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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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think +

opinion and editorial

Stigma rears its head again

by Glen Hillson

A recent article in the *New England Journal of Medicine* examines the issue of organ transplantation in people with HIV infection. To date, no HIV-positive person has received an organ transplant in Canada, although transplants are available to PWAs in a handful of centres in the US, Britain, and the EU. "It indicates yet another way in which we continue to discriminate against HIV-positive persons," the authors concluded.

The medical rationale for excluding PWAs that prevailed in the early days of the epidemic no longer applies. Previously, anyone with HIV/AIDS was expected to die quickly, so they were not considered appropriate recipients of scarce donor organs.

With improved HIV treatments, many of us can expect to live for a long time. Immunosuppressive drugs that prevent organ rejection are relatively safe for people whose HIV infection is controlled through treatment. Increasingly, evidence indicates that HIV-positive and HIV-negative people have comparable transplant outcomes.

Because end-stage liver disease is now one of the leading causes of mortality in PWAs, especially among those who are co-infected with viral hepatitis, there will surely be mounting pressure on Canadian decision-makers to change their rules.

To better appreciate the unique stigma attached to HIV/AIDS, you only have to compare HIV/AIDS to hepatitis C or alcoholism. Of the three, only HIV is grounds for automatic exclusion. Other patients are individually assessed and many receive transplants if they are medically eligible. In fact, hepatitis C is the leading cause of liver

transplantation in the US. The emotional and moral judgments that overlay decisions affecting PWAs are still very powerful.

Last year, a Dr. Peter Centre participant disclosed his HIV status on television when talking about how difficult it was to keep medical appointments during the transit strike. The following day he was evicted from his Surrey rooming house. I compared notes with Maxine Davis, executive director of the Dr. Peter Centre, on our media interviews about the incident. We were surprised by the number of people we knew who expressed astonishment and outrage that such a thing could happen in this day and age. Clearly, they thought all of society had moved on to a more inclusive and loving way of life. Even the news reporters seemed surprised that discrimination against PWAs still exists.

The stigma and discrimination suffered by PWAs stem from the same kind of thinking that makes people vulnerable to infection in the first place. It's the same kind of irrational, baseless fear that causes homophobia, racism, and gender inequality.

Denial of medical procedures such as organ transplants to PWAs provides further insight into the pervasiveness of the HIV/AIDS stigma. It doesn't just reside in the Bible Belt. It also occurs among academics and highly placed medical professionals.

We have every right to demand and expect to live in a world that Maxine describes as "being safe for a person with HIV to disclose their status any time and anywhere." ⊕

Glen Hillson is the chair of the BCPWA Society.

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

REALITY BITES



New staff at BCPWA

The BCPWA Society is pleased to welcome several new staff members. Zoran Stjepanovic is our coordinator of treatment information. A volunteer with various AIDS service organizations for over ten years, he recently graduated in social work from the University of Victoria. He did a placement in BCPWA's advocacy department last year, then did another placement in Vancouver's downtown eastside.

Mike Verburgt is our volunteer resources coordinator. A familiar and reassuring face at the BCPWA Society, Verburgt has worked as our lounge security person for the past three years.

Carl Bognar is our prevention coordinator. He has a PhD in Applied Psychology and recently completed a framework for integrated HIV services for the Vancouver Coastal Health Authority. Bognar has a special interest in using community-based research methods to explore prevention issues for HIV-positive gay men.

Marie Cambon is our new IT networks coordinator. With a background in writing and film studies, she switched gears two years ago to study networking computers at BCIT. She did her practicum at BCPWA.

Atazanavir early access program

Atazanavir (TAZ) is an experimental protease inhibitor (PI) that does not appear to cause lipid dysregulation, which has occurred with other PIs. It is currently in phase III clinical development by Bristol-Myers Squibb. The company has started enrolling patients in an early access program to provide atazanavir to eligible patients infected with HIV.

The program will provide atazanavir to HIV-infected patients who are failing their current antiretroviral therapy and are

unable to construct an alternative treatment regimen using other available antiretroviral agents due to prior virologic failure and/or drug intolerance. The program will also provide atazanavir to patients who have severe HAART-associated hyperlipidemia, despite lipid lowering therapy.

Patients may enrol in the program through their physicians only.

Charles Roy

Charles Roy, executive director of AIDS Committee of Toronto, passed away on August 24, 2002 from complications due to HIV/AIDS. Roy was a brilliant social worker, activist, educator, administrator, friend, and PWA. He spent over a decade dedicating his life to AIDS service and activism, especially championing the rights of persons living with HIV/AIDS. In his last year, he acted as a PWA representative on the board of directors of the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

Immune system breakthrough

Researchers in Melbourne, Australia have discovered special stem cells they hope can be used to rebuild the immune systems of patients ravaged by AIDS and chemotherapy.

A Monash University research team used the stem cells to grow a vital part of the immune system, the thymus, in mice. The discovery could help with a wide range of diseases, including AIDS, cancer, multiple sclerosis, and rheumatoid arthritis. "Once you can grow the thymus, you can start to repair immunodeficiencies, you can attack autoimmune disease and you can improve vaccinations," research leader Richard Boyd said.

Researchers say human application within 5 years is possible. The next step is human trials.

Source: Mediapolis, Inc.

New discovery in HIV

In a study published in Science magazine, researchers from the Aaron Diamond AIDS Research Center (ADARC), an affiliate of The Rockefeller University, announced that they have identified a group of proteins, called alpha-defensins-1, -2, and -3, that can inhibit HIV replication. The discovery, which could have significant implications for the future of HIV treatment, may help explain why some people infected with HIV live significantly longer than others with the virus without developing AIDS.

This discovery is a major breakthrough in understanding of how the body fights HIV. "Alpha-defensins are promising as a future addition to the HIV treatment arsenal," said Dr. David Ho, director of ADARC and a co-author of the study.

ADARC researchers are already pursuing new therapeutic approaches based on the data, and are currently working to improve the potency of the proteins by genomic and proteomic techniques.

Source: NATAP

Added safety information for Videx

The Videx (didanosine, ddi) label has been revised to include new, precautionary information about co-administration of Videx and ribavirin (a treatment for hepatitis C) in HIV/HCV co-infected patients.

Literature reports and 24 cases submitted to the U.S. Food and Drug Administration's Adverse Event Reporting System (AERS) were reviewed to examine cases of patients receiving Videx who added treatment with ribavirin. There appeared to be a relationship between the time that ribavirin was initiated and the occurrence of

REALITY BITES

News from home & around the world

toxicity, on average around 5 months.

The following has been added to the "Precautions" section of the label:

"Exposure to didanosine or its active metabolite (dideoxyadenosine 5'-triphosphate) is increased when didanosine is co-administered with ribavirin. Increased exposure may cause or worsen didanosine-related clinical toxicities, including pancreatitis, symptomatic hyperlactatemia/lactic acidosis, and peripheral neuropathy. Co-administration of ribavirin with Videx should be undertaken with caution, and patients should be monitored closely for didanosine-related toxicities. Videx should be suspended if signs or symptoms of pancreatitis, symptomatic hyperlactatemia, or lactic acidosis develop."

Kava warning

Health Canada has issued a stop-sale order for all products containing the herb kava after a safety assessment concluded there is insufficient evidence to support their safe use. The department is also requesting the recall of these products from all levels of the market.

Kava is found in herbal and homeo-

pathic preparations and may also be occasionally found in food. It has been used as a treatment for anxiety, nervousness, insomnia, pain, and muscle tension.

Find the Health Canada advisory at http://www.hc-sc.gc.ca/english/protection/warnings/2002/2002_56e.htm.

Sperm washing for pregnancy with HIV

Dr. Valeria Savasi from the University of Milan presented the latest results from their sperm washing insemination program for serodivergent couples (male is HIV-positive, female is HIV-negative) at the XIV International AIDS Conference. She noted that all couples should be screened first for infertility problems such as genital tract infections, sperm immobility or low counts, and female genital disorders such as endometriosis, tubal dysfunction, or anovulatory cycles.

Although the abstract reported 449 intrauterine inseminations in 175 couples, Dr. Savasi stated that over 4,000 inseminations in over 1,500 couples have been conducted since their program began. In her abstract, she reported a pregnancy rate of

10 percent. There has been no transmission of HIV to the uninfected female partners.

Source: *The Body*

Exercise may cut risk of metabolic syndrome

Researchers have found that men who exercised more than 3 hours per week decreased their risk of developing the metabolic syndrome by about 50% compared with the men who exercised no more than 60 minutes per week.

While previous reports have touted exercise's potential to reduce the severity of type 2 diabetes or heart disease, little evidence exists on whether physical activity prevents the metabolic syndrome that precedes these illnesses, researchers from the University of Kuopio in Finland report in *Diabetes Care*.

"These findings...suggest that intervention at an early phase in even relatively low-risk men may dramatically reduce the risk for development or progression of metabolic disturbances that eventually culminate in chronic and progressive diseases such as diabetes and (hardening of the arteries)," the researchers concluded.

Source: *Reuters* ⊕

AIDS Walk 2002 on September 22 was another resounding success. Photo, right: BCPWA Society chair Glen Hillson cuts ribbon to begin the walk, flanked by Chief Leonard George (l) and BC Premier Gordon Campbell



photos: Britt Permin



All talk and no action

Violence and HIV toll on women continues unabated

by Louise Binder

At the XIII International AIDS Conference in Durban two years ago, the link between HIV/AIDS, sexual violence, and coercion was on the conference agenda for the first time. Violence against women was finally recognized as one of the most overlooked factors driving the AIDS epidemic. At that time, 46% of infections worldwide were among women.

One would expect that two years later, this revelation would have led to strategies that reduced the number of women being infected. Nothing could be further from the truth. Fifty-eight percent of the 26 million people in sub-Saharan Africa infected with HIV are women, and a large proportion are young girls aged 15-24. In fact, two recent United Nations studies show that African women and girls are two to three times more likely to contract HIV than men are. Other studies yield similar findings in Brazil, Peru, and Thailand.

"The toll on women and girls is beyond human imagining," said Stephen Lewis, special envoy of the Secretary General of the UN at the XIV International AIDS Conference in Barcelona. He warned of a "looming cataclysm for the women of Africa."

Concurrent with the official AIDS conference, the "real" women's conference was taking place at modest government offices nearby.

The UN report blamed the "astonishing lack of knowledge about AIDS and transmission and prevention and sexuality among the young people." While these are no doubt important factors, other causes include the lack of treatment access, the continued violence against women, and the general lack of socio-economic power of women. The report concluded that violence with intimate partners is widespread and threatens women's ability to negotiate safer sex.

Former Canadian Prime Minister Kim Campbell gave an inspiring talk on the issue of women and power at a roundtable discussion. She clearly articulated the link between improving women's socio-economic and political power and reducing HIV infection rates. She also noted with disappointment that the women's move-

ment has generally not recognized AIDS as a feminist issue.

Those with the power to make necessary interventions have not turned this knowledge into a sincere commitment for action. In many areas, women are not permitted to own land, inherit property, borrow money, or run businesses. Lack of socio-economic status contributes to a culture that tolerates violence against women and directly affects the spread of HIV/AIDS.

Concurrent with the official AIDS conference, the "real" women's conference was taking place at modest government offices not far away. A collaboration of women's groups organized this four-day community program of women's activities, which consisted of a series of workshops, roundtables, and skills-building sessions.

Several barriers to treatment access were discussed, including

- the impact of the medical system's general lack of interest in women's health;
- the implications of the determinants of health, such as poverty, homelessness, education, and employment;
- cultural and religious policies and practices;
- fear of disclosure;
- lack of family-centered healthcare delivery systems.

Participants at this community symposium drafted a Bill of Rights for women. It declared a list of women's rights:

- dignity;
- equality;
- sexual and reproductive healthcare;
- freedom from fear of physical and sexual violence;
- education and information;
- employment;
- leadership roles in religious, cultural, and social institutions.

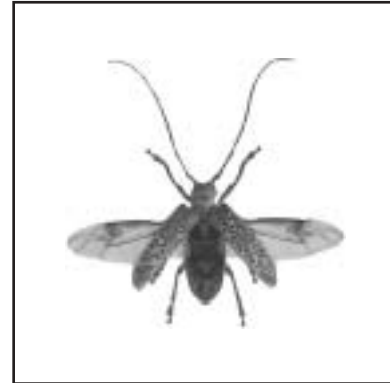
On the last day of the conference, a women's rally was held under the banner "Where are the Women?" Despite all the talk about the dilemmas women face that make them vulnerable to HIV infection, there seems to have been little progress toward solutions. In the 1990s, there was wide realization that a massive epidemic was raging out of control in poor countries, yet little action was taken. History is now repeating itself with the lack of response to the global catastrophe confronting women. ⊕

Louise Binder is chair of the Canadian Treatment Action Council and a member of the Ministerial Council on HIV/AIDS to the federal Minister of Health.

Bug chasing

Why do people deliberately seek to get infected?

by Andrew Barker



Bug chaser: A person who seeks to become infected with HIV.

Bug chasing: Actively engaging in sexual activity with the goal of acquiring HIV.

Gift: HIV.

Gift giver: A person who gives the gift of HIV to an HIV-negative person.

For years, rumours have circulated about gay men who set out to deliberately infect themselves with HIV. Whether it's through a personals ad, Web site, sex party, or other forum, some gay men are seeking HIV-positive men to be so-called gift givers who will give them the gift of HIV through condomless sex. This phenomenon (and the related language) first sprang up on various Web sites in the 1990s and was considered by many to be an urban myth. From perceived myth to reality—albeit, an unresearched one—we now know that bug chasing does, in fact, occur and not just in “other people’s communities.” Healthcare workers and HIV prevention staff throughout British Columbia have already seen isolated cases of bug chasing.

You may be asking yourself why someone would *want* to become infected with HIV. Surely not for the countless medical appointments and access to medications and their multitudinous side effects. However, for someone living in extreme poverty, there can be financial reasons for sero-converting, such as increased access to food and housing, entrée into social support networks, and until recently, a higher level of income assistance. As difficult as these reasons may be to accept, they make sense on one level. If basic immediate survival is at stake, then increased access to food, money, and housing may supersede long-term health concerns.

So what about those gay men who have been educated about HIV but make the deliberate decision to acquire it? For many of us, the idea that someone would want to become infected with a life-altering virus is inconceivable. However, that is precisely what a very small minority of gay men is choosing to do.

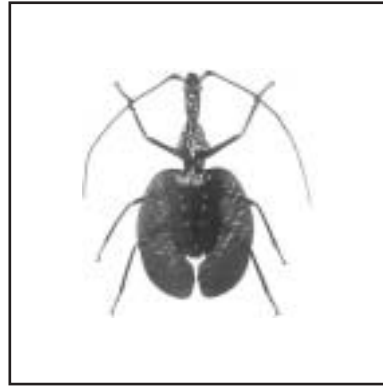
No hard statistics

Numerous articles have been written about bug chasing, yet very little research has been conducted. (This entire article is, in fact, based on anecdotal evidence from reputable sources such as counsellors, healthcare workers, and HIV prevention workers, not on hard statistics.) Not surprisingly, the stigma and fringe quality of bug chasing makes it something that very few people would admit to doing. Of course, people were saying the same thing about bareback sex a few years ago, and now the term—and the activity itself to a lesser extent—has become a normalized, if not accepted, part of gay culture.

Many gay men have seen friends and lovers die and may feel that HIV is an inevitability that they're tired of waiting for.

Perhaps the same factors that lead to someone having unprotected or bareback sex come into play with bug chasing. Various forms of abuse, drug and alcohol use, poverty, lack of social supports, homophobia, low self-esteem, poor mental health, perceived invincibility, survivor guilt, and other factors have all been cited as contributors to HIV vulnerability for gay men. Singly or in concert, these factors may result in someone's decision to forgo use of a condom.

Most gay men would tell you that they would prefer not to have HIV, yet some put themselves at risk anyway, causing great conundrums for prevention workers.



Dealing with the issue

An even greater conundrum is what to make of bug chasers. One school of thought says that we should grab these men by their shirt collars and give them a good hard shake. After all, they are being irresponsible with their lives and could ultimately end up costing the healthcare system large sums of money.

Then again, whose life is it? Do their bodies belong to themselves or to healthcare workers and taxpayers? Whose role is it to decide what is and isn't appropriate behaviour?

Vilification and punishments aside, perhaps these men deserve empathy and understanding. Many gay men have seen friends and lovers die and may feel that HIV is an inevitability that they're tired of waiting for. For HIV-negative men who are living in a community of HIV-positive men or for men who are in a serodivergent relationship (one partner is positive, the other negative), HIV can be an equalizer. It can be a means of acceptance and status, a way of truly understanding the experiences of so many other gay men and a way into social support groups, PWA retreats, and various alternative health services. Many of us know what social isolation and rejection can feel like.

Sexual thrill-seeking

Then there are the men who are bug chasers for the pure thrill of it. Many people engage in socially acceptable extreme sports for the rush, knowing that they're risking their lives jumping from planes or free-climbing a rock face. And

many do lose their lives. They are heralded by some as adventurous. One could argue that bug chasers are seeking a similar risky thrill.

A gay psychologist pointed out that people tend to become more conservative and take fewer risks when they have children. Gay men who don't have children or other responsibilities may be more inclined to take risks. For some gay men for whom sex is a recreational sport, the thrill and rush of possible infection can be the ultimate sexual high. Taking a load of potentially infected cum up the ass opens them to a level of intimacy and risk that has not been allowed by the AIDS establishment. It is at once both a rush—an intensely intimate connection with their sex partner—and a rebellion against safer sex.

Whether it is for social or personal acceptance, as a means of self-destruction, or for the ultimate sexual high, bug chasing is happening in our gay communities. It may make sense to you, or you may find the whole concept unbelievable. Consider this article a starting point for discussion. ⊕

Andrew Barker is a freelance consultant who focuses on gay men's health, health promotion, and community-based research. He has worked in gay men's health and HIV prevention for the past six years.



Buyer beware

Drug industry continues to lobby for direct-to-consumer advertising

by Philip Lundrigan

Since the mid-90s, the pharmaceutical industry has been very aggressively promoting its products, although what this industry calls a product is better known as a treatment or medication by consumers. This difference in terminology is more than just semantics. It is a fundamental difference in viewpoints. In a free-market society, a clearly defined relationship exists between the supplier of a product and the consumer of that product. The relationship adheres to principles of supply and demand.

In order to increase demand for their products, pharmaceutical companies invest quite heavily in promotion strategies. From the industry perspective, direct-to-consumer advertising (DTCA) is the most efficient and effective means of promotion.

Pharmaceutical companies are prohibited from using DTCA in Canada and most other countries because of concerns about safety and cost. In the United States, where such advertising has been permitted since 1997, regulators are rethinking their approach to DTCA because they are increasingly finding that instances of inappropriate advertising are resulting in either misleading or incomplete information.

In 2001, the pharmaceutical industry spent over \$2 billion on advertising in the US. Their counterparts in Canada have been applying more pressure to change the regulations here. They have been supported in their efforts to soften DTCA regulations by the Canadian media, who stand to cash in on the esti-

mated \$200 million that DTCA would generate annually in Canada.

Proponents of DTCA often use such words as “education,” “information,” and “promotion” interchangeably with “advertising” when attached to the phrase “direct-to-consumer.” These words conjure up entirely different images.



Information about cheaper, more efficacious, or less toxic products manufactured by competitors or about non-drug alternatives is not contained in DTCA. Advertisements are structured to present the product in the best possible light. In the US, these advertisements frequently come up short in presenting a fair balance between risks and benefits.

Information and education are fundamental to informed decision making. The most striking differences between

“education” and “advertising” are the scope, volume, and source of information that is presented. An advertisement presents information about one product. It is presented solely by the sponsor of the product, with the specific intention of increasing demand for that product. By contrast, education must be about enhancing overall knowledge and understanding.

Consumers have a right to accurate, complete, and balanced information about prescription drugs. Peer-driven programs such as community-based treatment information/education programs provide a more effective and less costly alternative to DTCA.

Consumers must mount strong opposition to DTCA in Canada. At the same time, we must exert pressure on the pharmaceutical industry to increase financial support for community-based treatment education initiatives. ⊕

Philip Lundrigan is a member of the board of directors of the Canadian Treatment Action Council. He lives in St. John's, Newfoundland. For more information about DTCA visit the CTAC website at www.ctac.ca.



THROWING A LIFE PRESERVER TO PREVENTION PROGRAMS

CBOs across the country respond to the need for new prevention strategies

by Sheena Sargeant

According to a recent national survey, only 54% of Canadians consider HIV/AIDS as a "very serious" issue. In response to this survey and to guidelines established at a national policy meeting earlier this year, Health Canada plans to launch a new national HIV/AIDS awareness campaign. Aimed at putting AIDS back on the Canadian popular agenda, this broad-based campaign marks one of several new prevention initiatives intended to support community based HIV/AIDS organizations (CBOs) in their individual activities.

Until recently, prevention initiatives had lost considerable momentum. The result has been rising infection rates, especially among particular groups of people. However, a great deal of dialogue about HIV/AIDS prevention is now happening across the country among key stakeholders, including government bodies, researchers, service providers, health-care professionals, and community members. Community groups have also begun to generate high-impact, targeted campaigns.

One of the most significant shifts in prevention initiatives is the move away from loose, diluted prevention messages to messages that are tailored to the specific needs and cultures of high-risk populations. These messages address the broader determinants of health so that people understand the context in which HIV exists.

CBOs are “moving beyond a model where the emphasis is on individual behaviour such as safer sex and needle exchanges,” notes Lori Crozier, executive director of Blood Ties Four Directions Centre in the Yukon. “The emphasis is now being placed on the social conditions that make some individuals and groups more at risk for HIV.”

HIV as part of the bigger picture

In that regard, it's difficult to encourage intravenous drug users to practice safer sex and use clean needles when many of them are living in poverty on the streets. HIV transmission through intravenous drug use is only one small piece of a very complex social picture, according to Ann Livingston, project coordinator for the Vancouver Area Network of Drug Users (VANDU).

Among aboriginal communities, generic campaigns have not been effective in speaking to the larger issues of alcohol and drug abuse and to the legacy of colonialism and residential schools that affect many aboriginal communities. Infection rates in aboriginal communities have increased steadily over the past two decades and show no sign of abating. Aboriginal peoples comprise only 2.8% of Canada's total population, but they represent a whopping 26% of all new HIV infections. That's why Elizabeth Benson at Healing Our Spirit in Vancouver sees a need for messages that are “consistent, repetitive, reliable, and culturally sensitive.”

Throughout Canada, community-based organizations are voicing concerns about funding levels, which have not increased nationally since 1995.

Targeting high-risk groups can be a challenge in itself. The most vulnerable populations are often the hardest to reach. CBOs continually fight to provide basic HIV prevention education to youth. Even when they make it through school doors, discussions of frank sexual behaviours and the risks involved are often barred. “When we neglect to talk about needle use, anal sex, and sex toys, youth are being taught not to believe that they are at risk unless there is penile-vaginal penetration,” says J. Evin Jones, executive director of YouthCO AIDS Society in Vancouver. “We know that this is simply not true.”

The importance of HIV testing

Encouraging people who engage in high-risk behaviour to be tested for HIV could provide an effective avenue for pre-

vention. Health Canada estimates that over one third of infected persons, or 15,000 people, have not been tested and are not even aware that they have the virus. “Knowing your HIV diagnosis is fundamental in making informed decisions about risk activity,” says Michael Rekart of the BC Centre for Disease Control. “If a person doesn't know they have contracted HIV, there is an increased likelihood that they may pass the virus on to someone else without their knowledge.”

When people go for an HIV test, the clinic has an opportunity to give them a refresher course on transmission. If an individual tests positive for HIV, post-test counselling offers an opportunity to discuss issues around disclosure and transmission. Healthcare workers can provide guidance on such sensitive topics as how to disclose to sexual partners and how to practice safer sex and safer injecting. They can also talk about the infected person's role and responsibilities in prevention.

The role of target communities

When targeting specific high-risk groups with tailored messages, it is not enough any more to merely point them to the “right” answers. CBOs need to ask community members what they think are the most effective ways of utilizing HIV/AIDS resources as a community.

James Murray, coordinator of Gay Men's Community Development at the AIDS Committee of Toronto (ACT), stresses the importance of involving target communities in prevention initiatives at all phases of project implementation. He feels that shifting control of community initiatives into the hands of the community itself is more likely to have a positive impact than ones designed by administrators in their offices. “Effective strategies are ones which are developed in partnership with community members and which utilize their networks, experiences, interests, and goals,” Murray says. “Simply saying, ‘condom, condom, condom’ is ineffective. I think we are trying to shift the discussion to: ‘What do you need to be happy? To be sexually satisfied? To be well in your life?’”

The same questions are being discussed in Vancouver with the creation of a new Gay Men's Health Centre. Phillip Banks at AIDS Vancouver envisions the creation of space that brings together the strengths of community groups across the city in the promotion of gay men's health. In this centre, Banks sees HIV/AIDS as one component working in tandem with other issues affecting gay men's health, such as homophobia and other sexually transmitted infections (STIs).

Involving PWAs in prevention initiatives is long overdue. For many years, HIV/AIDS prevention has existed in a vacuum, isolated from the experiences of those who have already contracted the virus. Community organizations are talking with their positive members about disclosure, about legal implications, about value systems, and about identifying their roles and responsibilities. At the same time, CBOs are taking care not to make this shift in prevention yet another burden for their members.

“HIV/AIDS has a lot of lessons to offer,” says Jonelle Garriock, health promotion worker at Blood Ties. “It teaches you about consequences, self-esteem, respecting yourself and others, making safer choices. It teaches about courage. It also has teachings about global inequalities and social inequalities. It teaches about discrimination.”

Health Canada pushes for integrated models

Neil Burke at Health Canada also sees the value of community development and the participation of HIV-positive individuals in program planning. He notes that Health Canada is working to better assess and increase the availability of models that amalgamate prevention, care, treatment, and support strategies. Following the recent national “Direction Setting” policy meeting, Health Canada put out a best practices request for integrated initiatives. Burke cites a number of reasons for this move, including the identification of treatment-resistant strains of HIV and the links between STIs and HIV transmission during unprotected vaginal/anal intercourse.

While that may sound like a good idea, many community organizations already face an overwhelming workload. Would this sort of amalgamation simply be another convenient way to place the entirety of community-based HIV/AIDS work into one neat and tidy fiscal package? Burke doesn't think so. He

Targeting high-risk groups can be a challenge in itself. The most vulnerable populations are often the hardest to reach.



hopes that groups will come to see the “value-added” benefits of this continuum. “We need to establish and maintain a coordinated framework for this integration,” he says. “We certainly need to examine the impacts of this endeavour and the roles of the feds, the provinces, and the territories.”

Burke realizes that many skeptics will think that the continuum is about money, but he argues that Health Canada feels differently. “It's about ensuring that our responses to HIV/AIDS reflect the changing reality of the Canadian epidemic.”

Tell that to the CBOs across the country. “I think we know what works: community-based, well-researched programs that build capacity in the community to address health needs,” counters ACT's James Murray. “The problem is that we don't have the human and fiscal resources to do them fully, comprehensively, pervasively, and with significant, on-going impact.”

CBOs feel the financial pinch

Throughout Canada, community-based organizations are voicing concerns about funding levels. They express a desire to do more—to provide better, more effective, hard-hitting, tailored prevention. But they are frustrated. Funding levels have not increased nationally since 1995, despite a growing HIV population and the continual addition of programs within each ASO to address the increasing needs of their members.

At AIDS Calgary, Katherine Morton expresses the frustration many small to mid-sized organizations feel with limited financial and human resources. “There is a challenge with so many groups and those messages need to be tailored.” Because of these limitations, many organizations are only able to provide “catch-all” prevention work that “doesn't reach everyone.”

Funding is a problem at provincial levels as well. Last year, the BC government regionalized HIV/AIDS funds. Perry Kendall, at the BC Ministry of Health, voices concern over the adequacy of these resources and the competition for funding it will fuel among CBOs. He also questions the stipulation that CBOs designate 25% of their programming to prevention in order to meet eligibility requirements. “The definition of this ‘prevention’ was left quite broad. How are we then to effectively measure this? How are we to increase our prevention focus and make it targeted?”

Community groups are continually thinking creatively in order to overcome these barriers to providing effective prevention programs. However, the bottom line is that it takes money to implement these initiatives. And organizations can't do it on their own. It will take a unified, concerted effort—and greater vigilance, as Canadians increasingly view HIV/AIDS as a “less serious” problem. ⊕



Sheena Sargeant is the educational programs coordinator for YouthCO AIDS Society.

A strong sense of community

The challenges of living with HIV in Northern BC

by Carlene Dingwall

People living on the margins of society are more vulnerable to HIV infection. As Northern British Columbians, we experience geographic marginalization, which translates into shorter life expectancies, lower birth rates, lower health statuses, and many other health-related issues.

Healthcare in Northern British Columbia is in a state of crisis and has been for a very long time. This is our reality. When we interject the issues of HIV/AIDS and hepatitis C into this picture, we see marginalized people living in a marginalized region trying to access a healthcare system that is in crisis.

The Northern Health Authority region encompasses more than half the geographical area of BC. One consistent concern that communities within this region raise is the lack of available physicians. Currently, 8,000–10,000 people are without a family doctor.

Health care in Northern British Columbia is in a state of crisis and has been for a very long time. This is our reality.

This region has no HIV/AIDS specialists, which means that HIV-positive people must travel to Vancouver on a regular basis for consultation. Because of this less than ideal situation, many people living with HIV don't have continuity in their healthcare. In addition, Vancouver can be a high-risk area, triggering a return to addiction behaviour. Travelling to the city for healthcare can actually be a health risk.

Living positive in Northern BC certainly has its challenges.

AIDS Prince George is a non-profit organization in the region that plays a central role in addressing the issues around HIV/AIDS and hepatitis C. Client support and community education are the two main services that AIDS Prince George provides. The ever-expanding nature of client support services involves addressing the multiple barriers HIV-positive people must manage on a daily basis. A spirited agency that fosters a sense of family, the client support services section of AIDS Prince George offers the support, stability, and sense of belonging that is crucial for people to come to terms with their HIV-positive status and to address issues that affect them in this rural community.

The community education service, which focuses on the prevention of HIV/AIDS, creatively addresses the issues related to

infection. It explores the relationship between HIV and problems such as racism, homophobia, and the social determinants of health. AIDS Prince George believes that the best AIDS educators are members of the community who are living with HIV. It therefore provides train-the-trainer education. One current project involves training First Nations people to become HIV/AIDS educators in their communities.

Living positive in Northern BC can also be a very positive experience.

Crisis often pulls people together. Because resources are so limited, a spirit of community develops between people and community agencies that is difficult to create in larger centres.



An HIV/AIDS conference held in Prince George in April 2002 brought together service providers from across the province. The conference, "Facing North," revealed that Northern British Columbians are a very progressive and cohesive bunch. Their vision is determined by the emergent issues faced by HIV-positive people, and their ability to meet those needs is directly related to the abundance of energy that is generated by living and working together as a caring family. In the words of Loretta Lynn, whose voice can still be heard on the radio in Prince George, "Maybe we ain't got much, honey, but we got each other." ⊕

Carlene Dingwall is a Metis two-spirited educator with AIDS Prince George, helping First Nations communities develop strategies to prevent the spread of HIV/AIDS.



The blame game

Behind every major epidemic is a conspiracy theory

by Paula Braitstein

One of the main distinguishing features of the AIDS epidemic compared to diseases such as cancer has been the discrimination that people living with HIV/AIDS face. Historically though, AIDS is only the latest in a long series of diseases for which ignorance and fear have shaped the public response. In fact, it is predictable that when a new epidemic emerges, particularly one that causes death or disfigurement on a large scale, people's reactions, motivated by fear, will be based on the social mores and values of the time.

Scapegoats through the ages

During the Black Death of 1346–1352, when thousands of people died from the bubonic plague (75% of those who became infected died), the extreme reactions of communities reflected their fear and panic. The plague, caused by a bacteria carried by fleas living on rats and other rodents, caused its victims to develop large painful swellings in their lymph nodes (called buboes), high fever, and black splotches from bleeding under the skin. Eventually the buboes would burst and the person would die a horrible death. People first thought the plague was caused by unfavourable astrological conditions. They also thought it was caused by miasmas, or noxious vapours, in the air.

However, when the epidemic didn't just blow over, it was assumed that someone—and not just something—must be responsible. Theories included deliberate contamination of the air by witches, Muslims (an idea proposed by Christians), Christians (an idea proposed by Muslims), and Jews (a theory proposed by both Muslims and Christians).

In Basel, Switzerland, city officials carried out the citizens' desires for retribution by enclosing the city's entire Jewish community in a wooden building and burning them to death. Victims of the plague, were sometimes executed by hanging or tortured by being placed on "the wheel" and having their limbs broken. In England, they locked people into their homes or "pest houses"—such as



a ship—to prevent the disease from spreading. This kind of quarantine probably just maximized the chance of being bitten by a contaminated flea.

A climate of xenophobia

Another example of how prejudice can insinuate itself into reactions to disease was in the emergence of syphilis in Europe in the 15th century. Xenophobia, the fear of others, represented the first wave of reactions: “Each newly affected country blamed their neighbours: Russians called it the Polish sickness, Poles, the German sickness, the Italians blamed the French, the French blamed the Italians,” writes Mary Spongberg in *Feminizing Venereal Disease: The Body of the Prostitute in Nineteenth Century Medical Discourse*. “In Asia, the Chinese blamed the Japanese, and the Japanese called it the Portuguese sickness. Muslims blamed Christians. The Moors were blamed in Spain and were driven out in 1492. Fallopius, the Italian anatomist, believed it was introduced to Naples by the Spaniards who mixed lepers’ blood with Greek wine. French observers believed it was introduced to their society by treacherous Neapolitans who put poison in their wells.”

In England and Scotland, women bore the brunt of the blame. In Aberdeen in 1497, the town council passed a decree that all loose women—that is, sex trade workers—be branded with a hot iron on their cheek and then banished from town. Bear in mind there was no germ theory of disease at this time. The intention was to distinguish the women who were blamed from upright women, who, of course, must have been immune to the disease. But they weren’t.

As time went on and more people became sick, doctors and officials came to believe that all women were possible sources of the disease. They theorized that normal vaginal discharges were actually sources of infection, and in 1830, the *Medical and Chirurgical Journal* concluded that “Purulent discharge may occur independently of sexual intercourse. Even the vaginal mucus of a maiden woman may be converted into a putriform fluid.”

During the Middle Ages, people had believed that leprosy was spread by having sex with a menstruating woman. Therefore, it came naturally that the “syphilis poison” must also have been introduced to men via menstrual blood. Spongberg notes in *Feminizing Venereal Disease*: “The hottest woman is colder than the coldest man: such a complexion is hard and extremely resistant to male corruption; nonetheless the putrid matter, coming from coitus remains in the womb and when a man penetrates her with his penis, made of sinews, enters into the vagina and, by virtue of its attractive force, attracts this matter to itself (and to the organs to which it is attached) and transmits it to them.”

Blaming the “women of the town”

The theory that women were responsible for spreading syphilis went even further. In an article published in 1836 in the *Lancet*, one of the world’s leading medical journals, it was suggested that there might be a “dose-response” effect of syphilis transmission, depending on the morals of the woman: “If delicate and modest

females, whose habits of life are moderate, who are cleanly in their persons, and who have never been tainted by venereal poison can inflict a gonorrhoea and sores, is it not fair, nay is it not an unavoidable conclusion that a ‘woman of the town’, labouring under high local excitement from venery, and high bodily excitement from drink would inflict a proportionately severe gonorrhoea and a proportionately severe sore.”

With continually increasing numbers of cases of syphilis, sex trade workers again became the focus of the public’s fear and panic. However, now this fear was entrenched through official public health initiatives. Medical professionals defined prostitutes as abnormal and classified them in the same category as alcoholics and lesbians. They presumed there must be some inherently pathologic nature to sex trade workers, so they began to look for medical abnormalities that would support their hypothesis. They did in fact find medical problems such as menstrual disorders and sterility, which are frequently seen among (disenfranchised) sex trade workers.

Thus, in the 1860s public health officials developed public health laws known as the Contagious Diseases (CD) Act, with medical evidence of the inherently pathologic nature of prostitutes in hand. This act dictated that any woman who was suspected of being a prostitute be forcibly hospitalized for up to six months, forcibly examined bi-weekly for up to a year under penalty of imprisonment, and forced to undergo “moral education.”

Disgusting, yes. But there was good news. There were doctors among the British medical elite who opposed the CD Act and challenged the idea that prostitutes were necessarily diseased. Then in the early 1870s, a group of women, including Florence Nightingale, Josephine Butler, and Mary Carpenter, wrote a petition called the “Ladies Manifesto,” collected signatures, and published it in the *Daily News*, resulting in the repeal of these punitive and misogynist laws.

Blame the victim

Many other historical examples are available of how we blame the victim for the diseases people get: smallpox, cholera, leprosy, and HIV/AIDS. Scientific empiricism is based largely on observation and association. The problem, of course, is that observations of associations are filtered through our social values, our fears, and our need to know.

Human beings don’t cope well with not knowing. Thus, a wrong answer is better than no answer, and the conclusions drawn are often based on half-truths. By knowing who to blame, we develop a sense of control over the situation—such as burning alive a community of Jews—and a plan of action. This need for control is why too often the first priority in responding to a health crisis is to establish blame. ⊕

Paula Braitstein is the senior policy advisor on health promotion for the BCPWA Society.

Secrets and lies

Stigma of disclosure a key prevention issue

by Glen Hillson

Disclosure of HIV serostatus has been a difficult issue for most PWAs since the beginning of the epidemic. In Canada and elsewhere in the northern hemisphere, gay men and injection drug users have been the most vulnerable to HIV infection and to the discrimination that goes with it. In the northern hemisphere, at least two-thirds of infections have been in gay men and men who have sex with men. Early in the epidemic, recipients of blood and blood products also accounted for a sizeable number of HIV infections. In the southern hemisphere, sexual transmission among heterosexuals accounts for the largest proportion of infections.

For gay men in North America, the gay rights movement was little more than a decade old when AIDS arrived on the scene. Gays were rapidly acquiring legitimacy as a social identity group. At the same time, they were experiencing sexual freedom and defining that freedom and their sexuality in distinctive ways.

As it became apparent that a plague was emerging that predominately occurred in gay men and which was likely related to sexual activity, there was a great deal of despair, denial, anger, and, of course, fear. In the 1980s, the political pendulum in North America had swung far to the right. Business and religious interests heavily influenced the ideologies of right-wing governments led by BC Premier Bill Vander Zalm, Canadian Prime Minister Brian Mulroney, and US President Ronald Reagan. Many people thought the epidemic was God's punishment. All the civil rights victories of the gay movement were in danger of being swept away by homophobes who would use AIDS as the cudgel to punish those who were already suffering and dying.

Fear of ostracism

Many gay men had adopted a sexual lifestyle that included frequent casual or anonymous sex with multiple partners. We met in parks, bathhouses, and bars, and often we had sex with very little prior conversation or exchange of personal information. Discussion of HIV status seldom occurred for many reasons. It didn't fit with

the excitement of spontaneous sexual encounters with strangers. Disclosure of positive HIV status had its own set of risks. HIV-positive people feared being cast as social pariahs accused of illegal behaviour and feared losing their cherished sexual freedom.

In addition to caring for those afflicted, one of the tasks of those in the community who first took up the challenge of responding to the epidemic was gathering and disseminating what little information was available about HIV transmission. Prevention efforts were well underway, even before the virus that causes AIDS was discovered.



From the mid-80s to the mid-90s, prevention campaigns were developed by community-based organizations working in partnership with government, public health officials, and other funders. Prevention work largely consisted of public awareness campaigns and condom distribution. These were augmented by support groups and discussion groups and by AIDS educators speaking to various audiences wherever opportunities arose.

With virtually no exception, the messages were directed at HIV-negative people. They sought to inform, support, and encourage the uninfected to practice safer sex and safer injecting habits to avoid contracting HIV. The critical role of HIV-positive people in prevent-

ing the spread of the virus was all but ignored. It is somewhat difficult to understand why this happened. After all, every time someone is infected, an HIV-positive person is one-half of the equation.

In that case, why were there no prevention messages that spoke to HIV-positive people, messages that provided information and support that would empower PWAs to make healthy choices for themselves and others in their community? One theory is that drawing attention to the roles and responsibilities of PWAs would fuel the fires of vigilantism in a political climate that was unfriendly to those who already lived on the fringes of society.

Civil liberties in jeopardy

In 1986, the BC provincial government passed legislation allowing for the quarantine of people with HIV/AIDS. (That legislation is still on the books.) The community was cautious about giving unnecessary exposure to the reality that the actions and behaviours of HIV-positive people were equally as important as those of HIV-negative people in the spread of the disease. For gay people, recently won civil liberties and other freedoms might have been in jeopardy if the large

In the '80s, civil rights victories were in danger of being swept away by homophobes using AIDS as the cudgel to punish those who were already suffering and dying.

er society saw gays as the vectors of catastrophic illness. For injection drugs users (IDUs), there were similar dangers of being exposed for criminal conduct or being mistakenly labelled as homosexual.

There were other shortcomings of the prevention strategies of the time. Despite growing recognition that the messages of prevention campaigns needed to move away from a "one size fits all" model, little effort was made to respond accordingly.

HIV/AIDS typically affects people who, for very different sets of reasons, are the most vulnerable. For gay men, two of the main contributors to vulnerability are homophobia and drug use. For

IDUs, society's persistent failure to recognize addiction as a health issue bolsters the stigmatization of drug use. For aboriginal Canadians and people of colour, racism creates vulnerability to HIV. Women are economically and socially disadvantaged throughout most of the world. Gender inequality leading to sexual and other forms of assault makes sexism the primary source of vulnerability. And so on.

Prevention campaigns on the wane

One might think that by the mid to late 1990s that increased knowledge about the spread of HIV would have led to improved prevention campaigns and greater success in quelling the spread of the epidemic. Instead, even the marginally effective messages from earlier times seemed to disappear.

Except for the recent "Arouse" campaign in Vancouver, there have been precious few visible messages about stopping the spread of HIV. The "Arouse" campaign was a reasonable start to getting the ball rolling again but was very limited in scope. The message was that HIV is still a serious matter and that HIV drugs are no picnic. Last year, a Toronto group launched the unfortunate "Condom Country—Ride Safely" campaign. With its outdated cowboy aesthetic, it appeared to be designed by and for the over-forty set.

We still have a very long way to go to develop evidence-based strategies sensitive to the needs and realities of different populations at risk. When people encounter a prevention message and think, "that's for someone else," it simply will not have any impact.

We have learned a lot about the spread of HIV/AIDS in the past twenty years. We need to continue to build on that evidence and hold our governments and community organizations accountable for getting prevention efforts back on track. It is only a matter of time before the volume is turned up on discussions about disclosure of HIV status. Now is the time to start preparing for those discussions to ensure people hear the valuable experience and knowledge of PWAs. ⊕



Glen Hillson is the chair of the BCPWA Society.

Upcoming BCPWA Society Board Meetings

Date	Time	Location	Reports to be presented
October 30, 2002	3:00pm	Training Room	Executive Committee / Written Executive Director Report
November 13, 2002	3:00pm	Training Room	Standing Committee / Written Departmental Reports
November 27, 2002	3:00pm	Training Room	Director of MVR / Written Executive Director Report
December 11, 2002	3:00pm	Training Room	Executive Committee / Written Department Director Report

The BC Persons With AIDS Society is located at 1107 Seymour St., Vancouver.

For more information, contact:

Katharine McEachern, Manager, Executive Operations

Direct: 604-893-2292

Email: katharin@bcpwa.org



treatment

information

TREATMENT INFORMATION PROGRAM MANDATE & DISCLAIMER

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

The Treatment Information Program endeavors to provide all research and information to members without judgement or prejudice. The program 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 program. 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 program is deemed to be accepting the terms of this disclaimer.

Why I chose heart over HAART

by *Devan Nambiar*

I just returned from a year in India. I miss the culture, the warmth of the people, the fiery sun, the torrential rains, and the lush greenery in Kerala. I miss the erotic temple sculptures of Khajuraho, local



foods (*idly, dosa, and chai*), Ayurvedic massages, and sunsets by the Ganges River. Life was so vibrant, intense, and fulfilling there that I hardly ever thought about my HIV status—or the medications and my blood work. But then, I haven't done either of those in nearly two years.

You may ask, "Is this denial or passive suicide?" Well, neither, really. I feel great.

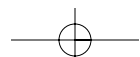
Though I am a little tired—of the HIV dos and don'ts: Do your blood work. Take your meds. Don't skip a dose. It's enough to give a person a migraine. Then we insist on the importance of quality of life.

Listening to my body

My non-treatment mode is not for lack of knowledge about such things. I'm quite well informed about treatments, clinical trials, and complementary therapies. I've taken triple-drug combinations and did my fair share of drug holidays before they were in vogue. I managed to achieve clinical efficacy and no drug resistance as I went back on the same combination after four drug holidays.

It's not luck. I just listen to what my body needs. This is an innate skill that one must cultivate over time: an eastern cultural belief, a knowing—not something one easily can explain to a person steeped in western culture.

I'm not worried about my blood counts. I stopped making fear-based treatment decisions and following what everyone else was doing a long time ago. Although studies have shown that muscle mass, bone density, height, weight, and body fat are different for women and men as well as for different ethnic populations, 90% of clinical trial participants are Caucasian



men. These clinical results are then applied to the general population. I write my own treatment guidelines based on my own clinical trials on my own body. When the need arises, I'll go back to getting my blood work done and taking meds.

Mantra initiation

In the west, we're so inundated with the allopathic AIDS mantra, making it seem like the only way to live healthily with HIV is by adhering to a regimen of scientific medicine. However, I believe that when you have made peace with life and death and have trust in creation, everything falls into place. It works for me. I've had HIV for twelve years.

My mantra is: "Health is a state of balance between mind, body, and soul." My recipe combines the best of east and a little of west: practicing yoga (for 21 years now); meditating daily; believing deeply in God; taking vitamins and supplements, as well as my Ayurvedic and Siddha (traditional Indian medicine) immune boosters; exercising regularly; using recreational drugs/alcohol minimally; maintaining a sense of humour; and having good creative sex!

Karmic callings

Each year my soulful desire beckons me to my parents' birthplace, India (I was born in Malaysia). I've been going to India for close to twelve years. I feel very at home there. My trips to the mystical land have taken me to spiritual centres, where I've met swamis, gurus, and other enlightened beings. I've spent time meditating in caves. I've done research into anti-HIV studies utilizing Ayurvedic and *Siddha* medicines and have met some of the researchers. This research has helped me discover more holistic treatments. Some of the immune boosters I've incorporated into my health regimen are *Bramha Rasayana*, *Aswagandha Leyham*, and *Narishamaya Leyham*—bio-available tonics prepared according to ancient Ayurvedic texts for boosting immunity, increasing muscle mass and energy, and reducing stress. Unfortunately, they're not available in Canada.

A visit to Tambaram Hospital on the outskirts of Chennai completed my journey this time. Tambaram is the largest AIDS hospital in South India. A trip to the hospital grounds dispelled any notion of wealth. Patients and families lined the road. Wild pigs, goats, and chickens were scattered about the acreage. This hospital is the best the government can do for the poorest of the



Entrance to Tambaram Hospital

poor—the abandoned, widowed, orphaned, illiterate, and marginalized AIDS patients.

When I first visited Tambaram in 1998, I was horrified at the plight of the AIDS patients, the opportunistic infections, wasting disease, and lack of access to things such as medications, food, and bedding. The scene took me back to the epidemic of the early 1980s in North America. I couldn't just walk away and pretend there was nothing I could do. So, upon my return to Canada, I set up the CareShed Project with assistance from a dear friend.

Through the CareShed Project, we raised funds to start a back-to-work program for the patients, hired a nutritionist, and built a room where patients' families can cook food and stay overnight. With my contacts in the AIDS community, I started a drug donations program to the hospital. I'm negotiating with Cipla Pharmaceuticals in India for low-cost anti-retrovirals. I suppose it's ironic that though I choose not to take meds, I'm making sure these patients get theirs. Choice is the operative word here.

My recent trip culminated at the children's AIDS ward in Tambaram Hospital. Seeing all the children was overwhelming, hardened even as I am by my years. I should be accustomed to this. But it angered me to see so much inadequacy. We have so few resources, the doctors explained to me. Then I look back and see so much wasted in the west.

A little goes a long way

I left Tambaram knowing that part of my life's mission was cut out for me: To make sure that the AIDS patients there get decent healthcare and access to medications and to ensure they know someone cares about them. With that goal, I know I'll be around for as long as it takes me to do what I must do, irrespective of my HIV status or my blood work.

I went to India for the first time in 1989, after I tested positive. I found my roots amidst the wealth, poverty, beauty, dust, silence, chaos, heat, rain, spirituality, compassion, and greed. India welcomed my soul; Tambaram set it free.

To read more on Ayurveda and Siddha medicines and the CareShed Project at Tambaram Hospital, check out <www3.sympatico.ca/devan.nambiar>.



Devan Nambiar is actively involved in HIV advocacy, research, and integrative health.

Grinding to a halt

Avascular necrosis can cause bones to collapse

by Carl Bognar

Since the beginning of the HIV/AIDS epidemic, people living with HIV have had to deal with a wide range of complex health problems. Now it seems that a new and potentially serious problem is emerging: osteonecrosis, a form of avascular necrosis (AVN) affecting bones.

“Necrosis” means death of tissue, and “avascular” means “without adequate blood supply.” Bones are living tissues and need a regular flow of blood to survive; in the absence of this blood flow, bones will die and possibly even collapse. The most common site for AVN is in the hips, which have a relatively constricted blood supply to begin with. However, AVN can also occur in shoulders, knees, feet, and wrists.

With AVN of the hip, the head of the femur—the large bone running from your knee up to your pelvis—can collapse. A collapse of the femur head leads to arthritis as the bone surfaces become deformed and start to rub against each other. This condition results in constant pain, especially while walking, but even while sitting or sleeping. There are only two ways of managing femur head collapse, by controlling pain or by replacing the hip. No other treatment beyond these two options is available. Currently, the wait to see an orthopaedic surgeon can be as long as one year, with another one-year wait before surgery can be scheduled.

Researchers don't know yet what causes AVN in HIV-positive people. Usually AVN is only found in people who have a history of excessive alcohol use, who have used corticosteroids for a long time to treat conditions such as lupus or arthritis, or

who have a history of traumatic injury.

Some researchers suspect that AVN may result from use of protease inhibitors (PIs), though they have yet to prove it. A possible explanation would be that PIs

Some researchers suspect that avascular necrosis may result from use of protease inhibitors, though they have yet to prove it.

strip fat from cheeks and buttocks—a well-known issue—and circulate this fat through the blood system. The circulating fat then blocks blood supply to the bones. The hips are especially vulnerable because they have little blood supply to begin with.

Early studies indicate that AVN occurs in HIV-positive people who have had HIV for a long time and who, perhaps, have more successful immune reconstitution. This idea has led other researchers to suggest that AVN is a by-product of HIV itself, but an easy explanation of why HIV or immune reconstitution would cause AVN has not yet been brought forth.

The cause(s) of AVN will be difficult to sort out. After 1996, when the standard of HIV treatment shifted to include multiple drug cocktails (highly active antiretroviral therapy, or HAART), over 90% of people treated for HIV were treated with protease

inhibitors. AVN was rarely seen before HAART, but HAART has extended the expected lifespan of people with HIV. It may well be that HIV and PIs (or other HAART drugs) both contribute to AVN. In some places, such as the State of New York, HIV treatment guidelines now recommend that PWAs who have proven cases of AVN should switch from PIs to another regimen and that they should be referred to a physiotherapist for continual treatment.

AVN has the potential to disable people living with HIV, and the causes clearly require attention from researchers.

What you should do:

- Report any hip or bone pain (especially in the legs) to your doctor and ask to have it investigated. Stiffness or reduced range of motion may represent earlier stages of AVN, and you may want to have this investigated, too.
- If you have AVN, take steps to avoid bone collapse, which can be painful. Avoid running and jumping. Cushion your feet, legs, and hips as much as possible by wearing soft-soled footwear and thick socks, even at home.
- Quit smoking. Smoking reduces the amount of oxygen that can be delivered to your bones.
- Avoid excessive alcohol. ⊕

Carl Bognar is the prevention coordinator for the BCPWA Society.



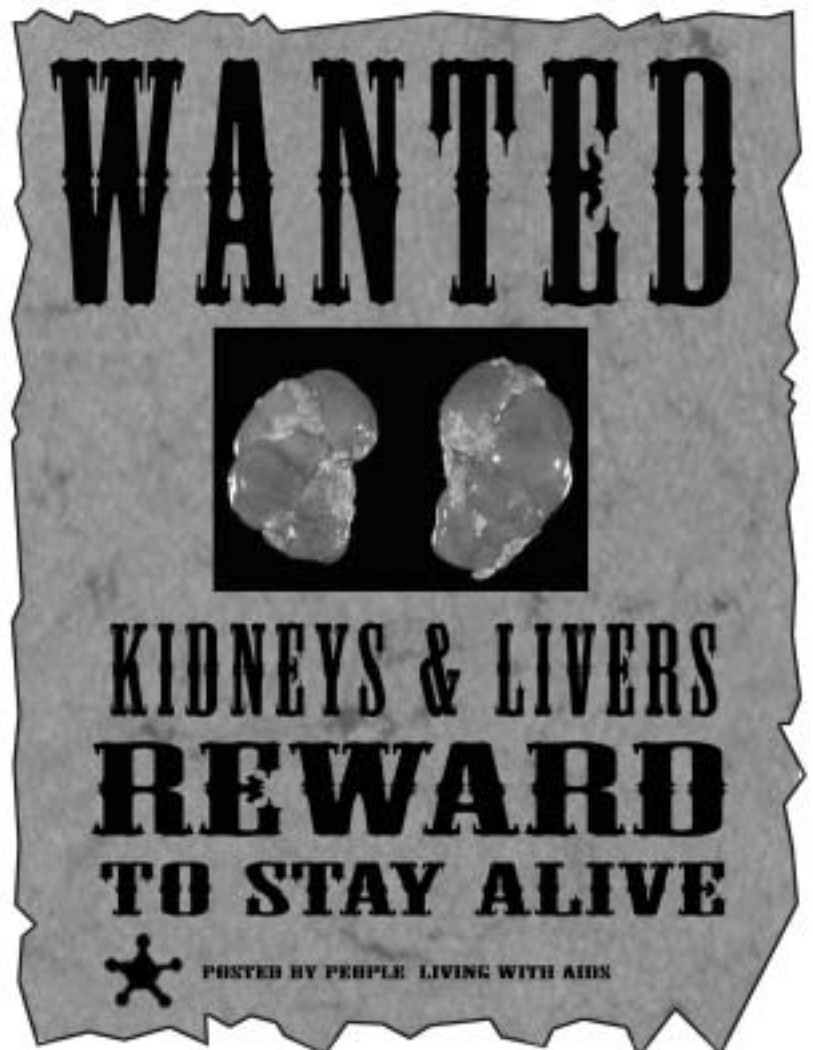
Wanted: kidneys and livers

PWAs try to break open the organ bank

by Paula Braitstein

Historically, being HIV-positive was considered an “absolute contra-indication” to getting an organ transplant. Consequently, there has yet to be a person in Canada living with HIV/AIDS to receive a transplant. Initially, it was thought that people would die of AIDS before they were able to get any real benefit from having a new organ such as a liver. It was also believed that the immune suppressive drugs that a transplant recipient must take to avoid rejection of the organ would aggravate the HIV disease. These issues, combined with the relative rarity of organs available for transplantation, meant that in the pre-HAART era it just didn't make sense for most HIV-positive people to get transplants.

Things are different today. Treatments such as highly active antiretroviral therapy (HAART) can extend a person's life for many years. At the same time, people living with HIV often have any one of a number of complicating conditions: hepatitis B or C, which can cause serious liver damage; diabetes, which can often result in needing a kidney transplant; and toxic side effects of antiretrovirals, which over time can interfere with organ function. However, not only are people living with HIV/AIDS for much longer and with better health, but because they are living longer, they are increasingly in need of organ transplantation in order to continue to survive.



HIV and transplantation, pre-HAART

Several pre-HAART era reports on individuals who were either infected with HIV at the time of the transplant (peri-operatively), or were retrospectively found to have HIV, suggested that the progression to AIDS in these individuals was extremely rapid. However, cases were also reported of HIV-positive people who received transplants and maintained normal graft function for at least eight years following the transplant.

Reports also show long-term graft survival in the presence of immune-suppression with variable rates of disease progression and death. The importance of these reports is that they concluded that AIDS progression was the most common cause of death in HIV-positive transplant recipients during this pre-HAART period.

“All published reports of transplantation in HIV-positive patients who are receiving multi-drug antiretroviral regimens have concluded that, in most cases, HIV infection does not affect the outcome of the transplantation.” – *New England Journal of Medicine*, July 2002

HIV and transplantation, post-HAART

Since 1996 and the use of HAART, the situation has changed substantially for HIV-positive individuals requiring transplantation. Reports from the United States, the United Kingdom, Japan, and elsewhere all suggest that liver transplantation is a viable option in terms of both overall survival and graft survival for people living with HIV/AIDS. The reports of these transplants show that there is variation in terms of survival rates and other outcomes among the HIV-positive individuals.

The largest group of HIV-positive people to have received transplants shows that their rate of survival at one year is roughly equivalent to the rate among HIV-negative people, at just over 90%. The variability in the other reports is due to a number of factors:

- many of the patients also have or had hemophilia;
- some had hepatitis C and some didn't;
- some were treated for hepatitis C and some were not;
- some were treated for hepatitis C with Rebetron (ribavirin and recombinant interferon alfa-2b) and some with pegylated interferon;
- patients were immune-suppressed with a variety of agents which may have influenced their survival;
- some had histories of AIDS-defining illnesses, while others did not.

In general, the data suggest that although not uniformly successful—nor are transplants in HIV-negative individuals

uniformly successful—transplantation offers an intervention resulting in increased survival, where otherwise death would be imminent.

Hepatitis C co-infection

Most of the deaths among HIV-infected individuals in the post-HAART reports were among those who were co-infected with hepatitis C, and the causes of death were not HIV-related. Causes of death in the HIV-negative, hepatitis C-positive populations were reported as infection, cardiac complications, graft failure, and multi-organ failure. These reported causes were not different from the causes of death of transplant recipients who did not have hepatitis C. As well, these causes of death are not substantially different from the causes of death in the HIV-positive recipients.

It is important to consider that novel and more effective drugs for hepatitis C are in development. A liver transplant may provide many people with the extra time needed until these improved drugs are available. Even though hepatitis may be the major complicating factor for an HIV-positive person needing a transplant, hepatitis C is also the leading cause of liver transplants in the United States and elsewhere.

HIV management issues

The literature indicates a number of important post-surgery issues specific to people living with HIV/AIDS. These include antiretroviral management and avoiding drug interactions with immune suppressants. Important references show that many positive and negative interactions occur between immune-suppressive drugs (exogenous immune suppressants) and antiretrovirals.

Much debate surrounds the use of cyclosporine to treat HIV. Researchers have noted that many of the HIV-positive transplant recipients who survived long-term prior to HAART were immune-suppressed with cyclosporine. While cyclosporine may be beneficial to HIV-positive patients, other exogenous immune suppressants may be harmful. The required amount of exogenous immune suppression in HIV-positive liver transplant recipients is unknown, but it is believed to be similar to non-HIV-infected transplantation recipients.

The use of antibiotic prophylaxis for opportunistic infections is an important consideration for both HIV-infected and non-infected transplant recipients. While the issue of preventing opportunistic infections is important for both groups, drug interactions with antiretroviral medication is a further complication among HIV-infected patients.

The ethics of transplantation

Several ethical issues arise about whether HIV-positive people should receive transplants. Transplantable organs are scarce; therefore, determining the most ethical system

continued on next page

of allocation requires simultaneous consideration of efficacy, urgency, and equity. The number of HIV-infected patients to have received transplants is still small enough that a direct comparison of efficacy is not yet possible. However, preliminary data do suggest that the rates of favourable outcomes between HIV-positive and HIV-negative recipients are similar.

Even if HIV-positive individuals have somewhat poorer outcomes, relative efficacy should not be the sole ethical criterion for determining eligibility. Patients with hepatitis C, diabetes, older patients, women, and African-American and Asian patients have more post-transplantation complications and diminished survival. These patient groups are nonetheless eligible for transplantation.

Medical urgency is the primary criterion for determining patient eligibility in the United Network for Organ Sharing (UNOS), and their policy regarding HIV/AIDS states clearly that HIV-seropositivity shall not automatically exclude individuals from receiving a transplant. The notion of medical urgency helps explain why patients who require retransplantation routinely receive it, even though the probability of survival in these people is substantially diminished.

A proposal is circulating to provide HIV-positive individuals with so-called marginal organs, such as organs from older individuals or other HIV-positive individuals. However, the outcomes for recipients of marginal organs are typically worse than outcomes for recipients of healthy organs. Furthermore, if an individual is medically recognized to require an organ transplant and meets the criteria for transplantation (such as medical urgency), no ethical justification can exist for providing this individual with anything but an ideal organ. It should be noted, however, that people with hepatitis C requiring liver transplants do receive HCV-positive donor organs in about 2–3% of cases. These livers are considered marginal, although they are only used when there is no fibrosis found on liver biopsy.

“The BC Transplant Society believes that the health-restoring benefits of organ transplant services should be available to those individuals who meet the suitability and eligibility criteria for transplantation in British Columbia.” – www.transplant.bc.ca

Conclusions

Sufficient evidence now indicates that, thanks to HAART, HIV-positive individuals can be the successful recipients of liver transplants. Regarding HIV as an absolute contra-indication to transplantation is a historical artifact and a practice

not based on current medical evidence. Ethical considerations regarding HIV-infected individuals are now on a par with other chronic illnesses, such as hepatitis C mono-infection, diabetes, or hemophilia.

The factors that will increase the probability of successful transplants in HIV-positive people include the following:

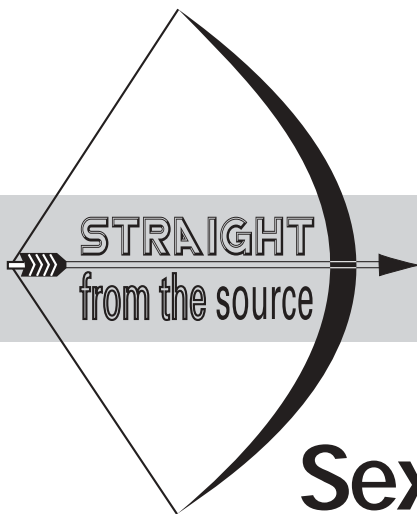
- The ability to suppress HIV replication using combination antiretroviral medication.
- A high CD4 count. It is more likely that the patient will survive if s/he is healthy at the time of transplant.
- Access to a multidisciplinary team of healthcare providers. In addition to hepatologists, clinical immunologists, and transplantation surgeons, this team must include a knowledgeable pharmacist, an HIV specialist, and a strong psychosocial support component.

While hepatitis C co-infection is an important negative prognostic factor, it is a leading cause of liver transplantation in the HIV-negative population, and with appropriate therapeutic management with the most effective anti-viral agents available (such as pegylated interferon combined with ribavirin), the probability of aggressive hepatitis C reinfection of the graft is minimized.

Transplanting the organ of an individual who is dying of AIDS would be an inefficient use of valuable resources in the same way that transplanting someone with metastatic liver cancer would be inappropriate. Both individuals would probably die of their respective illnesses before receiving any significant benefit from the new organ. However, in the era of HAART, people are *living* with HIV/AIDS—people are returning back to work, to school, and to life. ⊕



Paula Braitstein is the senior policy advisor on health promotion for the BCPWA Society.



what's new in research

Sex & drugs & hepatitis C

by Kevin J.P. Craib

The World Health Organization has estimated that three percent of the world's population (approximately 170 million) is infected with hepatitis C virus (HCV). In the United States, four million people are believed to be infected. In Canada, HCV infection ranks second among nationally reported diseases, with an estimated 225,000 to 300,000 individuals currently infected.

In both the United States and Canada, the majority of HCV infections have been associated with injection drug use or with transfusions of blood or blood products prior to 1990. But the sexual transmission of HCV remains a matter of debate, despite the presence of viral particles and HCV ribonucleic acid (RNA) in saliva and genital fluids.

Some evidence of sexual transmission of HCV has been provided by studies of heterosexuals and female sex workers. Center for Disease Control sentinel studies have suggested that 15–20% of patients with acute hepatitis C infection have a history of sexual exposure in the absence of other risk factors. However, other studies of heterosexuals have shown that transmission rates are low among monogamous, stable sexual partners of individuals with chronic HCV infection.

Evidence of sexual transmission of HCV has also been provided by studies of homosexual men. A study conducted in Italy reported that prevalence of HCV was higher among homosexual males compared to heterosexual males. An American study concluded that HCV infection in the male homosexual population is associated with sexual practices such as insertive anal intercourse. In contrast, other studies have suggested that HCV infection is uncommon in homosexual men, that sexual practices appear to play a minor role in its transmission, and that sexual transmission is rare in this population.

The Vancouver Lymphadenopathy-AIDS Study (VLAS) recruited more than 700 gay men aged 18–75 into a longitudinal study during the period November 1982 to December 1984. Participants were recruited through six primary care practices in central Vancouver. An investigation was carried out in Vancouver

to determine the prevalence of HCV infection in sexually active homosexual men and to identify risk factors (injection drug use, sexual practices, substance use, and HIV infection) associated with HCV infection. The most recent blood specimen from each of 662 VLAS participants was tested for HCV antibodies.

The study identified a total of 39 of 662 participants (6%) as HCV-positive. HCV prevalence was significantly higher among HIV-positive men compared to HIV-negative men (9% versus 3%).

Men who reported using injection drugs during their lifetime were estimated to be 30 times more likely to be HCV positive. HCV-positive men were also more likely to report having 20 or more male sexual partners in the previous year and 100 or more partners in their lifetime. These men were more likely to report engaging in active oral-anal contact, receptive anal intercourse, and insertive fisting with their sexual partners.

Self-reported use of psychoactive drugs—including MDA, LSD, cocaine, and amphetamine—and tobacco was also significantly higher among infected men. Among men who did not report any injection drug use, insertive fisting and active oral-anal contact were identified as significant risk factors. Men who engaged in both insertive fisting and oral-anal contact were three times more likely to be HCV-positive compared to men who did not.

This study of homosexual men demonstrated that a history of injection drug use was the primary risk factor for HCV infection. However, the data from this study also provide evidence of sexual transmission of HCV, accounting for approximately 50% of cases in this cohort. ⊕



Kevin Craib is the data centre director at the BC Centre for Excellence in HIV/AIDS and an instructor in the Department of Mathematics and Statistics at Langara College.

Barcelona briefs

More treatment news from the XIV AIDS conference

by Paula Braitstein



Pegylated now!

In a head-to-head comparison of pegylated interferon and ribavirin versus regular interferon and ribavirin, researchers found that using the pegylated version was most advantageous to people with HCV genotypes 1 or 4, the genotypes most commonly found in people who are also HIV-positive. Two individuals in this trial died of lactic acidosis. Both were on d4T (stavudine, or Zerit) and ddI (didanosine, or Videx), but the investigators felt that the ribavirin may have exacerbated the mitochondrial problem, which causes lactic acidosis.

Good news

Pittsburgh is leading the world in kidney and liver transplants among HIV-positive persons. Dr. Michelle Roland reported 45 cases (26 kidney, 19 liver) of HIV-positive solid organ transplants. Individuals were eligible if they had no history of major opportunistic infections and could tolerate antiretroviral therapy, preferably with a fully suppressed HIV viral load. Patients seeking liver transplantation had to have a stable CD4 count of over 100 cells/mm³ for at least three months prior to the transplant.

The average follow-up time thus far is 314 days, with a range of three days to 1696 days. There have been six deaths to date; two among kidney transplant patients and four among liver transplant patients, one of whom died from full-blown hepatitis C at 15 months post-transplant. One rejected the liver transplant after discontinuing HAART at 18 months post-transplant, and one died of post-operative pancreatitis. Several complete organ rejections occurred, of which 38% were in kidney recipients and 21% in liver recipients.

Despite these setbacks, the one-year survival rate among the whole group is encouraging. HIV-positive participants had a one-year survival rate of 92% for both kidney and liver transplants. HIV-negative participants had a one-year survival rate of 95% for kidney transplants and 88% for liver transplants.

Switching off a PI

Another head-to-head study compared 460 people who were randomly switched from two nucleoside reverse transcriptase inhibitors (NRTIs) plus a protease inhibitor to nevirapine (a non-nucleoside reverse transcriptase inhibitor, or NNRTI), the NNRTI Sustiva (efavirenz), or the NRTI abacavir.

When researchers looked only at people who remained on treatment for the entire year, the following proportions of people were able to sustain a viral load of below 200 copies/ml for the whole time:

- > 94% who took nevirapine;
- > 94% who took Sustiva (efavirenz);
- > 87% who took abacavir.

This difference was almost, but not quite, statistically significant.

When they looked at the whole group of people, irrespective of whether they had completed the treatment or not, they found the following proportions remained below 200 copies/ml:

- > 78% of people on nevirapine;
- > 74% of people on Sustiva (efavirenz);
- > 77% of people on abacavir.

These differences were not statistically significant. They all had similar increases in CD4 cells of about 45 cells. A much lower proportion of people on abacavir stopped the study

because of side effects (6%) compared to nevirapine (16%) or Sustiva (17%). This difference was statistically significant.

Supercalagilacticacidosis

Lactic acidosis is a potentially fatal condition. It is associated with the use of nucleoside antiretrovirals, particularly d4T and less so ddI. This presentation reported on several cases of lactic acidosis among HCV co-infected individuals in a hepatitis C treatment trial. It was suspected that ribavirin, also a nucleoside drug and one of the HCV treatments, might have increased the incidence of lactic acidosis among co-infected individuals receiving HCV treatment. In fact, though there were small numbers, the proportion of instances of lactic acidosis between the two groups (HCV treatment versus no HCV treatment) didn't differ. Nearly all the people who developed lactic acidosis were taking d4T.

Keeping the CD4 count stable

The International AIDS Society published updated treatment guidelines for HIV infection in July. Dr. Michael Saag referred to them in his plenary session talk. He indicated that once someone has developed viral resistance to two or more classes of drugs and for whom reaching below the limit of detection is no longer an option, the goal of antiretroviral therapy should be revised. The goal should become keeping the viral load to approximately 3 logs before what it was when the person began antiretroviral therapy—if it's known. This seems to be enough to keep the CD4 count—the main predictor of disease progression—stable.

To stop or not to stop

Dr. Saag commented briefly on the use of structured or strategic treatment interruptions (STIs). When people take STIs, their CD4 counts drop virtually immediately, and they often develop opportunistic infections rapidly. He warned that STIs should only be pursued when the lowest CD4 count you've ever had is more than 350 or if it's done in the context of a clinical trial.

Tenofovir versus d4T as a backbone drug

Tenofovir, a nucleotide drug, was compared to d4T, a nucleoside, in combination with 3TC and Sustiva (efavirenz) in a study of 600 treatment-naïve individuals who randomly received either tenofovir or d4T with the other drugs.

Both groups were equally likely to reach a viral load response of below 400 copies (87%) and below 50 copies (82%). Similarly, they were equally likely to have a CD4 cell increase of about 160 cells and to have moderate to severe adverse effects (18%). Two percent of people taking tenofovir had peripheral neuropathy, whereas 9% of those taking d4T experienced it. None of the people taking tenofovir developed lactic acidosis, compared to 1% of those taking d4T. Two percent of the tenofovir group developed high triglyceride levels, versus 8% of the d4T group. All differences were statistically significant.

Serostim for lipodystrophy

The human growth hormone Serostim used to be taken for wasting—in the rare cases people could afford it, since it cost about \$18,000 for a six-month course. The biotech company Serono is now looking at its applicability for reducing lipodystrophy and, specifically, for reducing visceral adipose tissue (VAT), the “protease paunch.” This 12-week study explored different doses. The investigators found significantly reduced VAT with the growth hormone. The more used, they found, the greater the change. People experienced increases in both weight and lean body mass, as well as decreases in both total cholesterol and non-HDL cholesterol levels. However, glucose concentrations also seriously increased, with most cases requiring either dose reduction or study discontinuation.

The author did not present percentages of side effects or study discontinuation and did not put any of the adverse effect information on the slides or in the abstract. This presentation was a lesson in corporate manipulation of readers and listeners.

Gp120 clinical trial

This international preventive vaccine trial will not have data available until late 2003, but no serious adverse events have been reported so far. After looking at the safety and efficacy of the vaccine at the mid-point of the trial, the Data Safety Monitoring Board (DSMB) decided that the study should continue, which means that none of the findings caused enough alarm to warrant discontinuation of the study.

“Treatment optimism” is bunk

One of the main hypotheses to explain the seroconversion of so many gay and bisexual men is the concept of treatment or HIV optimism: the notion that treatment advancements for HIV infection lead to an increase in risky behaviour because people believe that “HIV doesn't matter any more.” Research from Switzerland, Chile, Côte d'Ivoire, Netherlands, and Canada all suggest that this hypothesis isn't true. While nobody is sure what the answer is to this important question, it certainly does not appear to be related to antiretroviral therapy.

Bad news

No longer a news flash, a study was presented confirming that having both HIV and hepatitis C (HCV) is bad news. HCV mono-infected individuals had a projected average liver disease progression (cirrhosis) rate of 33 years from time of infection compared to co-infected individuals who had a significantly faster projected average progression time of 22 years. Everyone who is HIV-positive should have a hepatitis C antibody test. ⊕

Paula Braitstein is the senior policy advisor on health promotion for the BCPWA Society.

HAART attack

Metabolic complications of antiretrovirals

by *Diana Johansen*

Cardiovascular disease (CVD) refers to any disease of the heart (cardio) or blood vessels (vascular). The most common condition is atherosclerosis, the thickening and hardening of the arteries.

Atherosclerosis develops when fats, cholesterol, and other substances are deposited in the inner lining (endothelium) of the arteries. These substances can accumulate and form plaques. If the plaques grow large enough, they reduce blood flow through the artery, or they may rupture and form blood clots. These blood clots can block the artery at that location or break off and travel to other parts of the body. If a blood vessel that supplies the heart is blocked, it causes a heart attack; if a blood vessel that supplies the brain is blocked, it causes a stroke; if a blood vessel that supplies the legs is blocked, it can cause difficulty walking and, eventually, gangrene.

Elevated cholesterol and triglyceride levels, high blood pressure, and smoking tobacco have been proven to hasten the progression of atherosclerosis. Other risk factors include getting older, male gender, heredity, diabetes, obesity (especially central), and physical inactivity.

Cardiovascular disease is an important health issue for people with HIV infection because many of the metabolic complications of highly active antiretroviral therapy (HAART) include risk factors for accelerated development of atherosclerosis.

Risk factors of CVD

At the XIV International AIDS Conference in Barcelona, Dr. Judith Currier reminded us that the typical complications associated with HAART, including high LDL cholesterol and triglyceride levels, low HDL cholesterol levels, increased amounts of visceral fat, and insulin resistance, were independently associated with increased risk of cardiovascular disease. In other words, these symptoms increase the risk of CVD regardless of HIV infection or HAART.

Dr. Currier presented data comparing three different antiretroviral regimens, Combivir/abacavir, Combivir/nelfinavir, and d4T/3TC/nelfinavir, for changes in cholesterol and triglyceride levels after 48 weeks. Although changes were seen in all groups, the biggest changes were in the d4T/3TC/nelfinavir group. She and her group of researchers also found that there was a greater prevalence of diabetes in all age groups of HIV-positive people compared to HIV-negative.

The clinical data also suggested that an increased risk of having a heart attack was evident for HIV-infected persons with increased time on HAART or on a protease inhibitor if there were other risk factors present. They found that 63% of patients on protease inhibitors had insulin resistance, which was sometimes masked. People with visceral fat were more likely to have poor glucose tolerance. Having high blood pressure also correlated with visceral fat and elevated triglyceride levels.

In Dr. Currier's opinion, it is important to assess HIV-infected individuals for all the risk factors for CVD, not just HIV-related ones. All the modifiable risk factors should be identified and addressed through therapeutic lifestyle changes, which include eating a balanced diet, exercising, quitting smoking, and losing weight (if the person is overweight). Dr. Currier concluded by saying, "Making changes in a life-sustaining ART regimen without addressing the modifiable risk factors may be premature."



Clinical implications

In another presentation, Dr. Paulo Tebas talked about the clinical implications of metabolic complications associated with HAART. He started by saying that the prevalence of fat redistribution is 20–80 percent, depending on how it is defined. He commented on the psychosocial effects of stigmatization and easy identification of HIV infection, as well as the decreased self-esteem, sex drive, and daily performance that affect many people with this syndrome. The combination of fat redistribution and metabolic complications creates a constellation of risk factors for cardiovascular disease. He suggested that the most important ones are elevated triglyceride levels, low HDL levels, high blood pressure, and high blood sugar levels.

According to Dr. Judith Currier, it is important to assess PWAs for all the risk factors for cardiovascular disease, not just HIV related.

Dr. Tebas then presented the theory that lipodystrophy may result in decreased adherence to HAART, which then increases virologic factors and ultimately influences the risk of HIV transmission, decreases individual productivity, and increases morbidity (disease). Dr. Tebas also recommended lifestyle changes. Contrary to Dr. Currier, he said that in looking at data from a two-year period, he could find no evidence of increased hospital admissions or death due to CVD in HIV-infected individuals on HAART.

The prevalence of CVD

Dr. Thomas Luscher, a cardiologist, began his presentation by stating that cardiovascular disease is the most common cause of death in the

developed world, incurring enormous social and medical costs.

Dr. Luscher stated that HIV infection increases CVD risk because of lipid abnormalities, insulin resistance, diabetes, high blood pressure, early menopause, and perhaps the inflammation caused by HIV. The final pathway in the development of atherosclerotic plaques is inflammatory, and HIV is an inflammatory disease. High cholesterol levels contribute to plaque formation and decrease the ability of blood vessels to dilate. Given that serum cholesterol level predicts lifespan, he said, if you change your cholesterol level, you can increase your lifespan.

The bottom line

Cardiovascular disease is emerging as a potential health concern for people on HAART. Metabolic complications and fat redistribution include symptoms that are known to be associated with increased risk of CVD, but the long-term consequences of having these increased risk factors is still unclear. Several screening tools identify a person's risk factors, and they are helpful in identifying who may be at the most risk. It is particularly important to identify the modifiable risk factors so that these can be changed.

The smart thing to do while waiting for more information is to adopt therapeutic lifestyle changes: eating a balanced diet, exercising, losing weight (if you are overweight), and quitting smoking. It is important to see these changes as steps in a life-long process towards better health, not a temporary treatment for a specific problem. Healthy living is a long-term investment. ⊕



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

HIV positive people needed to provide volunteer Peer Treatment Information Counselling.

BCPWA'S Treatment Program needs HIV+ people who:

- *want to take an active role in learning about HIV and treatment*
- *will provide treatment information and support for individuals*
- *want to make a difference —Empower!*
- *are outgoing and friendly*
- *are able to commit to one shift a week for 3 hours*

Training starts in October.

If interested please contact Zoran (BCPWA)

604.893.2239 or email Zorans@bcpwa.org

Join the tip team!

Endocarditis in injection drug users

by *Fiona Gold*

Endocarditis is an inflammation of the inner lining, or endocardium, of the heart. This very delicate lining covers the inner chambers of the heart and the four heart valves.

Endocarditis can be caused by rheumatic fever or a bacterial infection. Injection drug users may develop endocarditis through bacteria or fungi entering the bloodstream at the same time drugs are injected.

The acute form can have a rapid onset and can be caused by *staphylococcus aureus*, Gram-negative bacteria, and fungi. The subacute form, which is usually caused by alpha-hemolytic streptococci or other bacteria, takes longer to develop. These bacteria and fungi can

damage the inner lining of the heart and cause damage to the heart valves. The result is circulatory problems.

Sometimes endocarditis is difficult to detect. Symptoms are non-specific and include not feeling well, fatigue, fever, shortness of breath, chest pain, and cough.

Usually the treatment for bacterial endocarditis is a ten-day course of antibiotics. Because of the serious nature of endocarditis, these antibiotics are usually given intravenously in a hospital.

If you are an injection drug user, you can take measures to help prevent endocarditis:

- Use a new sterile needle every time you inject.

- Use your own water, filters, and spoon.
- If possible, cook your drugs.
- Wipe the injection site with an alcohol swab before injecting.
- Keep the cap on the needle until you are ready to inject.
- Don't let the point touch any surface at all before you inject. ⊕



Fiona Gold, RN, is a team leader with the AIDS Prevention Street Nurse Program at the BC Centre for Disease Control.

Meet with HIV Experts in your own home!

BC Persons with AIDS Society announces its first: HIV Educational Tele-Conference

You are invited to participate in a new BCPWA initiative—the HIV Educational Tele-Conference. It will allow you to interact with an HIV health care specialist and a positive treatment counselor in real time from the comfort of your home or office. The Tele-Conference will present current antiretroviral treatment practices.

During the Tele-Conference you will be able to:

Participate in a PowerPoint presentation by an HIV health care specialist via telephone and follow along by Internet or a floppy disk or paper copy mailed to you beforehand; ask the specialist questions about your own health care treatment; learn from other participants' questions.

Please access our website www.bcpwa.org, email carolel@bcpwa.org or phone 1.800.994.2437 ext 309 for a registration form. Registration is on a first come, first-serve basis.

Date: December 3, 2002

Time: 6:30 - 8:30 PM

Topic: Overview of antiretroviral drug regimens and side effects

Target group: PWAs and APHAs in non-serviced areas of British Columbia

Registration deadline: November 23rd, 2002



Deciphering your diagnostics, part 2

Interpreting kidney and pancreatic lab results

by R. Paul Kerston

The kidneys

The kidneys filter blood and remove waste products in the form of urine. They also maintain normal water balance and compensate for variations caused by perspiration, diarrhea, and vomiting. Kidney failure can lead either to water excess or deficit, both of which are potentially life threatening.

Kidneys also help maintain the balance of electrolytes, such as calcium, sodium, potassium, phosphorus, and magnesium, which are crucial to proper cell function. Sodium measurement determines the balance of salt and water in your body and is an indicator of kidney and adrenal gland function. Too much sodium may be a symptom of dehydration; too little may result from excess fluids or can indicate other kidney problems. Eating salty foods will not affect your sodium levels as long as you're drinking fluids.

Rising potassium levels, which may become abnormal because of vomiting or diarrhea, may indicate kidney failure. Increasing phosphorus and uric acid levels, which are also affected by kidney problems, could have many possible meanings, including kidney failure. Lowered uric acid levels are common even among healthy adults.

Waste products of metabolism include urea (produced by the liver), creatinine, phosphate, and uric acid. All these substances gradually become concentrated in the blood when the kidneys lose the ability to excrete waste, including metabolized drugs. This inability to remove concentrations of waste products can lead to dangerous accumulations.

The most common measurements of kidney function are blood urea nitrogen (BUN) and creatinine. BUN is a measure of nitrogen (a waste product normally removed in urine) in the blood. High BUN levels can be a result of a high protein diet, dehydration, kidney failure, or even heart failure. Low BUN levels can reflect malnourishment or liver failure. This test is critical for people taking drugs that may affect the kidneys, such as Foscavir (foscarnet) and Vistide (cidofovir) for cytomegalovirus (CMV), as well as Preveon (adefovir dipivoxil). It is not used for predicting kidney stones associated with Crixivan (indinavir sulfate).

Creatinine is a waste product of protein digestion and muscle metabolism. Levels of creatinine directly indicate how well

the kidneys are removing waste products from the body. High amounts usually result from kidney problems. One of the most important values to monitor for kidney function is creatinine clearance from the blood over a 24-hour period.

The pancreas

The pancreas is a large gland behind the stomach, between the duodenum (the beginning of the small intestine) and the spleen. Along with the adrenal (near the kidneys), pituitary, and thyroid glands, the pancreas is part of the endocrine system, which regulates cellular and body functions. The pancreas releases hormones into the blood, including insulin and glycogen, which are essential to normal carbohydrate metabolism. It also helps digest fats and sugars.

Pancreatitis, an inflammation that can produce debilitating illness, nutritional problems, and even death, is one side effect of treatment, particularly with ddI (didanosine) but also ddC (zalcitabine) and d4T (stavudine). Symptoms include abdominal pain, nausea, and vomiting. Its onset can be predicted by rises in blood levels of the pancreatic enzyme amylase (which is also made by the salivary glands), used to aid the digestion of carbohydrates. Increases in amylase may indicate renal insufficiency. Decreased levels may mean pancreatic insufficiency or hepatitis.

Lipase can also be measured, with increases indicating pancreatitis or viral hepatitis. Lower amounts than normal may mean malnutrition or pancreatic insufficiency.

Normal values vary by laboratory, but here are some generally accepted ranges:

- BUN: 7/8–20/28 milligrams/deciliter of blood (mg/dL)
- Creatinine: 0.4/0.6–1.2//1.5mg/dL
- Creatinine clearance: 88–128 milliliters (mL)/minute (females); 97–137mL/minute (males)
- Uric acid: 2.5–6.1mg/dL (females); 3.7–7.8mg/dL (males)
- Amylase: 30–110 units/litre (u/L) ⊕



R. Paul Kerston is a researcher with the BCPVVA Society's Treatment Information Program.



The perils of protein

Are you getting proper nutrition from a high protein-low carb diet?

by Jennifer Adolphe and Diana Johansen

In the past, a common concern among people living with HIV was losing too much weight and looking wasted. Now, with the advances in highly active antiretroviral therapy (HAART), being overweight can actually become a problem. While being overweight does not impair an individual's ability to fight HIV, it can increase the risk for diseases associated with obesity, such as cardiovascular disease and diabetes. High-protein low-carbohydrate diets as a method of weight loss have recently become popular.

A dubious pitch

Promoters suggest that a diet high in protein and low in carbohydrates is the best attack on fat. The theory is that reducing carbohydrate intake decreases the amount of insulin the body produces. Insulin is a hormone that is released after eating a meal in response to a rise in the level of blood glucose—the sugar that results from carbohydrate breakdown. Insulin helps transport glucose into cells. Glucose is first stored as glycogen, but if the body already has enough glycogen, it will convert the glucose to fat for storage. Therefore, if you eat fewer carbohydrate-rich foods, you decrease the amount of insulin released, ultimately preventing fat storage.

However, scientific research shows that it is not the types of foods we eat, but excess calories that cause weight gain. So it is

not actually a reduction in carbohydrates that causes weight loss on a high protein diet. Dieters on this program have to restrict the variety of foods that they eat, especially grain products such as breads, cereals, and rice. When you restrict the variety of foods you eat, you usually eat less food overall. Initial weight loss from high protein diets is actually a result of water loss. Each glycogen molecule is bound to three water molecules. Reducing carbohydrate intake leads to a release of glycogen stores for energy, which results in glycogen depletion and a loss of the water bound to the glycogen.

The body's need for glucose

Remember that glucose is our body's preferred fuel and that some tissues, such as the brain, kidneys, and red blood cells, are able to use only glucose for energy. Without carbohydrates, our body is forced to use its second-choice fuel, fat.

When the body is primarily burning fat for energy, products called ketones form and the body enters a state called ketosis. Ketosis also occurs in starvation. In the case of very high protein diets, the body is being starved of carbohydrates. Depending on the severity of the ketosis, a variety of side effects occur, including loss of appetite, dehydration, fatigue, nausea, headaches, dizziness, and irritability.

Ketosis is especially dangerous for people with cardio-



vascular disease, hypertension, kidney problems, or diabetes. In extremely high amounts, ketones can create a potentially dangerous electrolyte imbalance and acid build-up in the blood.

likely result in gaining back the weight that was lost.

Osteoporosis. A very high protein intake can cause increased calcium excretion. Since bone is the primary storage site for calcium, a diet high in protein may increase your risk for osteoporosis. HAART may also accelerate bone loss. Together, a very high protein diet and HAART may wreak double havoc on bones.

Scientific research shows that it is not the types of foods we eat, but excess calories that cause weight gain.

The health risks

Being on a high protein diet has several negative side effects. A risk of developing nutrient deficiencies exists because eliminating foods or food groups from the diet can result in insufficient vital nutrient intake. High protein diets generally restrict grain products, fruits, and vegetables. Grain products are important sources of B vitamins. Fruits and vegetables provide many vitamins, minerals, and phytochemicals, which are thought to protect the immune system and decrease our risk of developing diseases such as cancer and heart disease.

Another possible side effect of a high protein diet is an increased risk of cardiovascular disease. Many foods that are high in protein, such as eggs and red meats, are also high in saturated fat and cholesterol. A diet high in cholesterol and saturated fat can lead to elevated blood cholesterol levels and increase the risk of cardiovascular disease. People on HAART already have an elevated risk of cardiovascular disease. That risk should not be further increased by unwarranted changes in diet.

As well, high protein diets can have a detrimental effect on kidney and liver function. The human body can only use 1.5–2.0g of protein per kilogram per day. Any extra protein that is ingested must be broken down to be used for energy or is stored as fat. The liver must break down excess protein for excretion by the kidneys, which places stress on these organs. Therefore, people with kidney or liver problems should be cautious when considering a high protein diet.

Here's a list of other negative side effects to consider.

Constipation. Dietary fibre, which helps promote regularity, is found in whole grains, fruits, and vegetables. Since high protein diets exclude many of these foods, constipation can become an issue.

Bad breath. Ketones produced by the body in the absence of carbohydrates can create an unpleasant breath odour.

Long-term failure. Maintaining a high protein diet is difficult and possibly unsafe. Returning to old eating habits will

How to lose weight in a healthy way

The bottom line is that excess calories, not certain foods, lead to fat storage. If losing weight were easy, no one would be overweight. Here are some strategies to lose weight safely.

Eat a balanced diet that does not eliminate any food groups. Doing this will help ensure adequate intake of vitamins, minerals, and proteins that are needed to stay healthy.

Increase your intake of complex carbohydrates and high fibre foods. Foods rich in complex carbohydrates include whole grains, fruits, and vegetables. These foods contain fibre, which improves regularity and helps maintain a feeling of fullness. Reduce your intake of foods high in simple sugars, including juice, pop, and desserts.

Eat a diet that is moderate in its amount of fat. Fat is very high in calories. Limiting fat intake may also help decrease the risk of cardiovascular disease.

Exercise regularly. Exercise burns calories and provides numerous other benefits, including protection against cardiovascular disease, bone and muscle preservation, and mood elevation. Include both aerobic exercises, such as cycling and walking, to increase your heart rate and strength-training exercises.

Avoid or limit alcohol. Alcohol provides no nutritional benefit, only extra calories. Alcohol can elevate levels of triglycerides, a type of fat in the blood, and can cause liver damage.

A healthy weight loss strategy meets all of the recommended nutrient intakes, supports doing regular exercise, promotes slow and steady weight loss (1–2 pounds per week), and includes plans to control weight over time. ⊕

Jennifer Adolphe is a dietetic intern. Diana Johansen, is the dietitian at Oak Tree Clinic in Vancouver, specializing in HIV.



Double standard for prisoners

Methadone maintenance program denied where it's needed most

by Kristi Yuris

AS HIV and HCV infections continue to rise among intravenous drug users (IDUs), methadone maintenance treatment (MMT) has become recognized as a critical component of HIV/AIDS prevention and treatment. MMT, a medically safe, narcotic analgesic with minimal side effects, is currently the most widely used intervention for the treatment of opioid dependence. Because it is administered orally and acts as an effective heroin substitute, MMT has been associated with a notable decrease in injection drug use and needle sharing.

For almost a decade, AIDS service organizations, prisoner advocacy groups, and inmates have been strongly asserting the need for the introduction of comprehensive MMT programs in Canadian prisons. Available data clearly indicate that IDUs continue to inject drugs in prison and are likely to engage in frequent needle sharing, thus increasing the risk of transmission of HIV and HCV among inmates. An anecdotal study conducted by the Expert Committee on AIDS in Prison indicated that because sterile needles are scarce inside prison, a single needle might be shared among 15–20 inmates.

In December 1997, Correctional Services of Canada (CSC), at last responding to years of political pressure and litigation undertaken by inmates within their facilities, agreed to provide MMT to inmates who were previously availing themselves of this treatment in the community. This policy shift followed the implementation of a similar and innovative program adopted by British Columbia Corrections Branch in September 1996. Regrettably, it has taken CSC almost five years to expand the MMT program to permit access to inmates not already on such treatment on the outside.

CSC released the terms of its new MMT policy to the public on May 2, 2002, under Commissioner's Directive 800, Health Services, in conjunction with updated methadone treatment guidelines. These guidelines specify the criteria that will be utilized by CSC to assess an inmate's eligibility for MMT. In order for an inmate to initiate methadone treatment within the institution, the following conditions must be indicated:

- Diagnosis of dependence to opiates as established in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* or a well-documented history of opiate addiction indicating a high risk of relapse as confirmed by a certified institutional physician.

- A small likelihood of benefit from non-methadone treatments, as evidenced by a history of treatment failures.

- Agreement to terms and conditions of the Methadone Maintenance Treatment Program, as evidenced by acceptance and willingness to sign the Methadone Treatment Agreement.

CSC guidelines warn that meeting the criteria above does not necessarily mean that an inmate will automatically be admitted to the MMT program. Because the "demand for methadone programs currently surpasses providers ability to supply the service," priority placement will be given to inmates who meet the additional criteria:

- Federally sentenced women who are pregnant and currently opioid dependent or were previously and are a high risk for relapse.

- Inmates who are HIV-positive and currently opioid dependent.

- Inmates who require treatment for hepatitis C.

- Inmates who are currently opioid dependent with a recent history (within the past three months) of a life-threatening overdose, endocarditis, septicemia, septic arthritis, and/or suicidal behaviour directly related to their opiate dependence.

- Inmates who are opioid dependent and will be released within the next six months.

Inmates interested in requesting admission will be required to undergo an initial MMT assessment by an institutional physician, participate in counselling, and perform urine toxicology screens twice per week or as requested by the methadone maintenance team, in addition to signing the Methadone Treatment Agreement.

CSC policy clearly states that violations of the agreement will result in involuntary termination of access to MMT. Serious infringements of the agreement include the diversion or dealing of methadone, continued use of illicit substances, falsifying

urine samples, and disruptive behaviour such as violent threats toward other staff or inmates. Inmates discharged from the program will undergo medical withdrawal from methadone (a reduction of dose of approximately 5mg per day) and must forward a request to in order to be readmitted to the program.

A study indicated that because sterile needles are scarce inside prison, a single needle might be shared among 15–20 inmates.

For those HIV-positive inmates interested in commencing MMT, it is critical that frequent consultation with the institutional healthcare staff be maintained once treatment begins. Methadone has been known to interact with antiretroviral therapies, in particular non-nucleoside reverse transcriptase inhibitors and protease

inhibitors, because these medications share metabolic pathways with methadone. Clinical studies indicate that those taking nevirapine and efavirenz in conjunction with MMT often experience symptoms of opiate withdrawal (restlessness, insomnia, vomiting, dilated pupils) necessitating an increased dosage.

For Commissioner's Directive 800 – "Health Services" visit: www.csc-scc.gc.ca/text/plcy/cdshtm/800-1-gl_e.shtml.

For "Methadone Treatment Guidelines" visit: www.csc-scc.gc.ca/text/plcy/cdshtm/b127-800_e.shtml.



Kristi Yuris is the prison outreach program (POP) coordinator for the BCPWA Society.

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604 984-4484

Queers, junkies, and harm reduction

Abstinence isn't always a realistic option

By Evan Wood, Paula Braitstein and Naomi Brunemeyer

Harm reduction is a pragmatic approach to reducing the extent of harm caused by a problem and is undertaken when eliminating the problem is an unrealistic objective. In other words, given that a situation exists, such as having unsafe sex or injecting drugs, harm reduction is a means of reducing the negative outcomes associated with these behaviours. The most well-known example of harm reduction is the “Don’t Drink and Drive” campaign, which was implemented after it became clear that youth were not responding to the “Don’t Drink” campaign.

“Fags” and “junkies” have much in common when it comes to harm reduction. Many gay men use drugs, and many drug users have sex with people of the same sex. Although numerous cultural differences exist between these two groups, there are probably more similarities than differences when it comes to the bottom line: staying alive and maintaining a good quality of life. Both groups have traditionally been marginalized. Both gay men and drug users are incredibly vulnerable to HIV, hepatitis C, poverty, stigma, discrimination, and violence. Drug users also risk overdose deaths or bacterial infections from lack of access to sterile equipment. In addition, they are more vulnerable to harm when there is public consumption of drugs. People who practice unsafe sex risk acquiring sexually transmitted infections and bacterial or parasitic infections.

Harm reduction exists along a continuum. One end of the continuum for gay men’s sex would be abstinence. The most successful way of reducing the harm associated with sex would be to not have sex at all, clearly an unrealistic option for most men. We know some gay men engage in bareback sex so we need to provide those gay men with options to practice safer sex, even if these strategies are risky, such as pulling out before ejaculation or using plenty of lube. The goal is to reduce harm in a way that recognizes the realities of gay men’s lives.

The harm reduction continuum for injection drug users also begins with abstinence, which is not an option for most people who use drugs recreationally, let alone those who live with drug addiction. Strategies such as methadone maintenance, heroin prescription, and safe injection sites are options that some people believe encourage drug use, but these approaches actually

help people who are at the greatest risk of disease and death. If we don’t provide “low threshold” harm reduction programs such as safe injection sites, we lose all opportunity to prevent harm.

Both gay men and drug users are incredibly vulnerable to HIV, hepatitis C, poverty, stigma, discrimination, and violence.

- Harm reduction strategies for injection drug users include:
- > encouraging drug injectors to not inject alone so as to avoid overdoses;
 - > needle exchange programs to promote the use of sterile syringes and encourage the return of contaminated needles; and
 - > safe injection sites, where injection drug users can use drugs safely, have their lives saved if they overdose, and where they can have access to other services including primary healthcare.
- Preventing harm to gay men engaging in sex is also paramount. These strategies include
- > sexual practices that don’t involve penis-anus penetrative sex;
 - > condom use; and
 - > sex with someone of the same serostatus.

The BCPWA Society would prefer not to acquire new members. We want to stop the spread of HIV. Anything we can do to reduce the harm associated with drug use or sexual behaviour is important to BCPWA Society members.

For more information check out www.lindesmith.org/reducingharm ⊕

Evan Wood is a research associate at the BC Centre for Excellence in HIV/AIDS. Paula Braitstein is senior policy advisor on health promotion for the BCPWA Society. Naomi Brunemeyer is director of communications and education for the BCPWA Society.




Updates from the Canadian HIV Trials Network

Trials to test vaccines, new classes of HIV drugs

by Jim Boothroyd

In the next five years, Canadians with HIV/AIDS will be asked to participate in an “unprecedented” new wave of clinical trials of promising vaccines and new classes of HIV drugs, according to a funding application by the Canadian HIV Trials Network (CTN) now being considered by the Canadian Institutes of Health Research (CIHR).

“HIV clinical trials research is on the verge of another quantum leap forward with the introduction of new classes of therapies, notably, fusion inhibitors and integrase inhibitors,” states the application for CIHR funding over the next five-year cycle of the Canadian Strategy on HIV/AIDS.

“Further, it can be expected that prophylactic and therapeutic vaccines will assume an ever increasing importance in HIV trials research. For these reasons, it is expected that there will be unprecedented clinical trials research opportunities in the years ahead.”

The Canadian HIV Trials Network aims to take advantage of these opportunities through these three complementary strategies.

First, it will create core teams to focus on four critical areas, with distinguished physician-researchers leading each team (names in parentheses): antiretroviral therapies (Julio Montaner, Vancouver); vaccines and immunotherapies (Rafick-Pierre Sékaly, Montreal); co-infections and concurrent diseases

(Richard Lalonde, Montreal and John Gill, Calgary); and clinical management science—toxicity, side effects, drug adherence, and other topical issues (William Cameron, Ottawa and Sharon Walmsley, Toronto).

Each core area will have its own national team of scientists, support staff, and access to the full range of CTN resources and technical expertise. The mandate of each team will be to remain current with evolving knowledge related to a specific area of concern in HIV/AIDS and to develop state-of-the-art trials responsive to needs for new knowledge.

The second strategy is to encourage the design and implementation of trials aimed specifically at addressing the needs of such hard-to-reach populations as injection-drug users, aboriginal people, and women. The third strategy is to pump more resources into support for recruiting participants at clinical sites.

CIHR is expected to make a decision this winter on the application for funding. ⊕



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

Trial registry goes live

An electronic registry of all HIV clinical trials in Canada is under construction in a joint initiative by the CTN and the Canadian AIDS Treatment Information Exchange. As of mid August, the registry included plain-language descriptions and details of 27 trials. It is expected that the registry will be widely consulted by investigators, physicians and people with HIV. Click on Clinical Trials at <http://www.hivnet.ubc.ca/ctn.html>.

CTN trials enrolling in BC:

CTN 110 – ESPRIT: Subcutaneous Interleukin-2
 BC Sites: Cool Aid Community Health Centre, Victoria
 CTN 145 – SILCAAT: rIL-2 to Slow Progression of HIV
 BC sites: Providence-St. Paul's Hospital, Vancouver
 CTN 161 – SPRINT: Simplified Protease Inhibitor Trial

BC Sites: Cool Aid community Health Centre, Victoria, Providence-St. Paul's Hospital and Viron, Vancouver

CTN 164 - STI (Structured Treatment Interruption) Trial

BC Sites: Downtown IDC, Vancouver; and Cool Aid Community Health Centre, Victoria

CTN 167 – OPTIMA: Options with Antiretrovirals

BC Sites: Downtown IDC and Providence-St. Paul's Hospital, Vancouver; and Cool Aid Community Health Centre, Victoria

CTN 169 - DAVE: D4T or Abacavir plus Vitamin Enhancement
 BC Sites: Providence-St. Paul's Hospital, Vancouver

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

Volunteering at BCPWA

Profile of a volunteer: Derek Bell



"Derek's calm demeanour and patience, along with a natural talent for teaching, make him a welcome addition to BCPWA for members who want to learn more about computers."

Ruth Marzetti

Volunteer History

BCPWA is the first organization that I've volunteered for, but I've enjoyed helping friends and family throughout my life. I began in April 2002. I've been volunteering in the Internet Cafe.

Why pick BCPWA?

The society provides services that are needed and appreciated by the members. As a member for many years, I've always liked the staff and wanted to reciprocate for the help I've received.

Why have you stayed?

I like the fun and positive atmosphere. I also feel encouraged and appreciated by members and co-workers.

Rating BCPWA

I think BCPWA has been doing an outstanding job in helping HIV-positive people live a better and healthier life. BCPWA has been a leader in fighting for the rights that its members deserve.

Strongest point of BCPWA

A sense of family. I've met a few people who I feel comfortable with and like a lot; I look forward to seeing them regularly.

Favourite memory

Joking around with Jackie Haywood in Support Services—she's very funny.

Future vision for BCPWA

Well, hopefully one day we won't need any AIDS organizations, but until then, BCPWA will continue to be a strong, member driven and well-financed source of support.

**Gain
and share your
skills for a
valuable cause**

IF YOU HAVE

- administration skills that include word-processing, or
- law and advocacy skills, or
- research and writing skills, and
- the ability to work independently and in a group,

WE CAN FIND A MATCH FOR YOU IN OUR NUMEROUS DEPARTMENTS AND PROGRAMS!

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

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



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To make a contribution to BCPWA, please contact
Melissa Davis, BCPWA Director of Development,
Tel: 604.893.2260, email: melissad@bcpwa.org

* Denotes monthly donors (reflects the total contribution for the year)



where to find help

If you're looking for help or information on HIV/AIDS, the following list is a starting point.

BC Persons With AIDS Society

1107 Seymour St, Vancouver BC V6B 5S8
 (604).893.2200 or 1.800.994.2437
 info@bcpwa.org
 www.bcpwa.org

A Loving Spoonful Location

Suite 100 – 1300 Richards St,
 Vancouver, BC V6B 3G6
 604.682.6325
 clients@alovingspoonful.org
 www.alovingspoonful.org

AIDS Memorial Vancouver

205 – 636 West Broadway,
 Vancouver BC V5Z 1G2
 604.216.7031 or 1.866.626.3700
 info@aidsmemorial.ca
 www.aidsmemorial.ca

AIDS Prince George

1– 1563 2nd Ave,
 Prince George, BC V2L 3B8
 250.562.1172
 ogodwin@bcgroup.net

AIDS Prince Rupert

Box 848 Prince Rupert, BC V8J 3Y1
 250.627.8823
 aidspr@rapidnet.net

AIDS Resource Centre – Okanagan and Region

202 – 1626 Richter Ave,
 Kelowna, BC V1Y 2M3
 250.862.2437 or 1.800.616.2437
 arc@arcok.com
 www.arcok.com

AIDS Society of Kamloops

P.O. Box 1064, 437 Lansdowne St,
 Kamloops, BC V2C 6H2
 250.372.7585 or 1.800.661.7541
 ask@telus.net

AIDS Vancouver

1107 Seymour St, Vancouver BC V6B 5S8
 604.893.2201
 av@aidsvancouver.org
 www.aidsvancouver.bc.ca

AIDS Vancouver Island (Nanaimo)

201 – 55 Victoria Rd, Nanaimo, BC V9R 5N9

AIDS Vancouver Island (Victoria)

1601 Blanshard St, Victoria, BC V8W 2J5
 info@avi.org
 www.avi.org

ANKORS (Nelson)

101 Baker St, Nelson, BC V1L 4H1
 250.505.5506 or 1.800.421.AIDS
 info@ankors.bc.ca
 http://kics.bc.ca/~ankors/

ANKORS (Cranbrook)

205 – 14th Ave N Cranbrook,
 BC V1C 3W3
 250.426.3383 or 1.800.421.AIDS
 gary@ankors.bc.ca
 http://kics.bc.ca/~ankors/

Asian Society for the Intervention of AIDS (ASIA)

210 – 119 West Pender St,
 Vancouver, BC V6B 1S5
 604.669.5567
 asia@asia.bc.ca
 www.asia.bc.ca

Dr Peter Centre

2nd Floor, 1056 Comox St,
 Vancouver, BC V5E 4A7
 604.608.1874
 info@drpeter.org
 www.drpeter.org

Friends for Life Society

1459 Barclay St, Vancouver, BC V6G 1J6
 604.682.5992
 ffl@radiant.net
 www.friendsforlife.ca

Healing Our Spirit

Suite 100 – 2425 Quebec St,
 Vancouver, BC V5T 4L6
 604.879.8884 or 1.800.336.9726
 info@healingourspirit.org
 healingourspirit.org

McLaren Housing Society

200 – 649 Helmcken St,
 Vancouver, BC V6B 5R1
 604.669.4090
 mclarenhousing@telus.net

North Island AIDS Coalition (Campbell River)

684B Island Hwy,
 Campbell River, BC V9W 2C3
 250.830.0787 or 1.877.650.8787

North Island AIDS Coalition (Courtney)

355 6th St, Courtney, BC V9N 1M2
 250.338.7400 or 1.877.311.7400

North Island AIDS Coalition (Port Hardy)

8635 Granville St, Ground Floor,
 Port Hardy, BC V0N 2P0
 250.902.2238
 niac@island.net
 www.island.net/~niac

Okanagan Aboriginal AIDS Society

202 – 1626 Richter Street,
 Kelowna, BC V1Y 2M3
 250.862.2481 or 1.800.616.2437
 oaas@arcok.com
 www.oaas.ca

Pacific AIDS Network c/o AIDS Vancouver Island (Victoria)

250.881.5663
 erikages@pan.ca
 www.pan.ca

Positive Women's Network

614 – 1033 Davie St, Vancouver, BC V6E 1M7
 604.692.3000 or 1.866.692.3001
 pwn@pwn.bc.ca

Red Road HIV/AIDS Network Society

Suite 100 – 2425 Quebec St,
 Vancouver, BC V5T 4L6
 604.879.8884 or 1.800.336.9726
 info@red-road.org
 www.red-road.org

Vancouver Native Health Society

441 East Hastings St, Vancouver, BC V6G 1B4
 604.254.9949
 vnhs@shaw.ca

Victoria AIDS Respite Care Society

2002 Fernwood Rd, Victoria, BC V8T 2Y9
 250.388.6620
 varcs@islandnet.com
 www.islandnet.com/~varcs/

Victoria Persons With AIDS Society

541 Herald St., Victoria BC V8W 1S5
 250.382.7927
 support@vpwas.com
 www.vpwas.com

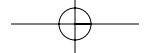
Wings Housing Society

12 – 1041 Comox St, Vancouver, BC V6E 1K1
 604.899.5405
 info@wingshousing.bc.ca
 www.wingshousing.bc.ca

YouthCO AIDS Society

203 – 319 Pender Street,
 Vancouver BC V6B 1T4
 604.688.1441
 info@youthco.org
 www.youthco.org

For more comprehensive listings of groups, societies, programs and institutions in British Columbia serving people touched by HIV disease and AIDS, please visit the Positively Happening section of the BCPWA Society website at www.bcpwa.org.



positively Happening
YOUR GUIDE TO JUST ABOUT EVERYTHING

OUR MAGAZINE provides 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 current and up-to-date information but it is not always possible.

VANCOUVER

Who to call

Pacific AIDS Resource Centre
604-683-2222 or 604-683-2223
HIVC Partners
461 Columbia St. #1001
BC Perinatal HIV/AIDS Centre Fax: 604-273-2222
HIVV Lines and Information Services
BCPWA Vancouver Information Project
604-222-2222 or 604-222-2223
Shediac, C 199 199 604-696-3273

AIDS Resources

HIV Line: 604-273-2222
711000: 604-683-2223
HIV Information Line
604-273-2222

AIDS Vancouver Island

604-253-8888
R.C. AIDS Line
800-665-2222 or 1-800-665-4222

Central Health Information

613-222-2222
Ministry of Health Information
613-222-2222
St. Paul's Hospital
604-683-2222
Provincial Health Services
604-273-2222
Provincial Health Services
604-273-2222

WRITE TO US, P.O. Box, Living + Magazine 1107 Seymour St., Vancouver, BC V6B 5S8
Call us 604.222.2222 • Fax us 604.222.2223 • e-mail us info@bcpcwa.org
or visit our website www.bcpwa.org

We have reduced our Positively Happening Section in the magazine in an effort to provide up to date accurate information on services available in the community.



Positively Happening can be found in its entirety on our website, www.bcpwa.org/resources.php. Please contact us at 604.893.2206 or pozhap@parc.org to be included in this listing.



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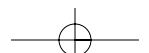
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1107 Seymour Street
Vancouver, BC
Canada V6B 5S8



LAST BLAST

Pill-uted waters

Antibiotics in our lakes are nothing compared to the ecological disaster of HIV meds

by Glen Hillson

Several months ago, I came across an article in the *Globe and Mail* about traces of antibiotics found in a lake in Ontario. It struck me that antibiotics seem almost benign compared to HIV drugs.

Those of us on HIV meds have watched in the mirror as our bodies morphed and mutated into creatures resembling something you might expect to find on the Space Channel. Dribs and drabs of flesh migrated, looking to relocate. Our

bums moved to our bellies. Arms and legs became cylinders of bone concealed beneath a thin layer of translucent parchment. Our faces look like the victims of too many skin grafts. Phyllis Diller would understand. Her navel, she has said, is now located in the middle of her forehead. We are left to tally up the number of folds in the skin that once stretched over firm, fleshy buttocks.

Recently, I sat before the tube listening to reports from the Earth Summit in South Africa where world leaders were pretending to be more concerned with saving the planet than their own political hides. It seemed ironic that at the World AIDS Conference, also held in South Africa just two years ago, much of the talk was about the global impact of arrested human development caused by the epidemic.

In 2002, I wonder what havoc is being wreaked on human development by the truckloads of life-saving HIV drugs that are constantly flushed into our oceans, lakes, and rivers.

Will facial lipoatrophy caused by d4T and protease inhibitors in our oceans mean the end of those succulent halibut cheeks we love? Have spawning salmon always had that bright red Chernobyl glow, or is it the infamous nevirapine rash? Could it be AZT and friends? There's a reason they call them nukes—right?

Maybe the culprit behind global warming and subsequent melting polar caps is the mitochondrial toxicity caused by nucleoside HIV drugs. Maybe mitochondrial toxicity is killing all the plankton in the oceans and depriving the earth's atmosphere of oxygen. Do single-cell animals even have mitochondria?

I've been led to believe that humpback whales have been around for a long time, but I wonder if there's a conspiracy to shield us from the real truth. Those might well be buffalo humps of the same variety you see in some PWAs on treatment. Orcas may also be suffering the effects. You may have seen that wildlife show where the Orcas beach themselves to catch baby sea lions, which they take back out to ocean for a nice game of volleyball. Sounds like a day on Sustiva if you ask me.

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Then there was the whole Walkerton mess. The sheer volume of cow poop that now forms the ground cover for this great land we call Canada seems to have contaminated all the ground water. And not just in Ontario—Alberta too. When it comes to poop, no cow could ever match the production of a PWA on nelfinavir or ritonavir.

One of the many things that worry me is that as PWA life expectancies increase and the effects of environmental meltdown accelerate, we may actually be alive to suffer—as we should—when it all goes up in a puff of toxic dust. ☉

Glen Hillson takes pills all day long and is happy to do so. They may be killing off the plankton, but, for now, they are keeping him alive.