you will be resistant to the other protease inhibitors. This is called cross-resistance.

One strategy for dealing with the emergence of resistant virus is to change your treatment regimen to a combination that can suppress the new virus. Unfortunately, this strategy also has shortcomings—more pills, more side effects, and no guarantee that it will overcome cross-resistance and actually work. Most importantly, if the reason your virus became resistant to the drugs was that you were having problems adhering, those problems will continue unless they are properly addressed. People may therefore soon run out of treatment options because of the limited number of antiretroviral drugs that are currently available and because of cross-resistance. For this reason, it is probably better to delay taking treatment or to stop taking treatment until you are ready to be 100% adherent.

Increasing your chances of survival

Until recently, most adherence studies have looked at the level of adherence required to prevent viral replication or to prevent the development of drug-resistant virus. Few studies have actually shown an association between high or low adherence and survival from HIV disease.

However, a recent study from the BC Centre for Excellence in HIV/AIDS demonstrated the importance of adherence for the most important outcome—development of AIDS and survival. In this study, a smaller proportion of highly adherent people died relative to those who were poorly adherent. As well, the highly adherent people were much less likely to develop AIDS,

whereas their less adherent counterparts developed more AIDS-defining opportunistic infections. This effect was observed for all levels of CD4 cell count, but it was particularly striking among people who had low CD4 cell counts.

Among those with CD4 cell counts above 200, those individuals who were poorly adherent were 3.5 times more likely to progress to AIDS or death. Similarly, among those patients with CD4 cell counts below 200 who were poorly adherent, the risk

You need to take at least 9½ pills out of 10 on time and as prescribed if you want the pills to keep on working.

of death increased 5–30 times. Overall, the study indicates that the short-term advantages of being highly adherent, such as preventing the emergence of resistance, translate into improved survival in the long term.

Promoting better adherence

To prevent the evolution of resistant virus and, in turn, HIV disease progression, people taking antiretrovirals should aim to take all of their medication, all of the time. Several predictors of poor adherence that have been identified include poor doctor-patient relationship, active drug and alcohol use, active mental illness (in particular, depression), and lack of access to primary medical care and medication.

Conversely, factors that have been shown to be helpful for high adherence include having social and family support, fitting medications into a daily routine or schedule, understanding that poor adherence leads to resistance, feeling comfortable taking medications in front of people, and making sure to keep all doctor or clinic appointments. Physicians who have experience in treating HIV can help people address the problems that make adhering difficult and equip them with the strategies they need to be highly adherent. Community AIDS organizations can provide similar assistance.

Without question, the side effects of HIV treatment and the rigors of daily therapy make taking all medications on time and as prescribed an enormous challenge. However, it is important to stress that physicians who treat HIV patients are becoming increasingly adept at helping persons with HIV choose a regimen that they can tolerate and adhere to without hindering quality of life. If you are considering treatment or are having trouble with adherence, talk to your doctor or contact your local AIDS organisation to arm yourself with the strategies you need to take control of your health. ⊕

Evan Wood is a research associate at the BC Centre for Excellence in HIV/AIDS.

Proposed trials reveal trends in HIV research

by Jim Boothroyd

Want to peer into the future of HIV clinical research? If so, take a look at the winning submissions of a recent competition for protocol development funding at the Canadian HIV Trials Network (CTN).

A protocol is a detailed road map for a clinical trial. Written by the principal investigator, it describes the hypothesis, purpose, design, entry criteria, and procedures of the trial, as well as the risks and benefits to participants. To encourage new researchers and state-of-the-art studies, the CTN occasionally invites investigators to put forward new ideas for trials and provides seed money to the most promising proposals.

In the latest competition, the CTN received no fewer than 23 letters of intent from researchers across the country and handed out a record six awards worth a total of \$150,000.

Three teams of researchers got in on the action, but one emerged with the lion's share of the research money. About \$100,000 of the total was awarded for the development of at least five protocols proposed by Dr. Julio Montaner and his team of investigators at Providence-St. Paul's Hospital: Drs. Val Montessori, Peter Phillips, Marianne Harris, Natasha Press, Sylvia Guillemi, and Kenny Chan.

The most highly rated of the team's letters of intent were titled "Rosiglitazone Therapy for Cardiovascular Risk," "L-acetylcarnitine in Peripheral Neuropathy," "Rx (Treatment) Intensification to Accelerate Immune Reconstitution," "Adherence Support in

Difficult to Reach Populations," and "T20 +/- (With and Without Pegylated Interferon Salvage (Therapy)."

The CTN also made two awards of \$25,000 each to investigators in Quebec and Ontario. Dr. Richard Lalonde of the Montreal Chest Hospital received funding for a proposal titled "The Safety and Efficacy of Trizivir in the Treatment of HIV Infection in Injection Drug Users With or Without Concomitant Hepatitis C Infection, with Part of the Doses under Direct Observation." Dr. Rolf van Heeswijk of Ottawa won support for his letter of intent titled "A Study of Gender-specific Differences in the Pharmacokinetics of Nevirapine During the First Eight Weeks of Therapy in Relation to the Incidence of Rash."

The letters were reviewed by 24 researchers and members of the CTN's Community Advisory Committee from across the country. The proposals were assessed for their scientific and social relevance and the degree to which they addressed the priorities of the CTN. ☺



Jim Boothroyd is communications manager at the Canadian HIV Trials Network.

Consenting adults

If you're considering taking part in a clinical trial, but you're debating whether to sign the informed consent, you might wish to read the second edition of the CTN's Model Informed Consent. Written in plain language for clinical researchers, ethical review boards, and members of the HIV community, this definitive document describes exactly what should and should not be included in a state-of-the-art informed consent form.

First published in 1998, the revised edition draws on the expertise of the CTN's Community Advisory Committee and

National Ethics Review Committee, as well as the National Council on Ethics in Human Research. It includes new sections about the communication of trial results to participants, the use of participants' tissue samples and data in future research, and the declaration of researcher incentives and conflicts of interest.

To read a copy, go to the publications section of the CTN website (www.hivnet.ubc.ca/ctn.html) or call us at 1-800-661-4664.

Co-infección hepatitis C y el virus del VIH



La co-infección del virus del SIDA con el virus de la hepatitis C, complica mucho los tratamientos contra el virus del VIH

par Alejandro De Vivar

LO mejor para las personas que vivimos con el Virus de Inmunodeficiencia Adquirida (VIH), es conocer qué es la hepatitis C (VHC), los medios de contagio y el potencial de riesgo de contraer el virus. Todo lo anterior es con el objeto de evitar una co-infección (VHC/VIH), y en el caso de ya estar infectado, mejorar nuestros hábitos para evitar complicaciones mayores.

El virus de la hepatitis C fue descubierto en 1988. Hasta este año se dudaba de la existencia de la hepatitis C, porque no podía clasificarse como hepatitis A ni B. El número de personas co-infectadas VHC/VIH en Canadá es de aproximadamente de 13,000 casos y la mayoría de los infectados son personas que se infectan al compartir agujas contaminadas. Las estadísticas indican que del 100% de los casos de contagio, el 85% desarrollan la infección del VHC, de los cuales, entre el 60 y 70 % desarrollan altos niveles de enzimas que degeneran en la enfermedad crónica del hígado; de éstos, el 20% desarrollan cirrosis progresiva en 20 años y sólo entre 1 al 4% desarrollan cáncer; es decir, que la co-infección VHC/VIH acelera la enfermedad de nuestro hígado a nivel de fibrosis y posteriormente cirrosis o cáncer.

Como comentamos anteriormente, el grupo que está a más riesgo de contagiarse, es el que consume drogas vía intravenosa con seringas infectadas. El riesgo de contraer por transfusión o productos de

sangre ha disminuido, gracias al chequeo de VHC en la sangre antes de usarla. El riesgo de contagio por transmisión sexual, aunque es bajo, es mayor en las personas con el sistema inmunológico deteriorado, como es el caso de los que vivimos con VIH, ya que estamos más expuestos a contraer las enfermedades oportunistas como es el caso de la hepatitis C (debido al ataque de nuestro sistema inmunológico por el VIH).

Muchos de los medicamentos (retrovirus) para combatir la reproducción de copias del VIH en nuestro sistema inmunológico, son metabolizados por el hígado, poniendo en éste mucha presión, lo que causa que el hígado se inflame como efecto secundario de las medicinas que uno toma para controlar el VIH. A toda inflamación del hígado se la llama hepatitis, y en la mayoría de los casos, es debido a una acción viral, como es el caso del VHC. Si nos encontramos en un grupo que solamente están infectados por el VIH, es muy importante no sobrecargar el hígado con una co-infección de la hepatitis C.

Es bueno conocer también, que una vez estando infectados por el VHC, existen circunstancias que comprometerían más aun nuestro hígado, como son los riesgos de tener más de una co-infección (como los otros tipos de hepatitis), el pasar de los 40 años de edad, la obesidad, CD4<200 y el consumo inmoderado de alcohol.

El tratamiento reconocido para el VHC

es la combinación de Ribetron terapia; 3 inyecciones a la semana de ALFA-2b1 mas pildoras de RIBAVIRIN tomadas 2 veces al dia, INTERFERON MONOTERAPIA, PEGYLATED INTERFERON (una inyección intramuscular a la semana), y no se sabe con claridad que interacción pueda tener con los medicamentos para el VIH.

En conclusión, existen dos grupos de personas que vivimos con el VIH; uno, los no co-infectados, pero que potencialmente están susceptibles a contraer VHC, y el otro grupo, el de personas co-infectadas VHC/VIH. Para ambos casos, es recomendable hacer todo lo posible por no recargar la presión sobre el hígado, para que éste funcione lo mejor posible y los resultados se vean reflejados en una buena salud. ⊕

Alejandro De Vivar, TIP writer

Información en Español

BCPWA Treatment Information Program (TIP)
Ofrecemos información en español sobre terapias y tratamientos para la infección de VIH y SIDA. Consejería individual es disponible todos los Miercoles 10:00AM a 5:00PM.

Visitenos a nuestra dirección:

BCPWA Programa de Información sobre los Tratamientos

1107 Seymour Street, Vancouver, BC V6G 5S8

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

O llámenos a nuestra línea directa: Tel: 604.893.2243

Información sobre tratamientos anti VIH via correo electronico nuestro email es treatment@parc.org

What's bred in the bone

Multiple factors likely at root of bone problems in PWAs

by Diana Peabody

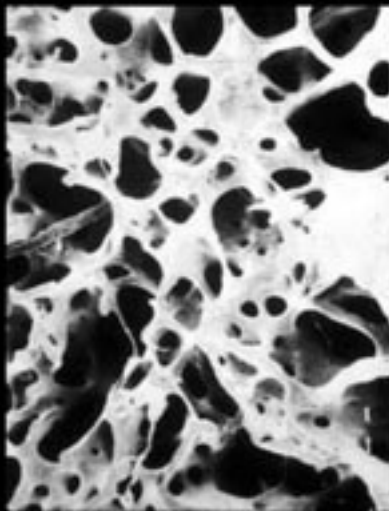
Low bone mineral density (BMD) has emerged as a major problem for people living with HIV. Every major conference in the last few years has presented research on osteoporosis. It has become increasingly clear that the prevalence of bone disease in HIV-positive people is greater than in the general population, and many questions are still unanswered.

Initially, researchers thought that osteopenia might be another metabolic complication of HAART. Early studies implicated protease inhibitors, though other research has not confirmed these findings. Some studies have shown that HAART improved BMD. There has been speculation that HIV suppresses production of osteoclasts (new bone cells) in the bone marrow or that the virus and/or HAART cause the bone to turn over faster, los-

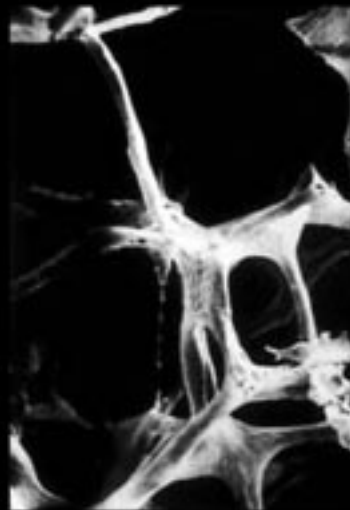
ing density in the process. As early as 1992, studies found that abnormal vitamin D or calcium metabolism and high levels of TNF-alpha appear to disturb bone metabolism.

The relationship between bone density and fat redistribution, high triglyceride levels, or lactate is still uncertain. However, an association has been found with weight, pre-HAART weight, BMI, and wasting. In HIV studies, the prevalence of osteopenia appears to be 21–47% and osteoporosis 8–22%. Dr. Julian Gold from Australia suggests that HIV infection accelerates bone loss over time by about 25 years, so that a 40 year old would have the bones of a 65 year old.

With osteopenia, the bone becomes less dense and weaker. This condition does not cause pain or loss of function. It is usually treated with diet and exercise rather than medications. Osteoporosis, the more severe form of the disease, can lead to painful fractures, decreased functional ability, and decreased quality of life. Osteoporosis is sometimes treated with medications, as well as diet and exercise, to improve bone density and strength.



Healthy bone



Osteoporosis of the bone

BONE 101

Bone is dynamic living tissue that provides structure and acts as a reservoir for calcium and other minerals. Serum (blood) calcium is tightly regulated, and if it gets too low, calcium is released from the bones. This process is controlled by many factors, including hormones, calcium intake, and vitamin D.

“Bone turnover” describes the flux of minerals into and out of bone. From 9 to 30 years of age, minerals are deposited at a fast rate to

build new bone and achieve “peak bone mass” density. From 30 to 50 years of age, the bone stays quite stable, losing 1–2% per year. At around 50 years, minerals are released at a faster rate than they are deposited. So the bone density that is acquired as a young person is like a long-term investment that can be withdrawn in later years; the more you deposit in youth, the better off you are later.

Bone is comprised of osteocytes (bone cells) with a protein matrix, like a lattice, that holds minerals like calcium, phosphorus, and magnesium. The strength of a bone depends on its architecture, protein, and minerals. Think of a house where the protein structure is the frame and the minerals are the bricks. You need both to make the building complete.

ASSESSING BONE STRENGTH

A DEXA scan assesses the strength of bone by looking at how dense it is. The bone density measurement provides a T-score which compares bone density to the peak amount that would be expected at 30 years of age and a Z-score which compares bone density to people of the same age.

World Health Organization standards for interpreting T-scores are as follows:

- Normal: T-score of greater than –1.0
- Osteopenia: T-score of –1.0 or lower
- Osteoporosis: T-score of –2.5 or lower
- Severe Osteoporosis: T-score of –2.5 or lower with a fracture

Genetics determine the amount of peak bone mass we can build and how fast we lose bone as we age. This predisposition is modified by what happens to us throughout our lives. The most powerful risk factors for osteoporosis are failing to achieve

Nutrition is the single most modifiable factor in the development and maintenance of bone mass.

our potential peak bone mass and having an accelerated rate of bone turnover throughout adulthood. These factors are influenced by malnutrition, inadequate calcium or D intake, chronic disease (such as HIV), and medications (such as HAART).

Low body weight and low amounts of lean body mass are consistently associated with low BMD, and losing weight can also cause some bone loss. Other factors commonly seen in HIV infection that decrease BMD include malabsorption, low male and female hormones, periods of bed rest, and liver disease.

TAKE A PROACTIVE APPROACH TO KEEPING YOUR BONES STRONG

Nutrition is the single most modifiable factor in the development and maintenance of bone mass. You can make a big dif-

ference in your bone health by choosing to be proactive. A number of things can improve bone density:

Stay well nourished

Eating well ensures you get a supply of all the nutrients needed for bones and overall health. Protein is especially important to strengthen the bone matrix that holds minerals. Recent studies show that low protein intake is associated with low bone mass.

Achieve and maintain a healthy body weight

Benefits many aspects of your health, including bones.

Build muscle

Improves strength and balance, which is especially important if you already have thinning bones, since falling is the most common cause of fractures.

Exercise

Weight-bearing exercise stimulates the bones to take up more minerals. The best type involves contact with the foot to the ground, the more forceful the contact the better. The key is to get some weight onto the skeleton, especially the spine, hips, and legs. Running, skipping rope, dancing, walking, and weight lifting are best, but *any* exercise will help. Do it regularly.

Calcium

Critical for bone health. Many studies have shown a positive effect on bone density. Getting enough calcium from diet or supplements means that calcium doesn't need to be released from bone to build up blood levels, which means more calcium is available to increase bone density. See inset on next page for how to get more calcium.

Vitamin D

Necessary to absorb calcium and maintain serum calcium levels. It must be activated in the liver and kidney before it can work. While studies have shown low serum levels of the activated form of vitamin D in HIV-infected people, these findings aren't consistent and we haven't found this in Oak Tree Clinic patients. See inset on next page for sources of vitamin D.

Phosphorus and magnesium

The other two main minerals in bone. Most people get enough phosphorus in the diet. The Osteoporosis Centre at the Women's Health Centre (BC) generally doesn't recommend magnesium supplements to enhance calcium metabolism. However, low magnesium has been found in people with HIV, and magnesium deficiency has been associated with osteoporosis, so it may be prudent for people with HIV to increase magnesium intake along with calcium. High doses will aggravate diarrhea but will help constipation. The upper tolerable limit is 350mg.

Zinc

Studies in animals show that zinc increases bone density, especially in conjunction with estrogen or vitamin D. In humans, low serum zinc levels have been associated with osteoporosis. However, zinc supplementation in HIV infection is controversial, so the total daily dose should not exceed the upper tolerable limit of 40mg.

Vitamin K

A fat-soluble vitamin that is critical to make osteocalcin, one of the bone proteins, and may be important in maintaining calcium balance. Found in green vegetables and dairy products and made by good bacteria in the gut. People with chronic diarrhea and malabsorption may have low levels of vitamin K. Vitamin supplements in Canada do not contain vitamin K, so eat your greens and keep your intestinal flora healthy with acidophilus, bifidus, and soluble fibre.

Vitamin C

Important in the synthesis of collagen, another bone protein. It has an additional benefit as an antioxidant if you smoke because it scavenges free radicals that can damage bone.

Fruits and vegetables

Eating generous amounts of fruits and vegetables is protective: they provide beneficial nutrients and create an alkaline environment in the body. Researchers believe an acidic environment causes minerals to be leached out of bone. Dairy products are neutral; meats and grains are acidic. Continue with dairy and meats for protein and minerals and increase fruits and vegetables, which are highly nutritious with many health benefits. Most people need to eat more of them.

Isoflavones

A type of phytoestrogen found in soybeans that may protect bone according to animal studies. The results of animal studies are promising but yet to be proven in humans. Get these compounds in soy foods such as milk, tofu, and

cheese, as opposed to pills, which may actually be harmful.

Boron, copper, silicon, manganese, and iron

All have been studied for their contribution to bone mineral density. These minerals are required in very small amounts and should not be supplemented separately. Choose a multivitamin-mineral that contains these nutrients.

Fluoride

Fluoride is rapidly deposited in bone and increases bone density but not strength. Therefore, it is not used to treat bone loss.

HARMFUL FACTORS

Things that are harmful to bone include:

Alcohol

Detrimental to bone in large amounts. Heavy drinkers have low BMD due to malnutrition, malabsorption, liver disease, and toxicity to osteoblasts (new bone cells). They're also more likely to fall and break a bone.

Caffeine

Increases urine calcium losses and decreases calcium absorption. Having coffee or tea with 2 ounces of milk (not cream) can offset the negative effect of caffeine.

Salt

Also increases calcium losses in the urine, so go easy on the salt shaker.

Smoking

Smokers have low bone density because smoking increases free radicals, which then increase bone turnover.

Low bone density, which is common in HIV/AIDS patients, is a complex problem that is not caused by any single factor. It is probably a combination of genetics, nutrition and lifestyle, chronic disease, and medications. Given these risks, you may want to talk to your doctor about having a bone density test. This test is covered by health insurance in BC if you are at risk for osteoporosis; the evidence certainly indicates that HIV-

infected people are at risk. In the mean time, take action to protect your bone health. Work on the strategies that are known to improve bone health and decrease activities that are harmful.

For more information on preventing osteoporosis, see a registered dietitian. In BC, call Dial-a-Dietitian at 604-732-9191 or 1-800-667-3438 for more information on calcium supplements. ⊕



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

Sources of calcium

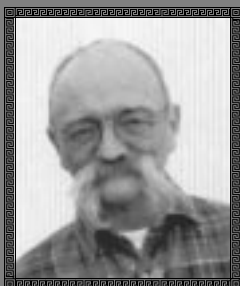
People living with HIV need 1200–1500mg of *elemental* calcium. The best dietary sources of calcium are dairy products (milk, yoghurt, cheese) and fortified beverages and foods (soy, rice, or potato beverage, orange juice, soy cheese, tofu). Because the requirements are so high, most people still need to take supplements. When buying supplements read the labels carefully to figure out how much is *elemental*. To increase absorption, take calcium in smaller doses twice a day with food. It can be a bit constipating, which is a bonus if you have diarrhea. If constipation is a problem for you, try to get more calcium from food and less from supplements. Also try to increase fibre and fluids in your diet.

Sources of vitamin D

Vitamin D is found in foods like milk, margarine, and fish, and can be absorbed from sunshine on bare skin with no sunscreen. These sources are not considered reliable so supplementation is usually required. The recommended dose is 400–800 IU daily and up to 1200 IU for people with low BMD. Most multivitamins have 400 IU and some calcium supplements contain D. Be sure to add up the D from all sources; the upper tolerable limit is set at 2000 IU.

Volunteering at BCPWA

Profile of a volunteer: Jake Thomas



"A man with an unforgettable moustache and theatre in his soul, Jake creates work which is thought provoking and passionate. Through his gentle guidance, love of the arts, and dedication to the spirit of diversity, individuals are supported from the heart to tell their unique story."

Jackie Haywood



Volunteer History

Working with Theatre Positive since 1993. Also volunteered for Polli and Esther's Closet for 2 years.

Started at BCPWA
1992.

Why pick BCPWA?

They were so good to my lover, Tony Steeves, and my friend Kenny Hooker. Both have since died. I was asked by Jackie to start up a theatre program.

Why have you stayed?

I like being useful, and enjoy the people.

Rating BCPWA

A good, hard-working society.

Strongest point of BCPWA

Member driven and advocacy.

Favourite memory

Any production of Theatre Positive, or any retreat.

Future vision for BCPWA

More involved with the membership and fighting for our rights.

In Memoriam

Don Fauth

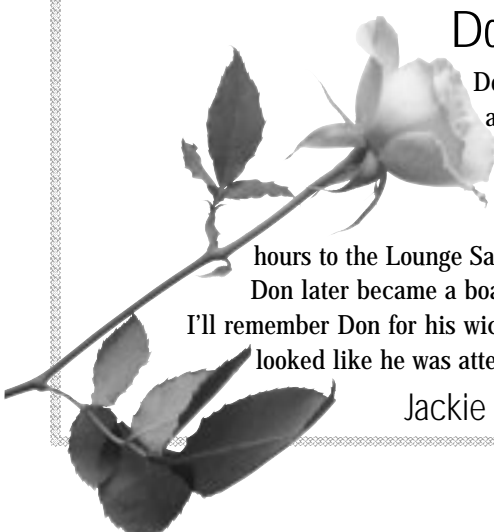
Don Fauth began volunteering at BCPWA in the mid-90s. As a peer counsellor, he took a large part in the peer counselling trainings. I could always count on him to have every base covered. When we desperately needed updated resource information he was tenacious, thorough, and professional.

Don's other life included time as a hairdresser. Fortunately for us, he donated many hours to the Lounge Salon. He churned out spiffy cuts in record time.

Don later became a board member of AIDS Vancouver. He was vice chair at the time he became ill.

I'll remember Don for his wicked cabbage rolls, the cherished boat of a car he lovingly drove, and how he always looked like he was attending a swank event when he attended our volunteer appreciation parties.

Jackie Haywood



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.

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

ocial Work Dept. 806-8221

Positive Women's Network

692-3000 or 1-888-692-3001

VANCOUVER

FOOD & DRINK

AIDS VANCOUVER GROCERY:

Free for PWVA/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.

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 PVWN 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 LUNCHESES:

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 V6J 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.

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

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 POSITIVE:

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 info contact stage manager Suzan at 893.2297.

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 Hemophiliac or Blood Transfused HIV+ individuals. HIV-T Support Group. Address: PO Box 78039 N. Side, Port Coquitlam, BC V3B 7H5.

THE CENTRE: (PFAME gay and Lesbian Centre) 1170 Bute Street, Vancouver, BC V6E 1Z6. Phone 684.5307.

DOWNTOWN EASTSIDE CONSUMER BOARD:

For information call 688.6241.

HEALING OUR SPIRIT B. C. 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. 201-1847 West Broadway, Vancouver, B. C., V6J 1Y6. Phone: 873.5013. Fax: 873.5002.

LOWER MAINLAND PURPOSE SOCIETY:

Health and Resource Centre and Youth Clinic. 40 Begbie Street, New Westminster, BC Phone 526.2522. Fax 526.6546

MULTIPLE DIAGNOSIS COMMITTEE:

c/o Department of Psychiatry, St. Paul's Hospital, 1081 Burrard Street, Vancouver, BC V6Z 1Y6. Phone 682.2344 Ext. 6254.

NATIONAL CONGRESS OF BLACK WOMEN FOUNDATION (UMOJA):

Family orientated community based group offering a holistic approach to HIV/AIDS & STD's education, prevention and support in the black community. 535 Hornby Street, Vancouver, BC Phone 895.5779/5810 Fax 684.9171.

THE HEART OF RICHMOND AIDS SOCIETY:

Weekly support groups, grocery vouchers, dinners, and advocacy for people affected by HIV/AIDS. Located at 11051 No.3 Rd., Richmond, BC V7A 1X3. Phone 277.5137 Fax 277.5131. E-mail: horas@bc.sympatico.ca.

THE NAMES PROJECT (AIDS MEMORIAL QUILT):

Is made of panels designed by friends and loved ones for those who have passed on due to AIDS. 5561 Bruce Street, Vancouver, BC V5P 3M4. Phone 604.322.2156. Fax 604.879.8884.

POSITIVE WOMEN'S NETWORK:

Provides support and advocacy for women living with HIV/AIDS. 614-1033 Davie Street, Vancouver, BC V6E 1M7 Phone 604.692.3000, Fax 604.684.3126, Toll-free 1.866.692.3001. Email: pwn@pwn.bc.ca.

WORLD AIDS GROUP OF B.C.:

607-207 W. Hastings, Vancouver, BC, V6A 3Y9. Phone 604.696.0100. Email: wagbc@vcn.bc.ca.

YOUTH COMMUNITY OUTREACH AIDS SOCIETY (YOUTHCO):

A youth for youth member-driven agency, offers prevention education services, outreach, and support. Contact us at 688.1441 Fax 688.4932, E-

mail: information@youthco.org, outreach/support worker confidential cell phone: 808.7209.

SURREY AND THE FRASER VALLEY

HEALTH

CHILLIWACK CONNECTION - NEEDLE EXCHANGE PROGRAM:

Needle exchange, HIV/AIDS, STD education, prevention, referrals counselling. #2-46010 Princess Avenue, Chilliwack, BC V2P 2A3. Call for storefront hours. Phone 795.3757 Fax 795.8222.

STREET HEALTH OUTREACH PROGRAM:

Provides free general health services including testing and counselling for sexually transmitted diseases, pregnancy, hepatitis and HIV/AIDS and an on-site needle exchange. Doctor/Nurse: 583.5666, Needle Exchange: 583.5999. Surrey Family Services Society #100-10664 135A Street, Surrey, BC V3T 4E2.

SUPPORT GROUPS AND PROGRAMS

SURREY HIV/AIDS SUPPORT NETWORK:

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

MENNONITE CENTRAL COMMITTEE:

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

AIDS GROUPS AND PROGRAMS

LANGLEY HOSPICE SOCIETY:

Offers support to dying and/or bereaved people while also providing education about death and dying to the community. For more information please call t 604.530.1115 f 604.530.8851 www.langleyhospice.com

PEACE ARCH COMMUNITY SERVICES:

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

VALLEY AIDS NETWORK:

Biweekly Wednesday evening support group in Abbotsford. For information call Nicole Giesbrecht at 604.850.6639.

Y.A.M.P. YOUTH AIDS MENTOR PROGRAM:

c/o #2-46010 Princess Avenue, Chilliwack, BC V2P 2A3. Phone 795.3757 Fax 795.8222.

VANCOUVER ISLAND

HEALTH

NANAIMO AND AREA RESOURCE SERVICES FOR FAMILIES:

Street outreach and Needle Exchange: 60 Cavan Street, Nanaimo, BC V9R 2V1. Phone 1.250.754.2773 Fax 1.250.754.1605.

NORTH ISLAND AIDS COALITION HARM REDUCTION PROGRAMS:

Courtenay 250.897.9199; Campbell River 250.830.0787; Port Hardy & Port McNeil 250.949.0432 and Alert Bay Area 250.974.8494.

TILLICUM HOUSE FRIENDSHIP CENTRE:

HIV, STD, Hepatitis, counselling and referrals; ECP Pregnancy Testing; Contraception Counselling; Vaccines; Needle Exchange; Outreach & educational Services. 602 Haliburton Stree, Nanaimo. t 250.753.6578; f 250.754.1390; www.thnff.com Clinic hours: Monday–Thursday 10AM–4.30PM. Needle exchange: Monday 5PM–10PM.

HOUSING

WINGS HOUSING SOCIETY (VANCOUVER ISLAND):

Leave messages for local WINGS rep Mike C. at 250.382.7927 (Victoria) or 1.800.665.2437.

AIDS GROUPS & PROGRAMS

AIDS VANCOUVER ISLAND (AVI):

Offers a variety of services for those affected by HIV/AIDS, including support, education and street outreach. Office located at 1601 Blanchert Street, Victoria, BC V8W 2C5. Phone: 1.250.384.2366 or toll free at 1.800.665.2437. Fax: 1.250.380.9411.

AIDS VANCOUVER ISLAND – REGIONAL & REMOTE, NANAIMO:

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

MID ISLAND AIDS SOCIETY:

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

NORTH ISLAND AIDS COALITION (NIAC):

All of our offices offer Individual Advocacy, Support and Education, and Harm Reduction Programs. E-mail: niac@island.net. Website: www.island.net/~niac. Contact the office closest to you for Support Group Meeting places and times. Courtney office: NIAC, 355–6th St., Courtenay, BC V9N 1M2. Phone 250.338.7400 or toll-free 1.877.311.7400. Fax 250.334.8224. Campbell River: NIAC, 684B Island Highway, Campbell River, BC V9W 2C3. Phone: 250.830.0787 or toll-free 1.877.650.8787. Fax: 250.830.0784. Port Hardy Office: NIAC, 8635 Granville

Street, Ground Floor, Port Hardy, BC V0N 2P0; mailing address: PO Box 52, Port Hardy, BC V0N 2P0. Phone and fax: 250.902.2238. Cell phone: 949.0432.

VICTORIA AIDS RESPITE CARE SOCIETY:

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

VICTORIA PERSONS WITH AIDS SOCIETY:

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

THOMPSON-OKANAGAN

HEALTH

OUTREACH HEALTH SERVICES:

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

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

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

AIDS GROUPS & PROGRAMS

AIDS RESOURCE CENTRE - OKANAGAN & REGION:

Information, referral, advocacy, peer support, social & support groups, education and resource library. Phone 1.800.616.2437 or Fax 1.250.868.8662, or write to #202 –1626 Richter Street, Kelowna, BC V1Y 2M3. E-mail: kares@silksilk.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. P.O. Box 6084, Williams Lake, BC V2G 3W2. Prevention Worker for Youth also available.

Phone: 250.392.5730. Fax 250.392.5743. Needle Exchange in Williams Lake. Phone 250.398.4600.

CIRCLE OF LIFE:

Held at the White Feather Family Centre every second Tuesday from 4:30-5:30. For information call Gail Orr at 397.2717.

QUESNEL SUPPORT GROUP:

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

NORTHERN B.C

AIDS GROUPS & PROGRAMS

AIDS PRINCE GEORGE:

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

PRINCE GEORGE AIDS PREVENTION NEEDLE EXCHANGE:

Providing outreach and nursing service. 1095–3rd. Avenue, Prince George, BC V2L 1P9. Phone 1.250.564.1727 Fax 1.250.565.6674.

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

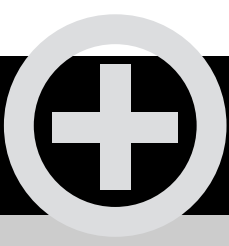
Office at 101 Baker Street, Nelson, BC V1L 4H1. Phone 250.505.5506 or 250.505.5509 or toll free 1.800.421.2437 Fax 250.505.5507. Website: http://ankors.bc.ca. West Kootenay/Boundary Regional Office 250.505.5506, info@ankors.bc.ca: East Kootenay Regional Office 250.426.3383, ankors@cyberlink.bc.ca; Cranbrook 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.



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Be careful what you wish for



The dubious distinction of living—and aging—with HIV

by *Glen Hillson*

Recently, a twentyish Asian female leapt to her feet proffering me her seat in the section of the bus reserved for the elderly and disabled. Much to my own surprise, I merely sighed with relief and gratefully accepted.

Yesterday a colleague told me the reason she likes working with me is that I'm a "cranky old curmudgeon." One doesn't argue with a six foot, two-inch, Valkyrie lesbian whose footfall is louder than Shrek's. Besides, when Gordo's Gang abolishes the ambulance service, at least I know someone who can toss me over her shoulder like a half-empty sack of potatoes and haul me off to St. Paul's Emergency without breaking a sweat.

I turned fifty this year and some malevolent cosmic force seems determined to keep me constantly reminded of that fact. I am also reminded of an era of the AIDS movement when PWAs took exception to being branded as "people dying of AIDS." With haughty indignation we countered, "We are living with AIDS, not dying from it." Most of us sought to keep on living and living and...well, here I am.

I'm now into my twenty-second year as a pozzzy, and I am finally learning to be more careful what I wish for. The wise goddess Cher once said, "I've been rich and I've been poor—rich is better"; my personal motto is "I was young and now I'm old. Young was better—way better."

I have reached a stage of life when my friends no longer dismiss me as a

hypochondriac. For fun times, we get together to compare notes on our operations.

The line between living and dying gets ever more blurred—unlike my blood brain barrier, which has apparently been sealed off permanently. My geriatric friends find themselves in similar predicaments. The best part is that my secrets are safe with them because they can't remember them either.

Just the other evening, as I readied myself for bed with some light reading on the less than great debate about the future of Canada's healthcare system, it occurred to me that life was much more fun in the days when, upon regaining consciousness from a sojourn with Lucy in the Sky with Diamonds and assorted male companions, I applied my mind to more pressing existentialist questions: "Who am I" and "Where am I" and my all-time fave "Where the hell are my clothes?" I can live without sex now, but not without reading glasses. Times change.

Ben, the token pozzzy on Queer As Folk, tries to preserve his quality of life by dabbling in Buddhism, meditation, and other forms of new age hoo-ha in his quest for "inner tranquillity." Puleez! No one will ever accuse me of seeking or possessing inner tranquillity—other than what's inside a bottle of Pepto-Bismol or a peaceful flight aboard Puff the Magic Dragon. There was a time when I could find all the tranquillity I needed in a bottle of tequila and a hit of MDA, but those

sources of tranquillity have given way to Geritol and the occasional Tylenol 3.

I intend to die standing, and I am firmly convinced that when it comes time for someone to inherit the earth, the meek will be far back in line.

Luv ya—but it's time for my afternoon nap. ⊕

Advice to the youth-obsessed?

Don't let the excitement of youth cause you to forget your Creator. Honor him in your youth before you grow old and no longer enjoy living. It will be too late then to remember him, when the light of the sun and moon and stars is dim to your old eyes, and there is no silver lining left among the clouds. Your limbs will tremble with age, and your strong legs will grow weak. Your teeth will be too few to do their work, and you will be blind, too. And when your teeth are gone, keep your lips tightly closed when you eat! Even the chirping of birds will wake you up. But you yourself will be deaf and tuneless, with a quavering voice. You will be afraid of heights and of falling, white-haired and withered, dragging along without any sexual desire. You will be standing at death's door. And as you near your everlasting home, the mourners will walk along the streets.

Excerpt from Ecclesiastes, Chapter 12