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A matter of perspective

by Glen Bradford

In life, there are always more perspectives than our own, and HIV/AIDS is a health concern fraught with a multiplicity of views.

Recently, the media asked me to respond to a situation concerning a Canada-wide search for an HIV-positive heterosexual man who was suspected of having unprotected sex with seven women. Two of these women tested positive. He was being charged with criminal negligence and aggravated assault.

I spoke about the importance of HIV prevention targeted towards HIV-positive people as the preferred course of intervention over criminal charges, on the increased rate of infections of heterosexual women, and the need to support women in ways that they can feel safe. I expressed compassion for the women infected. As is the case with most media, they picked what they liked and tossed the rest.

During the next 24 hours, the man's face and name were plastered all over the media. The BCPWA Society received several calls. Some people felt we were not sympathetic enough to the issues of women, others felt we should respond to the media's violation of this man's right to keep his HIV status private, and some were concerned that this type of media behaviour would prevent others from getting tested. Questions of racism were raised. All are valid perspectives. Who is right? Do we pick a side or do we carefully try to represent all sides of the issue and risk alienating everyone?

This type of political navigation, although uncomfortable, is nothing new to the BCPWA Society. Prisoner advocacy while educating corrections staff, pharmaceutical boycotts while scrambling to find program funding, and positive prevention while maintaining the right to negotiate bare-backing are just some of the situations we constantly juggle.

Social justice work is messy. As much as George Bush would like to think it's as simple as "either you're with us or against us," real life is not like that. The line we draw in the sand is more of an octagon, with a stranger standing at a different angle looking in on the same issue and probably struggling as much as we are to grasp the complexities of different views. We must be vigilant to ensure that one HIV-positive sub-population is not viewed as having more value than another.

Whether we are intravenous drug users in Vancouver's Downtown Eastside, gay men, or aboriginal women in the BC Interior, as HIV-positive people we all have the right to have our views considered with dignity and respect. We all have the responsibility to listen to one another in the same way. To do anything less will only undermine the AIDS movement. We are all in this mess together and, whether it works smoothly or not, we must be open to diverse views. Single-minded bullies hold us back. When we can see our strength in this diversity, the AIDS movement will move forward as one.

As the chair of the BCPWA Society, I stay spiritually grounded, have a smart cocktail in the evening, and buy the family-size box of headache medication. ⊕

Glen Bradford is chair of the BCPWA Society.

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 almost 4000 HIV+ members.

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REALITY BITES

BCPWA at the Pride Parade

Join the BCPWA Society's parade contingency at the 26th Annual Pride Parade on Sunday August 1. The parade has become the most visible celebration of the year for the GLBT community and one of the most popular summer events in the city.

Our float will be a New Orleans funeral theme. The funeral procession is about celebrating lives and mourning losses, about the shame and disappointment at our government's inaction, and about remembering that we must never waver in our vigilance in demanding action…and then to party!

The recommended attire is mourning dress, outlandish attire, or over the top cocktail wear—always in black.

If you are interested in participating, please contact Adriaan de Vries at 604.893.2298 or email volunteer@bcpwa.org.

Gene therapy may block HIV spread

Three people with HIV have shown promising initial results on a new experimental gene therapy treatment to try to boost their immune systems. VIRxSYS, the company behind the technique, says it will soon test it on another two patients before embarking on a larger trial.

The technique involves taking T-cells from patients and re-engineering them so that they can destroy HIV. The cells are treated with a "gutted" form of HIV in the laboratory, which has been genetically engineered to stop HIV in the body from replicating and spreading. The re-engineered cells are then reintroduced into the body where they lie in wait until HIV attacks.

The idea is that the re-engineered cells will paralyze HIV and prevent it from spreading to other cells. It does this by cutting up the virus and inserting its own genetic material, which is designed not to spread.

The three patients were all resistant to some of the drugs normally used to treat the virus.

Source: BBC News

New EDs at YouthCO and Friends for Life

Sheena Sargeant is back at YouthCO AIDS Society as the new executive director.

She was at YouthCO for four years, as education program coordinator and then as communications director, before assuming the position of communications coordinator at Positive Women's Network for the past year.

Former YouthCO executive director Jennifer Evin Jones has moved on to Vancouver Friends for Life Society as executive director.

Diabetes drug eases HIV treatment effects

A diabetes drug could help reduce some of the health-threatening side effects of AIDS medications, US researchers report. They say Avandia can help reduce the redistribution of body fat that occurs when patients take highly active antiretroviral therapy (HAART) and can also reduce some of the diabetes-like changes in metabolism.

Researchers at Massachusetts General Hospital and Harvard Medical School found that daily doses of Avandia (rosiglitazone) helped patients better handle naturally-occurring insulin.

In their study, 27 patients randomly received either Avandia or a placebo for three months. The Avandia patients had a 20 percent improvement in insulin sensitivity, a measure of a patient's risk of diabetes.

The researchers were able to demonstrate that this class of agents can slow down or reverse fat loss in patients with fat atrophy.

Source: CNN

Breast enlargement from efavirenz reported

Spanish doctors have reported five cases of breast enlargement (gynaecomastia) in HIV-positive individuals taking efavirenz-based HAART regimens. Four of the cases were in men.

Gynaecomastia is widely recognized as a possible manifestation of lipodystrophy in HAART-treated individuals. Several cases of gynaecomastia have been previously reported in individuals taking HAART regimens based on a protease inhibitor. These five case reports from the Hospital of San Juan in Alicante, Spain implicate the non-nucleoside reverse transcriptase inhibitor (NNRTI) efavirenz in this condition.

An earlier case review conducted in

REALITY BITES

the UK found that the side effect was associated with the three main classes of anti-HIV drugs. Investigators argued that the condition was not a true manifestation of the lipodystrophy syndrome, as it involved glandular disturbance.

After reviewing the literature on previous cases of the side effect in protease inhibitor-treated patients, the Spanish researchers concluded that the condition could be caused by immune restoration, or an increase in the female estradiol hormone caused by efavirenz's interference with the P-450 enzyme.

Source: Aidsmap

Link between caffeine consumption and liver protection

A US population study conducted by researchers at the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) has found a strong association between coffee drinking and caffeine consumption and a lower risk of liver injury in persons at high risk for liver disease.

The researchers defined the high-risk population as heavy drinkers of alcohol, or people with hepatitis B or C, iron overload, were obese, or had impaired glucose metabolism. Liver injury was defined as a serum alanine aminotransferase (ALT) activity level in excess of 43 U/L.

Researchers reported that overall, the greater the coffee consumption, the greater the association with liver protection. Because caffeine consumption is so highly associated with coffee drinking, it is difficult to untangle the two statistically. The mechanisms of action, if any, for coffee and caffeine are completely unknown.

Although coffee has many known effects on the body and has been studied extensively, its specific effects on the liver have been largely unexplored.

Source: NATAP

Coming soon to Canada?

The protease inhibitor nelfinavir (Viracept) is now available as a 625mg tablet in the US. Nelfinavir was initially approved by the US Food and Drug Administration in 1997, but has been available only in a 250mg tablet formulation and in oral powder form. The 625mg formulation was approved by the FDA in April 2003; however, commercial release of this dosage was delayed until recently.

The recommended adult dose of nelfinavir is 1250mg twice a day, or two 625mg tablets twice daily. Until now, patients had to take five 250mg tablets twice daily. The new dosage option will substantially reduce the pill burden of nelfinavir, though the frequency of diarrhea may increase.

Suicidal ideation during treatment of hepatitis C

A study conducted by the Veterans Affairs Medical Center in Minneapolis has found that psychiatric and substance use disorders affect most patients with chronic hepatitis C and are the most common reasons for exclusion from antiviral therapies. Suicidal ideation (SI)—having any thoughts of suicide—is often cited as a reason to exclude patients from interferon-based treatment or to terminate antiviral treatment.

This study examined SI in 55 hepatitis C patients untreated and treated with interferon, which is commonly associated with depression.

A total of 15 of the patients reported SI while not on interferon therapy. Of the 42 patients treated with interferon, 18 endorsed SI at some point during antiviral treatment. However, 17 out of 18 patients finished at least a 6-month course of interferon therapy. No subjects attempted suicide.

Although SI in some form is common in hepatitis C patients, in most cases it is mild in nature. With adequate support most patients can successfully complete a full course of antiviral treatment.

Contraceptive choices of HIV-positive women

HIV-positive women choose different forms of contraception depending on their partner's HIV status, according to a French study published in the *Journal of Acquired Immune Deficiency Syndromes*. Whereas women with HIV-negative partners tend to use condoms, the use of oral contraceptives and IUDs is more common among women with HIV-positive partners.

The study's authors argue that their observations are due to HIV-positive women with HIV-negative partners choosing a contraceptive method that is better suited to prevent HIV transmission. Conversely, women in seroconcordant relationships—that is, both partners are HIV-positive—tend to choose methods to avoid pregnancy, and are seemingly less concerned about the transmission of sexually transmitted infections or new strains of HIV.

"Although they are associated with a high degree of protection against HIV transmission, [condoms] provide less protection against pregnancy," the authors state. "Oral contraceptives, IUDs and sterilization are highly effective means of contraception. However, they do not prevent HIV transmission."

Source: Aidsmap ⊕

Pedalling to wellness

by Dan Christianson

In the summer of 2003, I cycled solo from Edmonton to Kelowna. My original plan was to cycle from Edmonton to Vancouver via Jasper. Because of the fires in Jasper and Mount Revelstoke National Parks, I had to cycle via Calgary to Kananaskis. From there, I took the BC section of the Trans Canada Trail. Starting from Elk Pass, I made three substantial detours around major forest fires before fire officials ended my trip at Kelowna. I cycled almost 1500 kilometres in two weeks. I met some wonderful people and saw some fantastic scenery. Despite the fires, I had a great time. The best part of this trip was that it gave me the impetus to plan a trip for this summer.

Back in May 1999, when I arrived at St Paul's Hospital emergency by ambulance, cycling was the furthest thing from my mind. I had a CD4 count of 2, a viral load approaching 3/4 of a million, meningitis, PCP, MAC, wasting syndrome, thrush, salmonella poisoning, complete kidney failure, and a host of minor ailments. I weighed less than 90 pounds. My immune system was virtually non-existent, so antivirals were almost useless. The next six months (whenever I was conscious) were full of nausea, night sweats, vomiting, diarrhea, constant pain, and extreme fatigue.

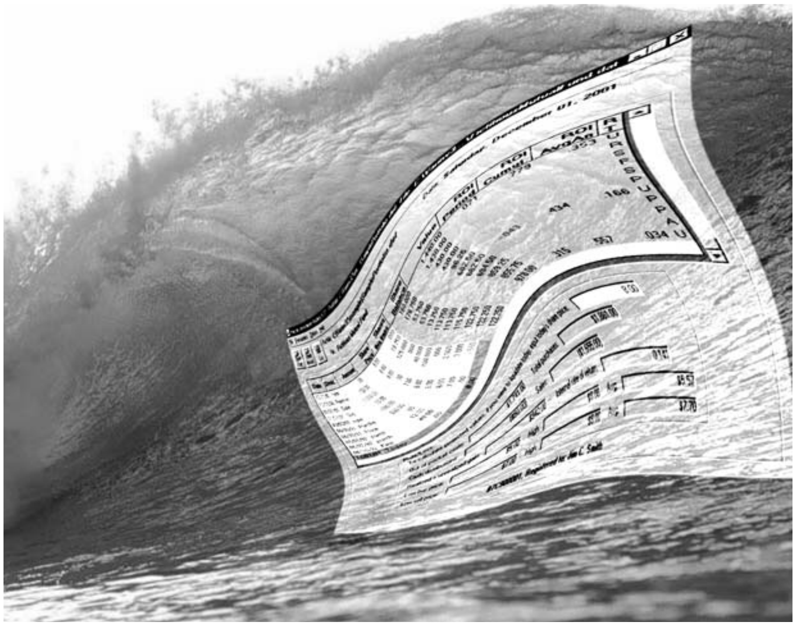
Being bedridden for such a long time and the effects of wasting caused my muscles to atrophy. I had to relearn how to feed myself, dress myself, and write my name. I could not stand up without collapsing. Walking was impossible. My mother would push me around in a wheelchair. The first time I saw myself in a full-length mirror, I stared in horror and shock. What I saw was this emaciated, sickly, and completely unrecognizable person. No words could describe what I felt; all I remember is that I cried until I was too weak to cry any more.

By February 2000, my CD4 count was up to 30, and I weighed 101 pounds. That was when I first attempted to ride my bike. Crazy was not the half of it—I was still in need of a walker. All I had going for me was determination. Because of an almost complete lack of muscle coordination, strength, and flexibility, I began numerous frustrating and comical attempts to mount my bike. Finally, I walked to the nearest bus stop, crawled onto the bench, and mounted the bike. To dismount, I stalled the bike over a patch of grass, fell sideways, and climbed from beneath it. Unfortunately, for a ride of less than 200 metres on level ground, I spent four very painful days recovering in bed.

After that, I would try again to cycle whenever possible. I set goals. Most of these attempts were followed by two or three days of recovery in bed from the fatigue and pain. These rest periods became known as my down times. Slowly, month by month, as I set more goals, I felt little positive changes.

For the summer of 2002, I began the massive process of building my confidence enough to cycle from Vancouver to Kamloops via Whistler. That four-day trip included cycling through a blizzard and an exceedingly large amount of swearing. Later that summer, I cycled the Columbia and Western Rail Trail and the Kettle Valley Railway Trail from Castlegar to Hope. The cycling was easy and relaxing because I was on old rail lines with no steep grades. Although crossing unplanked trestles did challenge my fear of heights, I had fun. I found that nine-day trip so enjoyable that I prayed constantly I would be healthy enough to make another trip in the summer of 2003.

I carefully research all my trips, checking road conditions, duration, basic requirements, medical facilities, and the possibilities for fun along the way. With the constant reminders of asthma, osteoarthritis of my hips, peripheral neuropathy, and a current CD4 count of 230, my motto is to prepare for the worst but expect the best! ⊕



Surfing for savings

Online financial planning information for PWAs

by Jeff Anderson

People with HIV/AIDS have made great use of the Internet for political action, for social contacts and discussions, and for medical information. As the life expectancy of PWAs increases, we find ourselves needing to establish or re-establish a sound financial footing. The Internet offers various information resources, depending on your current assets and future needs.

A large segment of low-income PWAs in BC are supported by federal CPP programs, but most receive provincial assistance through the Ministry of Human Resources (MHR). Some of us have a few assets, but as our outlook for a healthy life improves, so does our need to develop as much financial stability as possible for our future.

The increasing likelihood that we may outlive partners, parents, and siblings brings increased likelihood of a lump sum inheritance, which may improve your short-term cash flow but could easily destroy your safety net of benefits. With careful planning, a financial trust can often prevent a one-time cash windfall from eroding your long-term MHR benefit eligibility. While trust rules and regulations are complex, a trust may be the only viable solution to retaining benefits while receiving an inheritance. The ministry provides an excellent online pamphlet for preliminary research. Before creating a trust or filing one with the ministry, applicants are urged to consider consulting a trust lawyer or advocate. Do as much research as possible before consulting with professionals to save time and consulting fees.

Although the BCPWA Society and other AIDS groups offer general financial information to PWAs, the Planned Lifetime Advocacy Network (PLAN) offers extensive assistance and information for families and support networks. PLAN provides information and referral services for developing a will and estate plan, creating discretionary trusts, and maintaining government benefits. They also provide information and recommendations on home ownership and legal guardianship options. They receive no direct government funding to lobby government for reform of tax and trust legislation.

> **As our outlook for a healthy life improves, so does our need to develop as much financial stability as possible for our future.**

Also, Voice of the Cerebral Palsied of Greater Vancouver recently created a very thorough and easy-to-use pamphlet entitled "How to Create a Trust: A Resource Guide for People Receiving 'Person with Disability Benefits' and their Families".

PWAs with more assets to manage and an ability to manage them personally will find more varied Web resources. Of course, the Internet is chock full of investment and financial Web sites for the general investor, but the advice may be too general for PWAs. Few Web sites offer specific HIV financial advice and information. Moreover, United States and United Kingdom-based Web sites are of limited value to Canadian PWAs because their advice is shaped by the laws in their respective countries. That said, they still offer good general investment and HIV financial strategies. One of the best, Positive Finance, is a UK site which bills itself as "the first finance website for the HIV community." It offers mort-

Internet & organization resources

MHR pamphlet on trusts
<www.mhr.gov.bc.ca/PUBLICAT/pdf/DisabilitiesTrusts.pdf>. You can obtain a printed version from an MHR office.

Planned Lifetime Advocacy Network (PLAN)
<www.plan.ca>

Voice of the Cerebral Palsied of Greater Vancouver
Email: vcpgv@vcn.bc.ca

Positive Finance
<www.positivefinance.com>

POZ Canadian
<www.pozcanadian.com>

BCPWA Society Advocacy Department
Email: advdesk@bcpwa.org

BC Coalition of People with Disabilities
<www.bccpd.bc.ca>

Coast Society
<www.coastfoundation.com>

gage and other strategies for PWAs and their partners.

If none of these sites answers your financial quandary, consider e-mailing AIDS groups in BC, such as the BCPWA Society Advocacy Department or disability groups such as the BC Coalition of People with Disabilities or the Coast Society. Their staff members are trained in specific trust strategies. You may also want to consider starting a discussion group of your own on chat sites such as POZ Canadian. Someone else with HIV might have just the experience you need.

Remember, with no watchdog agency to ensure truth or reveal bias, Internet information can be misinformed, misleading, or downright false. As with all Internet or financial information, facts should be verified with professionals. Seek legal advice before taking any action based on that information. With caution and a good browser, you can find a lot of information to help you in your search for financial security. Get going and good luck! ⊕

Jeff Anderson is a long-time activist and volunteer, including treasurer of the BCPWA Society from 1997 – 2002.

MENTAL HEALTH AND HIV

A VIDEO PROJECT BY BCPWA

Where:
Pacific Cinematheque
(on the corner of Howe and Davie)
When:
August 31, 2004 @ 7:30pm
Doors open at 7pm)
Who:
Open to everyone.
What:
Video Launch and Panel Discussions to follow
RSVP:
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FREE Popcorn and Pop

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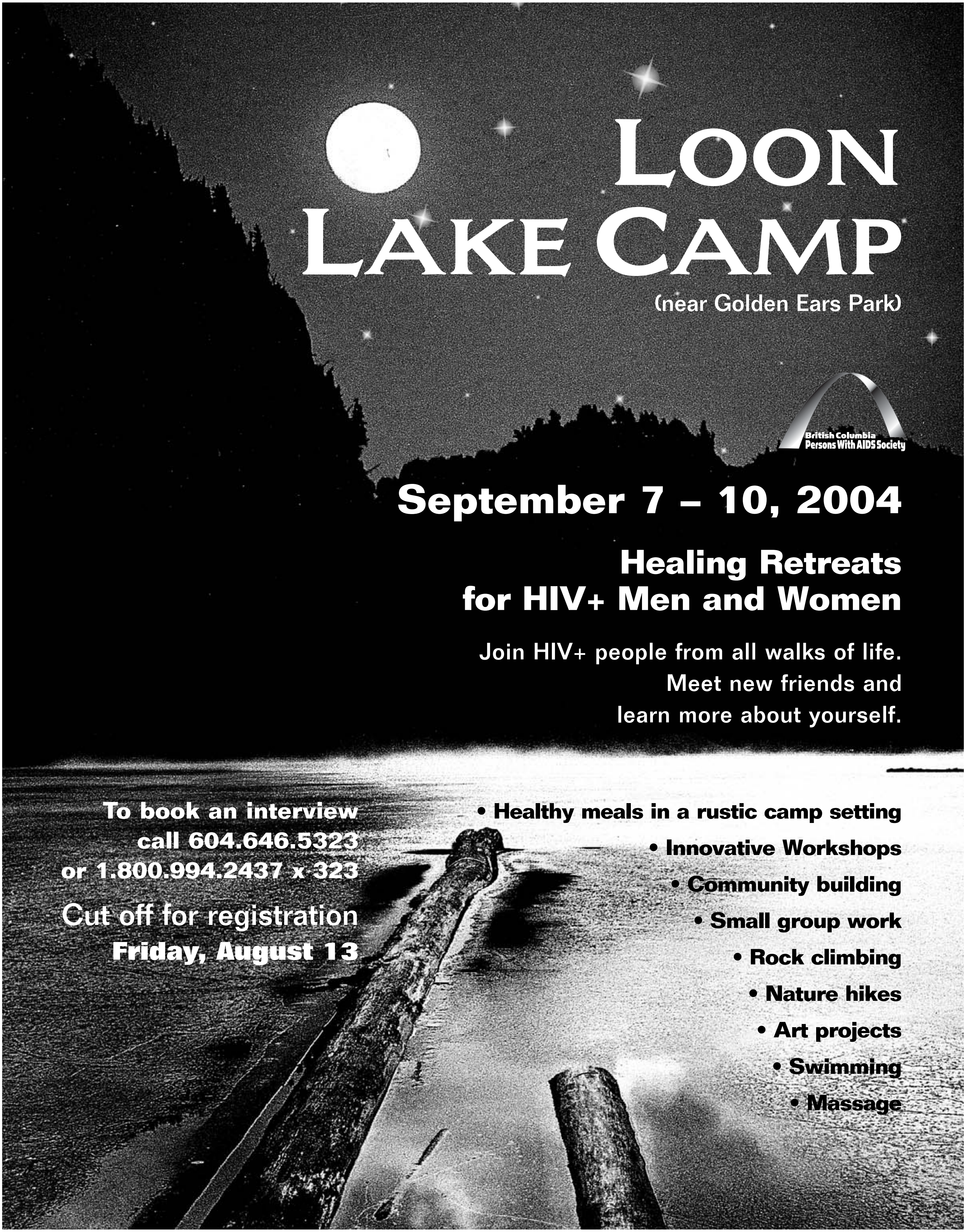
**Supported in part by an unrestricted educational grant provided by Bristol Myers Squibb and GlaxoSmithKline in partnership with Shire BioChem.*

British Columbia Persons With AIDS Society



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- **Massage**

Critical care?

How Ottawa has run down the Canadian Strategy on HIV/AIDS

by Jim Boothroyd

We should have been popping champagne corks the night in May that Ottawa announced, at last, that it would double the budget of the Canadian Strategy on HIV/AIDS (CSHA).

After all, hadn't AIDS organizations achieved their goal, after years of organizing, advocating, and letter-writing? And didn't this mark the first infusion of new money for HIV prevention, treatment, and research in 11 years?

Yes and yes.

Still, on the evening of May 12, after the Minister of Health rose in the House of Commons to make his announcement, few members of Canada's HIV community were celebrating. And most of those following the issue were left shaking their heads and wondering: why and what? Why would our government continue to nickel-and-dime an epidemic that is imposing such an enormous burden on our society, healthcare system, and economy. And what's in the cards now for Canada's troubled AIDS strategy?

Confused? A bit of context helps to explain the response of the HIV community and what to expect next.

continued on next page

Broken promises from the outset

First, some history. The federal government first established a national AIDS strategy in the early 1990s. Brian Mulroney's Progressive Conservative government decided in 1993 that the appropriate amount to allocate to prevention, treatment, and research was $42.2 million per year. As the official Opposition, the Liberals rightly decried this figure as inadequate and vowed to increase it to $55 million once in power. However, once in power, the Liberals ignored this promise as they galloped off to slay the federal deficit.

And that's the way its been for 11 long years. Yes, in 1998, the Grits did make funding of the Canadian Strategy on HIV/AIDS permanent—more difficult to cut, that is—but that's all, despite their promises. (And of this writing in mid-June, the first $5 million installment of the promised new money has yet to reach Treasury Board for approval, making it vulnerable to any change of government.)

With 11 years of inflation factored in, Canadians are fighting HIV/AIDS today with less than three-quarters of the money that they had in 1993.

This is all the more alarming for two reasons. First, the Canadian Strategy on HIV/AIDS is—warts and all—the best weapon we've got to fight the epidemic. Second, the menace of HIV has grown steadily in the last decade and has become *much* more complex.

As a weapon against HIV/AIDS, the federal strategy is credited with informing Canadians about prevention and the relationship between vulnerability to the disease, discrimination, stigma, and other social determinants of health. It has also fostered a constellation of national and local organizations addressing various aspects of the epidemic. And it has encouraged innovative practices such as needle exchange programs across Canada.

In brief, without the CSHA, our homegrown HIV epidemic would be much worse.

And it's already bad enough. Health Canada estimates that 56,000 Canadians were infected with HIV by the end of 2002, up 40 percent from 1996. Worse, nearly one-in-three of these people did not know that they were carrying the lethal virus. This ignorance no doubt contributes to Canada's stubborn incidence rates: 4,200 new infections every year.

The stats aren't pretty

A closer look at these numbers reveals an ever more complex epidemic. According to Health Canada figures published in April, men who have sex with men now represent 44 percent of new HIV infections (down from 75 percent in the period 1985-1994). Women account for 25 percent of new infections, up from 9 percent in the period 1985-1992. Meanwhile, the latest AIDS case reports reveal that 21.5 percent are black Canadians (compared to 8.4 percent in 1993) and 13.4 percent are aboriginal Canadians, up from 1.2 percent in 1993.

This hydra-headed epidemic has also collided in the last decade with the even bigger epidemic of hepatitis C. This situation has further complicated the task of prevention and added to the challenges of treatment, not the least of which is the failure of antiretroviral therapy for many Canadians, as drug resistance, side effects, and poor adherence take their toll. The development of effective vaccines, immunotherapies, and simplified dosing has been hampered meanwhile by the chronic under-funding of HIV research in this country.

> **What seems to have finally focused the minds of our leaders was the real threat, on the eve of an election campaign, of a National Day of Protest.**

The economic burden of HIV is becoming intolerable. In terms of the thousands of person-years of work lost to illness and disability. In terms of the social costs of supporting families with parents sidelined by disease. And in terms of the direct future medical costs. Remember: each new infection costs our healthcare system about $180,000. With 4,200 new infections each year, that amounts to $756 million annually.

These high-level stats are numbing, so it helps to remember what's happening on the ground. Take British Columbia, for example. A study published last year in the *Canadian Medical Association Journal* reveals that 40 percent of aboriginal women injection drug users have HIV. Infection rates in this group are among the worst in the world. Another authoritative study published last year shows that one-third of HIV deaths in BC were among individuals who had never received any HIV treatment. Other recent research blames government policies, including drug enforcement actions, for actually facilitating the transmission of HIV/AIDS and complicating the delivery of HIV care.

All talk and no action

How can an affluent country such as ours allow this to happen? Particularly a country that in 2001 solemnly signed a United Nations declaration that committed signatories to an unprecedented ramping up of the fight against HIV at home and abroad.

We can't, our legislators cry in unison. Soon-to-be prime minister Paul Martin, for example, said as much at the 2002 AIDS Walk in Montreal. After special hearings on the Canadian Strategy on HIV/AIDS, members of the all-party House of Commons Standing Committee on Health went further, recommending an immediate increase in funding to $100 million. And former health minister Anne McLellan vowed publicly in June 2003 to recommend to Cabinet last fall that same increase.

The Honourable Anne McLellan didn't follow through on her vow. Nor did her successor, Pierre Pettigrew, despite expressions of sympathy. And Paul Martin's March budget didn't even mention Canada's HIV/AIDS epidemic.

Canadians are fighting HIV/AIDS today with less than three-quarters of the money that they had in 1993.

What seems to have finally focused the minds of our leaders—after their decade of indifference—was the real threat, on the eve of an election campaign, of a National Day of Protest: prime-time news footage of a crowd lying down in a Montreal street during a noon-hour die-in outside the offices of Health Canada. Hundreds of red-shirted protesters marching through downtown Edmonton and banging drums outside the riding office of the Deputy Prime Minister Anne McLellan. A wacky piece of street theatre in Vancouver starring the Canadian Strategy on HIV/AIDS (patient on life-support) and Prime Minister Paul Martin (negligent doctor).

On Friday, May 7, posters and draft news releases (protests planned for May 14) arrived at the offices of the Minister of Health—and, voilà, five days later Mr. Pettigrew rose in the House to announce the increase.

Details are sketchy, but he promised to increase the budget of the CSHA over five years to $84.4 million. The trouble is, after 11 years of no increases, this amount is too little too late. A detailed Health Canada report of June 2003, for example, notes that an *immediate* increase in the budget to $84.4 million would amount to the equivalent of what was invested in 1990 (adjusted for inflation and increased HIV prevalence). The report, therefore, recommends an immediate increase to at least $106 million per year.

This level of funding is needed "to get ahead of the epidemic." Without it, badly needed initiatives will be nixed, the Health Canada report states. No action plan for promoting population health and social justice. No major efforts to promote more equitable access to services—for people in rural communities, for example. And no money for community-based prevention, treatment, or care programs tailored for specific hard-hit demographic groups—aboriginal peoples, prisoners, and women, among others.

Mr. Pettigrew has offered less money, phased in gradually: $5 million in year one for community organizations only; $8 million each in years two and three; and the remaining $21 million or so in two dollops in 2007 and 2008. As well, the money could be reduced from year to year or cut all together.

Hence the groans of disappointment on May 12. (Community organizers decided for political reasons to call off the National Day of Protest on May 14. Instead, they issued news releases and articulated their concerns in a formal letter to the Minister of Health, the Minister of State (Public Health), and the Prime Minister.)

What the future may hold

But where does this leave the Canadian Strategy on HIV/AIDS in the summer of 2004?

The results of the election (two weeks away at the time of writing) will provide part of the answer. There may be cause for hope if the Liberals squeak back into office with the support of the NDP. Minister of State (Public Health) Carolyn Bennett has promised, after all, to discuss accelerating the funding increase if her party forms the next government.

However, the prospects could be gloomier if the new Conservatives come to power. True, members of the Canadian Alliance (now Conservatives) on the House of Commons Standing Committee on Health, including health critic Robert Merrifield, recommended an immediate doubling of the CSHA budget. But they favour a shift in emphasis to abstinence-based prevention programs for youth at the expense of other initiatives. And Stephen Harper has yet to distinguish himself as a friend of the AIDS community.

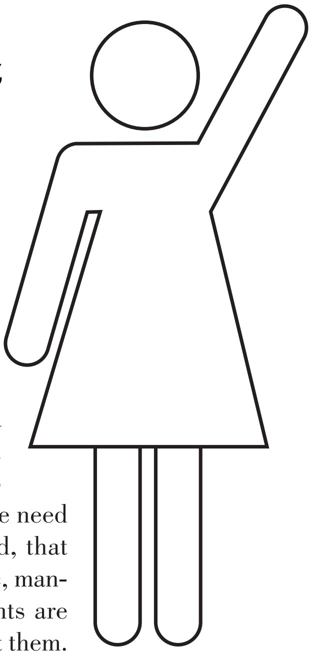
One thing is for sure, though. Further inaction on HIV/AIDS will trigger more protests, die-ins, and street theatre. And this time, Canada's homegrown epidemic and the failure to fight it will be the focus of world media at the 2006 International AIDS Conference in Toronto. ⊕

Jim Boothroyd is secretary to the Canadian Coalition of HIV/AIDS Stakeholder Organizations and Communications Manager at the Canadian HIV Trials Network. The views expressed in this article are his only and do not necessarily reflect those of the Coalition or the Network..

Bearing the brunt

An abridged version of a speech on International Women's Day, March 2004

by Louise Binder



There is a common belief today we have the HIV epidemic under control in Canada. People think that infection rates are down, that HIV is no longer a killer, that people therefore need not worry about becoming infected, that treatments have made this a chronic, manageable disease, and that treatments are available to all Canadians who want them.

These beliefs are simply not true, and I would argue that women dispel these mistaken beliefs most starkly. In 2002, women accounted for nearly one-third of the new infections in Canada. Even more startling, in the 15 to 29 age group, they made up nearly one-half of all new infections.

What a devastating situation for these young women whose lives have barely begun. I remember too well the feeling of complete shock and total hopelessness I felt when I was given my diagnosis over the phone by my family doctor.

Is this tragedy an inevitable result of the perceived invincibility of youth or have we as a society failed these young women? I would argue that we must bear a portion of the blame for these infections. We know that women are biologically, economically, socially, and culturally more vulnerable to HIV infection than men. In a practical context, it means that women in violent relationships or who fear violence cannot negotiate safer sex practices. It means that women who are raped are more likely to be infected due to physical trauma that opens wounds for HIV to enter. It means that women who are dependent on their sexual partners for food and shelter for themselves and their children cannot demand condom use.

We have failed as a society to provide women with sufficient resources to leave unsafe relationships or with the tools to protect themselves. We need education and awareness programs targeted to women and their partners, more shelters for women to escape the nightmare of violent relationships, adequate social assistance programs to give them independence, and more drug rehabilitation programs to ensure they can participate fully in supporting themselves and their families. We also need more money for research for microbicides, a user-controlled form of HIV protection. And we desperately need to tackle the stigma and discrimination that has made so many of us ashamed to declare our medical status publicly.

One of the most heartbreaking moments I can remember is a phone call informing me that my wonderful, bright, funny girlfriend Candace had jumped to her death from the fifteenth floor of her apartment building as her care worker made her bed in the other room. Her body had not yet succumbed to this disease, but the depression, fear, and shame she felt about her HIV status drove her to end her life.

There is clearly much work to be done to recognize the vulnerability of women to HIV. It is also clear that some groups of Canadian women, such as aboriginal women, have additional risk factors that increase their vulnerability to HIV. Research and common sense tell us that social factors, including racism and sexism piled on top of stigma, discrimination, and poverty, have more to do with vulnerability to HIV than does individual behaviour. Shockingly, aboriginal women make up one-half of all new infections among aboriginal people. Nearly one-half of these women are between the ages of 15 and 29. Aboriginal women are twice as likely to be infected by injection drug use than by sexual contact.

We need new and dedicated resources to reach these women and their partners. We need better harm reduction strategies, more affordable housing, more resources for women to leave violent relationships, and more childcare for single mothers.

Our society must create the necessary social environment to support self-determination. Otherwise, we will merely perpetuate the terrible situation in which this generation of women finds itself.

Imagine the layers and layers of discrimination a woman feels because of her gender, because she is aboriginal, because she is an injection drug user, and because she is poor, unemployed, and probably homeless or underhoused. Nowhere is this social recipe for HIV more apparent than in Vancouver's Downtown Eastside.

Studies in Vancouver show that the incidence of HIV among female drug users is 40 percent higher than among male drug users. These women are more likely to be aboriginal, to be young, to have had non-consensual sex, to have an intravenous drug-using male partner, to inject heroin and cocaine, to smoke crack, and to need assistance with injecting.

"There is clearly much work to be done to recognize the vulnerability of women to HIV."

I have watched, first hand, the impact of drug addiction and HIV on women. Last year, a dear, HIV-positive friend and colleague at Voices of Positive Women died. She was also an injection drug user, on and off, for many years. When she wasn't using, she was one of the most reliable and hard-working people I knew. She had a dignity I truly admired, and she never appeared to feel sorry for herself. She just couldn't beat her addictions. Finally, her liver failed due to a combination of disease and drug toxicities. Once again, the inescapable and only logical conclusion is that we urgently need resources for gender and population-specific programs, such as needle exchanges, safe injection sites, and street nurses.

Women from HIV-endemic countries in Africa and the Caribbean are another group who have been sadly overlooked and underestimated regarding their risk for HIV infection. When a report from the Toronto Hospital for Sick Children found that 70 percent of the maternal-infant transmissions of HIV at that hospital in 1996 had occurred among people from HIV-endemic countries, the magnitude of the problem could no longer be ignored. In-depth research showed that HIV-positive women from endemic countries represented a startling one-third of AIDS-related deaths in 1996 in Ontario. An estimated 30 to 40 percent of those infections occurred after the establishment of residence in Canada, contrary to the popular belief that these immigrants brought the virus to Canada.

For these women, deeply rooted socio-cultural and structural factors intersect with gender, race, class, political, and economic conditions. In these societies, where the well-being of the family and the community supersedes the well-being of the individual, strategies must target whole communities in order to modify cultural values, beliefs, norms, and practices that increase the risk of HIV infection.

Women in prisons also face high infection rates for HIV as well as for hepatitis C. Some enter prison with HIV, but many are infected in prison due to injection drug use and tattooing. These infections are easily prevented by implementing policies that ensure access to clean needles and safe injection practices.

Clearly, we are dealing with an epidemic among women that is fuelled by complex social, economic, cultural, and racial factors. Discreet strategies are required to reach these groups of women effectively and to reduce their risk for HIV. This will require new resources and strategies developed by the communities themselves.

Not only is there much to be done for each group on the prevention front, but Canada also has much to do to ensure that treatments are reaching all of these populations. Treatment and prevention are inextricably linked. For those of us who have been able to obtain treatments, they have been nothing short of life saving. There is a widely held belief that everyone in Canada who needs treatment can access it. This is simply not true. Most provinces have a program to provide some medications to people, but these plans are not universal, comprehensive, or easily accessible.

Studies have shown that many women do not access medications. One Vancouver study showed that a shocking one-third of people who died from AIDS between 1995 and 2001 had not been taking antiretroviral treatment—in a province where medication is free. Those worst off were aboriginals, women, and the poor. Inability to access and navigate the system due to money, culture, language, and power barriers impedes access to medications.

In some cases, the system is simply too costly, with unaffordable co-payments or deductibles. Or it requires an ability to understand bureaucratic forms and procedures that are too complex for most people, or a level of tenacity that a marginalized person may well not have.

Canada made a wonderful start to turning this situation around when it introduced the Canadian Strategy on HIV/AIDS in the early 1990s. Sadly, this strategy is now woefully underfunded to meet the particular challenges faced by women, among others. More funding is also required by provincial governments.

Canada wisely endorsed the United Nations Declaration of Commitment on HIV/AIDS in June 2001. Full implementation of the priorities set out in this Declaration will go a long way to combat HIV in Canada.

I believe that HIV is much more than a virus. It has socio-economic, political, and ethical dimensions, the likes of which humanity has never before encountered. It has brought out the worst in some of us. But I believe that it has also brought out the best and will continue to do so. ⊕

Louise Binder is the chair of the Canadian Treatment Action Council.

FIGHTING WORDS

US government could gain access to our medical records

by Glen Bradford

The BC government is in the process of contracting out the administration of PharmaCare and the Medical Services Plan to Maximus, a company based in the United States. It is our understanding that no guarantees are currently in place that Maximus will be able to protect the privacy and confidentiality of BC patients' records. The BCPWA Society has, therefore, written to BC Premier Gordon Campbell about this serious issue.

All American companies and their affiliates are subject to the USA Patriot Act and, therefore, could be required by the FBI to turn over personal information if there is concern about a criminal offence. Evidence of a criminal offence in violation of US laws is not limited to terrorist activities.

Section 156, an amendment to the US Foreign Intelligence Surveillance Act, grants the FBI the authority to compel production of medical records, in addition to business records, educational records, and library records, without showing probable cause (existence of specific facts to support the belief that a crime has been committed or that the items sought are evidence of a crime). Persons served with a search warrant under this law may not disclose, under penalty of law, the existence of the warrant or the fact that records were provided to the US government.

> **In a letter to Premier Campbell, BCPWA has demanded that the BC government secure meaningful privacy guarantees or scrap the Maximus deal.**

Numerous provisions in the Homeland Security Act permit the centralization of information obtained under the auspices of the USA Patriot Act and other sources into enormous secret databanks. These databanks are routinely available to various law enforcement and other US government agents, but the individuals concerned are given no notice and are not allowed access.

Issues of privacy and confidentiality are paramount to people living with HIV/AIDS. People living with HIV/AIDS are currently banned from travelling to the US, but some need to go there for various reasons. If US immigration discovered an individual is HIV-positive, he or she would be turned away and entered permanently into a national database.

We are alarmed by the potential for the US government to gain access to personal medical records and by the possible consequences. This turn of events is disturbing enough for the average Canadian citizen; for HIV-positive British Columbians, it's downright scary.

In a letter to Premier Campbell, the BCPWA Society has demanded that the BC government secure meaningful privacy guarantees or scrap the Maximus deal. We urge Premier Campbell to secure a written guarantee from US Attorney General John Ashcroft to the effect that BC residents' medical records will never be subject to search or seizure by any agent of the US government for any reason. Guarantees offered by anybody else, including Maximus, are worth about as much as the latest Internet miracle cures for AIDS.

The effective administration of the healthcare system in BC, including the protection of individual British Columbians' privacy, is the responsibility of the BC government. It cannot be shuffled off onto others. The federal government cancelled contracts with an American company over privacy concerns; the provincial government should do the same.

Be assured that we will continue to use *Living*+ and the news media to keep HIV-positive British Columbians and uninfected populations informed about this issue and to ensure that individuals understand what is at stake. ⊕

Glen Bradford is the chair of the BCPWA Society.

Making assumptions

A national social marketing campaign reinvigorates gay men's HIV prevention

by Phillip Banks

HIV infection rates are increasing among gay men across Canada. This news is surely new to few. What is new is that to address this increase, Health Canada and other organizations across the country have funded a national, community-based social marketing campaign to reinvigorate gay men's HIV prevention. This exciting opportunity has brought together HIV prevention organizations from coast to coast to develop and implement an intervention that goes beyond "wear a condom every time" messages to examining the complex issues that contribute to the transmission of HIV in gay men's communities.

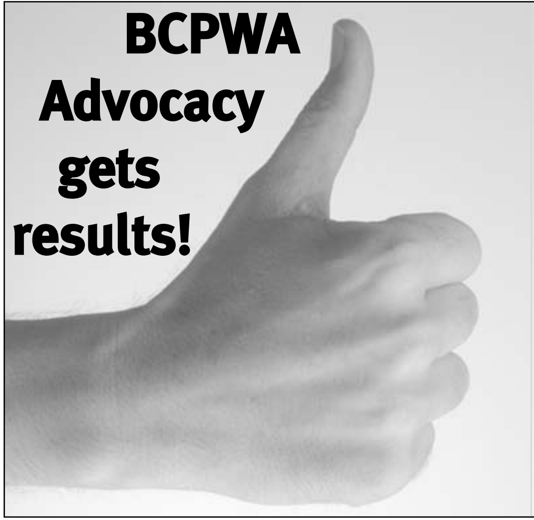
Given the lack of social marketing initiatives targeted at gay men in the last eight to ten years, this project will provide many AIDS organizations working with gay men the opportunity to come together and share collective knowledge, experience, and resources in an effort to positively promote HIV prevention across Canada. The need to stimulate dialogue and reinvigorate HIV educational initiatives that acknowledge and respect the strategies gay men have been using to reduce HIV risk is urgent. Gay men need prevention efforts that support and assist them in recognizing the risk conditions inherent in the shifting sexual safety norms of their own communities.

To revitalize HIV prevention initiatives targeting gay men, a national project team led by AIDS Vancouver—with representatives from the AIDS Coalition of Nova Scotia, AIDS Community Care Montreal, Action Séro Zéro, AIDS Committee of Toronto, Two-Spirited People of the First Nations, Canadian AIDS Society, Nine Circles Community Health Centre, HIV Edmonton, the Asian Society for the Intervention of AIDS, the Community-Based Research Centre—has launched Assumptions, a campaign originally developed and implemented in San Francisco in 2000. This campaign has been adapted and expanded to address the Canadian cultural context based on feedback from focus groups conducted in six cities across the country. The campaign will target these six cities, and at least 20 other cities will implement the campaign to some degree over a two-month period.

Produced by the San Francisco AIDS Foundation and Cabra Diseño, the Assumptions campaign is based on local researchers' findings that many gay men engaging in anal intercourse without condoms frequently do so based on the faulty assumption that they and their sex partners share the same HIV status. In assuming the same status, many men underestimate the risk associated with engaging in unprotected anal intercourse.

Assumptions brings the difficult and complex issues of sexual assumptions and sexual silence into the open and asks men to reconsider the specific assumptions behind their own choices about how to protect their health and that of their sex partners. The hope is that the Assumptions campaign will be a strong tool for stimulating gay men to rethink their personal HIV risk reduction strategies. It is also hoped that the partnerships strengthened in this campaign will form a solid foundation for building upon the successes of the first phase into the second and beyond. ⊕

Phillip Banks is the gay mens health program coordinator at AIDS Vancouver.



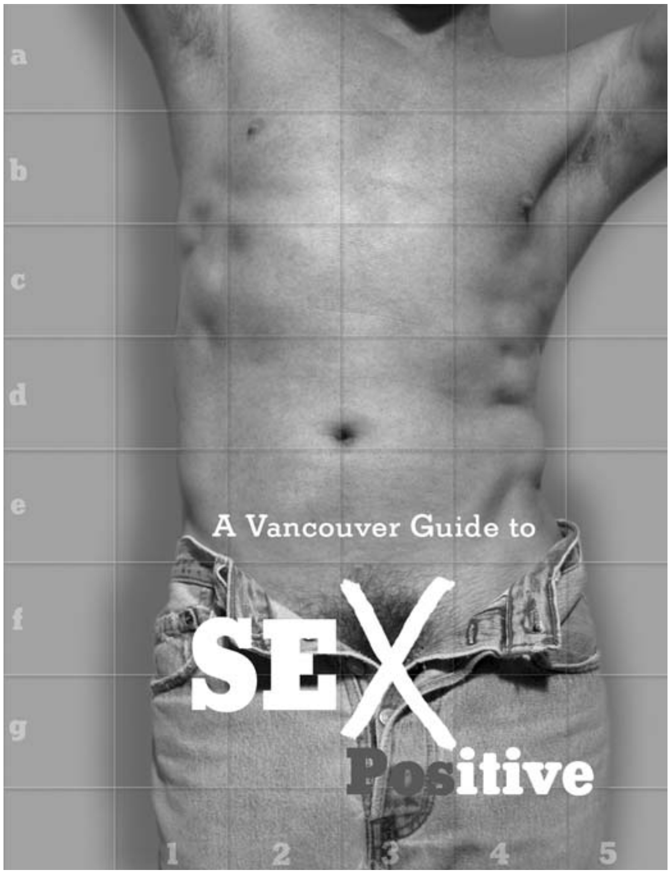
The BCPWA Society's Advocacy Program continues to work hard to secure funds and benefits for HIV+ individuals. The income secured for April and May 2004 is:

- ▼ **$48,363.33 in debt forgiveness.**
- ▼ **$60,770.12 in housing, health benefits, dental and long-term disability benefits.**
- ▼ **$29,955.00 in Monthly Nutritional Supplement Benefits.**
- ▼ **$371,671.59 into members' hands for healthcare needs, from grandfathered Schedule C benefits.**

Sex in the city

BCPWA produces prevention booklet for HIV-positive gay men

by Lisa Gallo



HIV-positive gay men in the Lower Mainland will soon have at their fingertips an innovative, West End focused, "Sex Positive" booklet containing sexual health information with sexually explicit male imagery.

The booklet was created by the BCPWA Society's Positive Prevention department because of an apparent growing need to initiate dialogue with the average gay male around disclosure and negotiation.

The BC Centre for Disease Control reports that there are more than 5,000 HIV-positive men who have sex with men (MSM) in BC. Yet, very few prevention interventions have been directed to HIV-positive gay men.

According to the published results of the Sex Now survey conducted in 2002, 70 per cent of men expected that if their partner were HIV-positive, he would disclose his status prior to sexual activity. But only 53 per cent of HIV-positive gay men expect their sexual partners to disclose. These numbers represent a growing problem that requires a comprehensive, long-term solution.

The BCPWA Society insists that HIV-positive persons have the right to a healthy and fulfilling sexual life and deserve to have interventions to help them stay safe while playing an active role in curbing the epidemic.

A possible barrier to promoting safer behaviours is that safe sex messages do not promote safe sex as being "fun". HIV-positive gay men may want support in changing their behaviours, but may not pay much attention to messaging that is neither fun nor erotic.

The Sex Positive booklet uniquely combines erotica and fundamental prevention messaging, including the importance of engaging in safer sex, a risk reduction menu, disclosure and negotiation techniques, recreational drug use and safety tips, community services and resources, a map of locations to meet other sexually active men, and a condom.

To receive a copy of the Sex Positive booklet after August 15th, please email prevention@bcpwa.org or call 604.893.2225. For more information about BCPWA's Positive Prevention programs, visit <www.bcpwa.org/prevention.php>. ⊕

Lisa Gallo is the Director of Communications and Education for the BCPWA Society.

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 responsibliity 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.

More PEP talk

by Rob Gair

In the Nov/Dec 2003 issue of *Living +*, I talked about the temporary use of antiretrovirals—usually three drugs for one month—as soon as possible following exposure to HIV to prevent seroconversion. Better known as post-exposure prophylaxis (PEP), this method of HIV prevention has been effective for healthcare workers and sexual assault survivors.

The use of PEP following non-occupational exposures—consensual sex or injection drug use, for example—remains controversial. People who are against using PEP in these situations have three main concerns: lack of evidence that it works in these groups; fears that widespread availability of PEP will only serve to increase risky activities; and cost effectiveness. Despite these issues, certain jurisdictions are actively studying the use of PEP following non-occupational exposures.

In Brazil in 1998, a group of 200 known high-risk HIV-negative gay men in Rio de Janeiro were given a four-day supply of twice-daily lamivudine plus zidovudine (Combivir). They were instructed to begin therapy immediately after any mucous membrane exposure to blood, semen, or vaginal secretions. Individuals with eligible exposures were given an additional 24-day supply.

Data collected two years later showed that 68 of the 200 men started PEP a total of 109 times. The majority (72 percent) used the 28-day course of PEP only once, and 90 percent used it no more than twice. Eight to nine percent completed the full 28 days of therapy even though nausea was frequently reported. Despite the easy access to PEP, frequent use was not common and high-risk sexual activities decreased over time. Eleven seroconversions occurred, which is a rate similar to rates in the absence of PEP. However, ten of them occurred in people who failed to use PEP when they should have, indicating that some men underestimated their risk. The study did not assess cost-effectiveness.

In Australia, guidelines were implemented in 1998 stating that people with a known sexual or needle exposure to HIV should start PEP within 72 hours. Early results from a study observing implementation of the guidelines showed a general lack of awareness about PEP availability. Awareness improved with a promotional campaign.

The latest data show that over 800 men, most of them gay, have participated in the program. Over 60 percent fully completed the course of medications, with approximately 50 percent reporting mild to moderate side effects. No HIV seroconversions have occurred among program participants. Some stated that using PEP

continued on next page

has given them valuable insight into the reality of taking antiretrovirals for treatment of actual HIV infection, thus deterring them from risky activities. Cost effectiveness analyses are not available.

> **The use of PEP following non-occupational exposures — consensual sex or injection drug use, for example — remains controversial.**

A recent online news item discussed the use of antiretroviral prophylaxis before HIV exposure. The idea behind *pre-exposure* prophylaxis (PREP) is to give daily low-dose antiretroviral therapy to high-risk individuals to stop HIV when it first attacks the body. According to the report, several agencies are expected to launch studies in the next year examining the effect of once-daily doses of tenofovir. Participants are expected to include high-risk groups such as heterosexual women and men in West Africa, prostitutes in Cambodia, and gay and bisexual men in the US. Whether PREP will work remains to be seen. Results are not expected for at least two years.

Despite controversy over the use of PEP for non-occupational HIV exposures, several jurisdictions continue to study its feasibility. Most of the published data show that PEP is effective and relatively well tolerated. Knowledge about its availability does not appear to increase risky activity. Using PEP is expensive for the number of real HIV infections it prevents, so its cost effectiveness is debatable. Whether long term PREP is feasible or cost effective also remains to be seen. ⊕

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

AGM

Notice of Annual General Meeting

British Columbia Persons With AIDS Society

WHEN: Saturday, August 21, 2004 at 11:00 AM

WHERE: The Training Room, 1107 Seymour Street, Vancouver

REGISTRATION: 10:00 AM – 11:00 AM

MEETING BEGINS AT: 11:00 AM (Sharp)

The membership will meet to receive the Annual Report of the Directors, consider amendments to the by-laws of the Society, if any, elect the Board of Directors of the Society for 2004/2005, and conduct other such business as is deemed necessary in accordance with the constitution and bylaws of the Society.

Important Dates to Remember:

For individuals who do not receive mail, AGM Packages will be ready for pick up from Member Services(Reception) Desk on **August 3rd, 2004.**

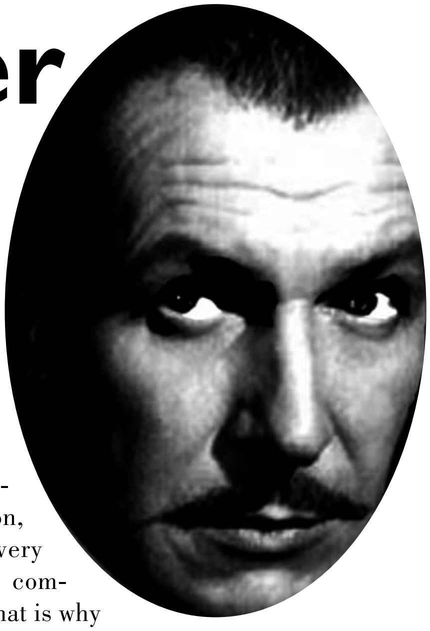
Last day Proxies are Mailed is **August 6, 2004**

Last Day Proxies May be Requested for Pick up is **August 13, 2004**

If you have any questions or would like to receive a copy of the Society's Annual Report please call Paul Lewand, Secretary, at 604.893.2232 and leave a confidential message. To ensure accuracy please spell your last name slowly in the voice message and leave a contact phone number.

A lunch will be served.

The great deceiver



Syphilis is notoriously hard to diagnose accurately

by Sam Friedman

Syphilis is caused by the organism *Treponema pallidum*. If not treated early and correctly, syphilis will cause damage over several months or years to the eyes and liver. The nervous, cardiovascular, and skeletal systems will be attacked, causing neurologic problems, blindness, dementia, and eventually death.

Syphilis can be transmitted only through direct physical contact between syphilis chancre sores, which are rash-like lesions, and any mucosal membrane or cut on the body. Condoms, gloves, and dental dams will not always prevent transmission.

The symptoms and damage caused by syphilis depend on the stage of infection. Primary stage symptoms are chancre sores that develop individually and in groups within two to six weeks after infection and then heal a few weeks later on their own. When these chancre sores stop developing and have completely healed, the patient has progressed to the secondary stage.

Secondary stage symptoms are the rash-like lesions that appear anywhere on or in the body, including the palms of the hands and the soles of the feet. They are highly infectious only when the skin is broken. They take weeks, months, or years to completely heal and disappear.

Studies show that HIV-positive individuals with suppressed immune systems progress from the primary to latent stage of syphilis faster.

The latent stage begins when all symptoms have ceased. A latent-stage infected person is a non-infectious carrier since they have no chancres or lesions. However, syphilis remains in the body and over several months to years causes further damage, including neurosyphilis, which can lead to neurologic damage, impaired muscle movement, paralysis, numbness, gradual blindness, dementia, and finally death.

Studies show that HIV-positive individuals with suppressed immune systems progress from primary to latent stage faster than their HIV-negative counterparts. Also, syphilis sores make it easier to transmit and acquire HIV.

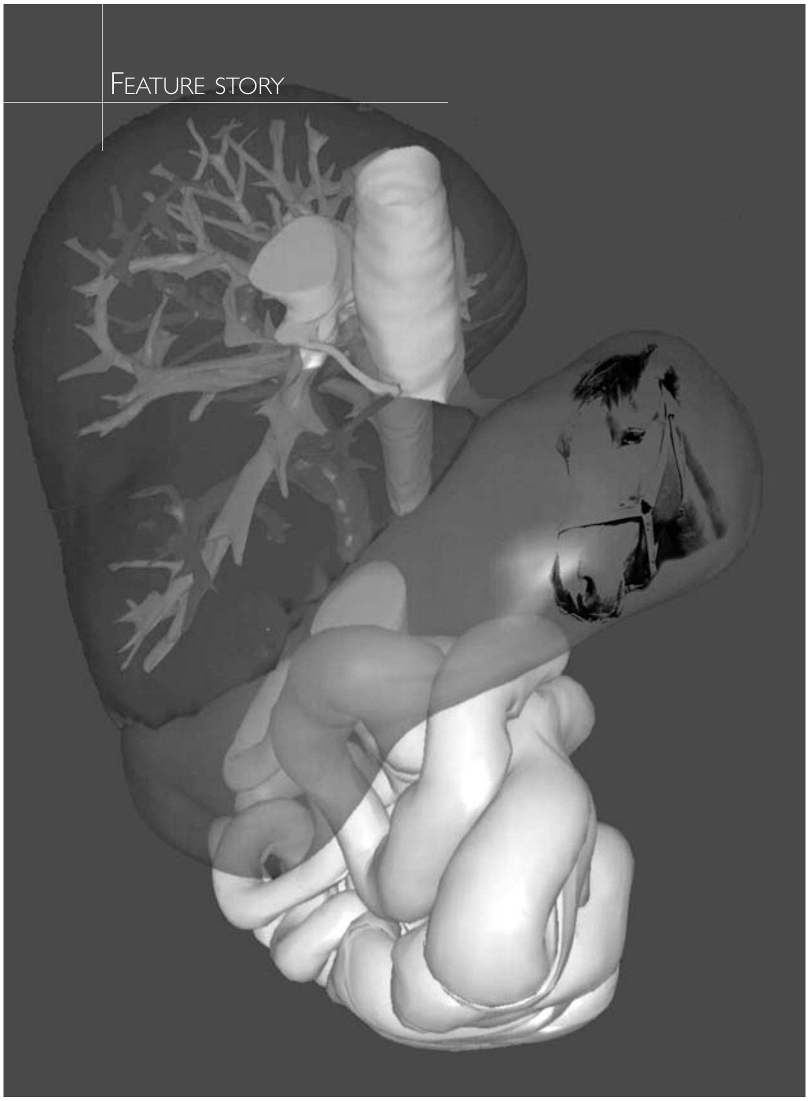
Syphilis is notoriously hard to diagnose accurately by visual inspection only. The chancre sores are painless and the rash-like lesions do not itch, so both symptoms often go unnoticed. On visual inspection, these outbreaks appear very similar to several other commonly known infections. That is why syphilis is often referred to as the “great deceiver.” Visual misdiagnosis and incorrect treatment are common, which allows syphilis to progress and, over a relatively short period, to cause systemic damage that only vigilance in screening, proper testing, and early and correct treatment will prevent.

The best tools to accurately diagnose syphilis are a skin biopsy of a chancre or lesion and blood tests. Antibody testing will only provide meaningful results if performed at least six weeks after initial infection because the body takes that long to produce detectable antibodies. A blood culture test will confirm definitively if the organism is present or not, even if no symptoms are present.

HIV-infected people who are sexually active should check their partner’s bodies and their own bodies regularly for any unusual sores or lesions. If you find anything of concern, ask your doctor to examine it and request the proper tests to confirm or rule out a syphilis infection. If you are still uninfected, make sure you get screenings twice a year.

In people with HIV, treating primary and secondary stage syphilis requires weekly intramuscular injections of penicillin for three weeks or more. Treating HIV-infected patients for latent-stage syphilis and neurosyphilis requires an intravenous line to administer even higher doses of penicillin every four hours for at least two weeks. For PWAs who are allergic to penicillin, doxycycline is recommended, though it is not as effective as penicillin. ⊕

Sam Friedman is a member of the BCPWA Society and a treatment information counsellor for the Treatment Information Program. He has advanced HIV disease.



The body's workhorse

Keeping your liver humming along and preventing toxicity

by Derek Thaczuk

The liver is certainly not a glamorous organ—it's a football-sized glob tucked underneath your ribcage. If you've ever seen liver in the supermarket, or eaten it, you know exactly what it looks like.

It doesn't need to be lovely, though. The liver is one of the body's real workhorses. It filters toxins, or poisons, out of the blood, builds vital proteins and chemicals, breaks down other substances such as medications into usable forms, and controls the levels of all of them so that you get the right amounts. Everything that goes into your body gets processed through your liver. It's a full-scale, 24-hour chemical plant.

Your liver is built tough enough to handle all of this. In fact, it's made to tackle the tough jobs. But it has its limits. If stressed too hard for too long, it can wear out. Stress on the liver is called liver toxicity (or hepatotoxicity, where hepato- means anything liver-related). It can be serious. If your liver isn't working correctly, your body chemistry goes askew and toxins can build up to poisonous levels. In extreme cases, liver damage can be fatal. Let's talk about how to keep that from happening.

Liver function tests measure liver health

Two main blood tests called aminotransferase level tests measure enzymes—chemicals produced by the liver—to gauge the amount of stress on the liver. ALT, or alanine aminotransferase, is a chemical produced by liver cells that leaks into the bloodstream when the cells are damaged or die. High ALT levels in the blood are a sign of liver damage, though normal ALT levels do not necessarily mean there is no damage. SGPT is an older term for it. AST, or aspartate aminotransferase, is similar to ALT, but it is produced by other bodily organs as well. SGOT is the older term.

These two enzyme levels, taken together, give a picture of your liver status. ALT and AST results are given in multiples of ULN, or "upper limit of normal", as follows:

- Normal range: 0 to 1
- Mild: 1 to 5 = grade 1 or grade 2 toxicity
- Moderate: 5 to 10 = grade 3 toxicity
- Severe: Over 10 = grade 4 toxicity

Grade 3 or 4 levels, that is, more than 5 times higher than normal, are considered serious. However, recent studies have shown that people with HIV may do worse in the long run if their ALT and AST levels are even mildly elevated. Hepatologists, or liver specialists, consider levels over 2 times normal to be warning signs. Many HIV specialists have become a little blasé about slightly elevated liver enzymes because they're so common. Perhaps it's time for that to change.

Other blood tests include measurements of bilirubin, alkaline phosphatase, gamma-glutamyl transpeptidase (GGT), and lactic dehydrogenase (LDH). These measures are used as supplemental tests, along with ALT and AST.

Checking for liver damage

If you have any reason to believe your liver is damaged, the only way to confirm it is by examining it through a biopsy. This means sticking a long needle into your side and grabbing a little bit of your liver. The whole procedure takes a couple of hours, including preparation and recovery. Many people don't even feel lingering pain afterward. (See "Understanding Liver Biopsies" in the May/June 2003 issue of *Living*+.)

The liver tissue cells are then examined in detail under a microscope. Changes in cell tissue can be graded as follows:

- normal or minor changes
- fibrosis, a progressive hardening and toughening of the liver tissue
- cirrhosis, severe scarring, bordering on complete liver failure

Another liver condition, called hepatic steatosis, is a dangerous buildup of fat in the liver tissue.

Low-grade damage is often reversible if the cause of the problem is removed. The liver is very good at rebuilding itself. Serious damage like advanced fibrosis and cirrhosis usually takes a long time to develop.

Hepatitis is one culprit of liver damage. The word "hepatitis" simply means inflammation, or abnormal swelling, of the liver. It's a blanket term for liver problems in general. Viral hepatitis refers to viral infections that target the liver. At least three different kinds of viruses can infect the liver, each leading to a distinct kind of disease—hepatitis virus A (HAV), hepatitis B (HBV), and hepatitis C (HCV).

If you're living with HIV and hepatitis, your liver is already under chronic stress, so keeping other forms of liver toxicity to a minimum is crucial. For most people with co-infection, keeping your liver healthy is one of the best things you can do.

Some meds are tough on the liver

Since your liver is in charge of processing just about every chemical in your bloodstream, it's no wonder that medications can stress it. Let's face it, most drugs are toxic—they're meant to kill (or at least control) HIV and other infectious organisms. Think of them as bug killers: necessary poisons. The trick is finding ones that do what they're supposed to without being too toxic to your body.

When it comes to the liver, a few specific antiretrovirals tend to be the toughest. Ritonavir (Norvir) is definitely the hardest on the liver (at the full dose of 600mg, twice a day). Almost nobody takes high-dose ritonavir any more, though. These days, it's usually used as a booster for other drugs. This strategy actually takes advantage of its effects on the liver. Ritonavir slows down the chemical pathways that clear other drugs out of the body. Taking certain drugs along with a small dose of ritonavir gives you higher active drug levels in the blood, the same way traffic backs up on the highway when a lane is blocked. These "baby" doses of ritonavir—like the small amount included in lopinavir/ritonavir (Kaletra) capsules—are easier to handle.

> **Since your liver is in charge of processing just about every chemical in your bloodstream, it's no wonder that medications can stress it.**

However, any amount of ritonavir in a drug combination is worth watching. In a recent study by Mark Sulkowski, 30 percent of people taking ritonavir showed severe liver toxicity, and 9.4 percent of HIV/HCV co-infected people had severe liver toxicity from other medications. Only 2.7 percent of those without hepatitis C experienced severe liver toxicity.

The other two medications to watch out for most are nevirapine (Viramune) and efavirenz (Sustiva). These are the next most likely drugs, after ritonavir, to cause serious liver toxicity. A recent "Dear Dr." letter from Boehringer Ingelheim, the manufacturer of nevirapine, warned of severe, possibly fatal, reactions, particularly in women with CD4 counts higher than 250, whose risk of liver trouble increases twelve-fold if they take nevirapine. (Men with CD4 counts over 400 are at three times greater risk of hepatotoxicity from nevirapine.) Yes, that does say *higher* CD4 counts: it sounds odd, but it's probably a result of immune reconstitution—the increased immune activity that happens when HIV-positive people begin taking antiretrovirals. Ironically, the immune boost may actually drive the liver toxicity.

A lot of evidence also links nucleoside analog drugs such as didanosine (Videx, formerly ddI) and stavudine (Zerit, formerly d4T) to mitochondrial toxicity. This damage to the mitochondria, the tiny power plants inside our cells, can sometimes lead to serious problems, including the hepatic steatosis mentioned above.

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Great, you say. What can I take that isn't worse than the disease? Don't forget, though, that it's all a matter of chance. As one doctor put it, "I have patients with hepatitis who drink, who are still fine with nevirapine." Just because these drugs are likely to cause liver trouble doesn't mean they will, but they should be watched closely. If your risk of liver toxicity is low to begin with, even a significant increase in risk may still be acceptable. Like any serious medical condition, treating HIV comes with risks that must be managed with care.

> **If your liver isn't working right, your body chemistry goes askew, and toxins can build up to poisonous levels.**

Avoiding alcohol to give your liver a break

Medications aren't the only thing that can whack your liver. Toxins of any kind will also do it, first and foremost, alcohol. Your liver has to work hard to get it out of your system. Cutting down on alcohol consumption or cutting it out completely is probably the single biggest boost you can give your liver. For many, though, avoiding alcohol is easier said than done. If you're dealing with liver toxicity, especially if you have chronic hepatitis, cutting down on your drinking is a huge help. According to current medical recommendations, if you can't abstain, keep your alcohol intake under 50 grams per day. That's 3.6 standard drinks daily, each drink meaning one bottle of beer, glass of wine, or shot of liquor.

The effects of other recreational drugs aren't so certain. Cocaine is definitely bad news for HIV infection because heavy use takes a toll on the immune system. But there's not a lot of evidence about the effect of other party drugs on the liver. Marijuana has not been shown to have any serious liver toxicity. But other drugs, such as heroin and opiates, speed, crystal meth, ecstasy, and K, put the liver through its usual paces, so moderation is probably in order.

Dealing with it

How do you keep your liver happy? The answer is common sense: try to avoid what's stressing it. That can mean balancing medical necessities against some reality checks.

If you're HIV/HCV co-infected, you and your doctor will have to work out the best treatment strategy. This may mean treating your hepatitis C before tackling the HIV. Hepatitis C treatments are tough, but unlike HIV, they may eliminate the hepatitis virus from your body for good. One less virus, one less stress on your liver.

If you're taking HIV drugs, watch those liver levels. Liver-toxic medications are best avoided if you're co-infected. Otherwise they may be okay, but choose with care. Anything that raises those ALT/AST levels should signal a switch.

As with anything else, harm reduction works wonders. Watch the booze, and anything else you put in your body. A lot of good advice is available for living healthier with HCV. Check the sidebar for some other articles and resources. You know yourself better than anyone: if "don't drink" doesn't cut it, "don't drink every day" may be more realistic.

If you can't avoid liver stress, you may be able to soften the blow. Many people swear by antioxidant or herbal remedies to detoxify and de-stress the liver. Milk thistle is the most commonly suggested herbal remedy, although not everyone agrees there's enough evidence to show that it is effective. Antioxidant supplements that lessen oxidative stress may help. (Think of oxidative stress as your cells getting rusty. Antioxidants provide the rustproof paint.) A good antioxidant program could include selenium, n-acetyl cysteine (NAC), L-carnitine, alpha-lipoic acid, and co-enzyme Q-10.

If possible, find a good naturopath who is experienced in treating HIV to help you pick supplements tailored for your individual situation and budget. If that's not possible, Dr. Jon Kaiser has an excellent Web site that's a goldmine of good advice on natural and complementary treatments. At the end of the day, it's all about you—watching your liver tests and seeing how you feel are your best bets for finding what works. ⊕

For more information

WEB SITES:

Dr. Jon Kaiser <www.integrativehealthconsulting.com>
Canadian Liver Foundation <www.liver.ca>
American Liver Foundation <www.liverfoundation.org>

ARTICLES:

"Nutrition: 13 Ways to Love your Liver ",
The Positive Side, CATIE, Spring/Summer 2002
<www.catie.ca>

"Antiretrovirals and Liver Toxicity: How Big a Concern?",
ACRIA Update, Vol. 11, #3
<www.thebody.com>

"Towards a Healthy Liver",
Project Inform, January 2000
<www.projectinform.org>

Derek Thaczuk is the treatment information coordinator at the Toronto People With AIDS Foundation and a freelance writer and health educator.

Formerly formulary

An update on what's on and off BC's drug formulary

by Sam Friedman

The BC drug formulary is a list of drugs approved for full or partial coverage in BC. The formulary has two categories for access and funding, full listings (with no restrictions) and restricted listings requiring Special Authority.

In December 2003, a new super category was implemented. By entering a super category code into PharmaNet when a Special Authority request for a medication is approved, the patient is automatically eligible for Special Authority coverage for any medications within the same super category group. This procedure is intended to assist physicians, pharmacists, and the public when a change in a Special Authority medication is required. However, a simple increase or decrease to the dose of an approved Special Authority drug still requires re-application.

In January 2004, two drugs were added to the BC formulary: citalopram, an SSRI antidepressant, and rosuvastatin, a CoA reductase inhibitor. Both are available in brand name form (partial coverage) and generic form (full coverage).

This year, PharmaCare's Drug Benefit Committee reviewed two other drugs and recommended that they not be added to the BC drug formulary: telithromycin, an antibiotic, and glimepiride, an oral hypoglycemic medication.

In March 2004, citalopram and the female hormone patch estradiol were moved into the low-cost alternative category of the formulary. For full coverage, these drugs must now be dispensed in their generic form. The estradiol patch requires Special Authority (for generic and brand-name versions) and must be dispensed in the generic form for full coverage. The brand-name version is available for partial or full payment, depending on your drug plan.

> **The redundant layers of bureaucracy required to review a drug for placement on the BC formulary is an enormous waste of our healthcare dollars.**


Photo Sam Barker

Thirty-four other drugs that have been previously unavailable or available only through very restrictive Special Authority are currently under review by the Drug Benefit Committee and by the federal Common Drug Review process. It will take at least six months for each of these medications to go through the triple-review process that exists in BC, and none are guaranteed approval for placement on the formulary.

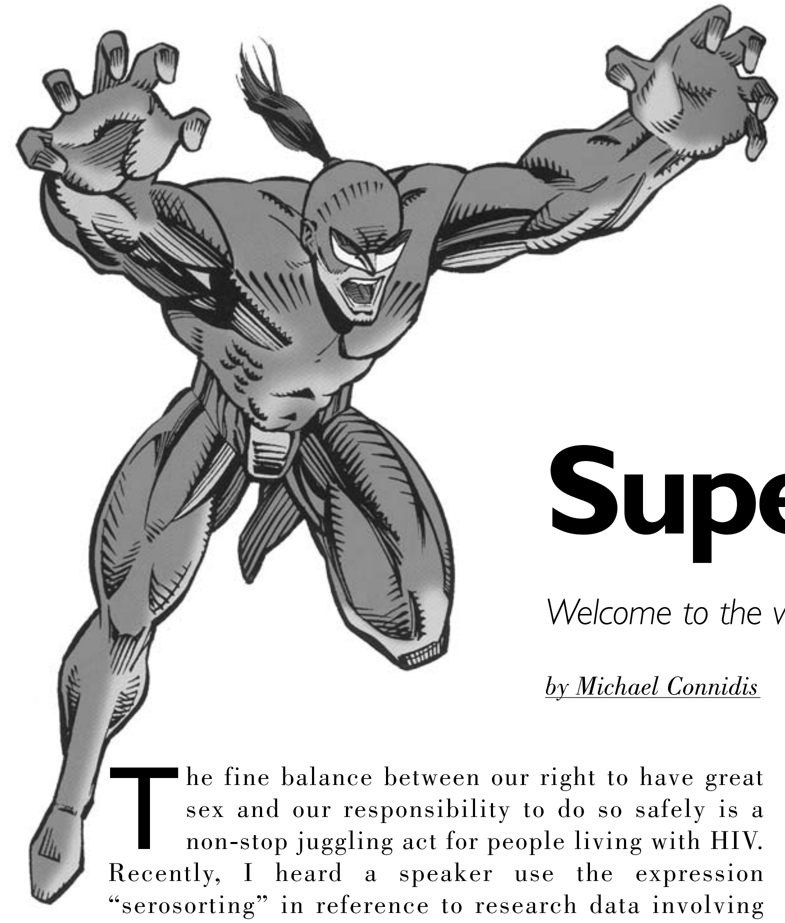
The redundant layers of bureaucracy required to review a drug for placement on the BC formulary is an enormous waste and mismanagement of our BC healthcare dollars. Time and money are being wasted on misinformation and prejudice. For example, injection drug users make up a large majority of chronic hepatitis C infections in BC, but because they are actively using injectables, the government considers them unreliable and, therefore, ineligible for coverage of a treatment that could cure them.

Replacing all this unnecessary bureaucracy with programs to support the special needs of injection drug users is a more humane and cost-effective use of our healthcare dollars.

Studies have proven that injection drug users do not miss doses or drop out of their treatment programs because they are "high" or "unreliable." They miss doses or drop out of treatment for the same reasons non-injection drug users do—the treatment is extremely difficult to tolerate and makes them feel terribly sick.

The BCPWA Society is gathering data on which drugs have been dropped from the BC formulary since the provincial Liberals came to power. If a drug you use has been delisted, please email the Collective Advocacy department at collective@bcpwa.org with that information. ⊕

Sam Friedman is a member of the BCPWA Society and a treatment information counsellor for the Treatment Information Program. He has advanced HIV disease.



Supersizing HIV

Welcome to the world of superinfection

by Michael Connidis

The fine balance between our right to have great sex and our responsibility to do so safely is a non-stop juggling act for people living with HIV. Recently, I heard a speaker use the expression "serosorting" in reference to research data involving men who have sex with men.

A study had observed a rise in the incidence of syphilis among subjects with no parallel rise in HIV infection. Upon further investigation, it was apparent that a sorting process was occurring: HIV-positive people were figuring out through direct and indirect means who was HIV-positive and then choosing HIV-positive sex partners. One possible reason for serosorting of sexual partners was that it eliminated the concern of infecting someone with HIV. Although this strategy may seem like a good way to halt the transmission of HIV, it may not be advisable if serosorting opens the door to unprotected sexual pleasures.

When considering the relative risks of our sexual practices, several questions remain unanswered. If a person is already infected with HIV, can they be re-infected with another strain of HIV and if so, how likely is such re-infection to occur, under what conditions, and what effect will dual or multiple infection have on disease progression?

We already know that an individual can be infected with more than one strain or subtype of HIV before seroconversion. This co-transmission of multiple strains occurs before the body has mounted an immune response and produced antibodies. Theoretically, HIV re-infection after seroconversion is possible because the human immune system is not able to conquer the virus and develop full immunity to it. A similar partial immunity occurs with other viruses such as the common cold or influenza viruses. If a person could be re-infected with different strains of HIV, why has so little evidence been gathered to support such a theory?

No longer just a theoretical possibility

Conducting a structured research program to determine if re-infection occurs would be difficult. The first cases of suspected re-infection were observed by mere chance. One case was documented in Canada in 1997 but later disputed. A small number of cases of suspected re-infection were documented several years later. Given the apparently low incidence, some viewed these cases as almost anecdotal. In recent years, research teams in various countries have looked into the question of re-infection. What was once considered theoretically possible has now been established as fact. HIV re-infection does occur and has been renamed. Welcome to the world of HIV superinfection.

Superinfection happens when you are already infected with one strain of HIV to which you have developed antibodies and you then become infected with a second, different strain of the virus. Studies have shown that both superinfection and co-transmission can accelerate disease progression, unrelated to drug resistance. Why this happens is not well understood. In the dance between the genes of the virus and our human genes, our immune system struggles constantly to rebuild itself while fighting the virus.

Having more than one strain of HIV can pose a greater challenge to the immune system, causing greater damage and hastening the onset of AIDS. Infection with multiple strains of HIV may also result from differences in an individual's immune system, which makes them more vulnerable to infection and less able to control the virus. Currently, no known genetic or immunologic factors can confirm these possible explanations. These factors have already been proposed as an explanation for why disease progression is rapid in some individuals and slower in others.

Evolution of dominant strains of drug-resistant HIV

"Know your enemy" is a great axiom in battle and also applies to HIV. HIV reproduction is continuous, even when you are on highly active antiretroviral therapy (HAART) and have an undetectable viral load. Over time, one strain of HIV can generate a variety of mutant populations or quasi strains of the original wild-type virus infecting one individual. When two or more strains are present, they are able to recombine, crossing over and sharing their genetic identities and creating a new hybrid form of HIV. These mutant, recombinant hybrids can become the dominant strain.

This capacity to mutate and recombine is reflected in the multitude of HIV types and strains worldwide. With greater diversity comes greater potential for the virus to more effectively reproduce and overcome obstacles at any stage in its life cycle. Will superinfection and subsequent mutations and recombinations of the HIV genome give rise to a form of super-HIV? The emergence of super-HIV is now more probable with the documentation of superinfection with drug-resistant HIV.

Since antiretroviral monotherapies (ARV) began and evolved into the HAART regimens that are the current standard of care, a parallel evolution of ARV drug-resistant strains of HIV has also occurred. The selective pressures of ARV therapies are pushing the virus to diversify to an ever greater degree. The incidence of infection with drug-resistant strains is increasing in newly infected individuals. These drug-resistant strains were once considered less infectious and weaker than wild-type HIV.

This theory has been disproved. Resistant strains are known to persist as the dominant or subdominant population. Studies have shown that individuals with wild-type virus can be superinfected with ARV-resistant HIV and that individuals with ARV-resistant virus can be superinfected with wild-type HIV. Levels of resistance to the different classes of drugs also varies. The longer a particular class of drug has been in use in ARV therapies, the higher the incidence of viral resistance to that class.

HAART may provide protection

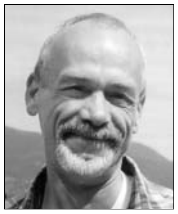
At times, there doesn't seem to be much room to maneuver in this game of living with HIV. Still, some things definitely work in your favour. Adhering well to your HAART regimen helps to keep your virus in check, reduces the chance of it becoming resistant to ARV, and may also reduce the risk of superinfection with another strain. A study of HIV-positive couples on ARV therapy and with high risk for exposure to each other's virus showed no signs of superinfection over a two-year period. Another study that tested stored blood samples from several thousand individuals on ARV showed no evidence of superinfection.

Although these studies suggest that HAART may provide protection, the level of protection remains unknown. The real possibility of superinfection that results in rapid disease progression and wipes out the benefits of your HAART regimen is worth keeping in mind.

> **Superinfection is associated with unprotected, high-risk sexual activity and sharing needles when injecting drugs.**

Using current tools and knowledge, it is impossible to gauge the actual risk of superinfection. Case studies and data indicate that superinfection, like initial infection with HIV, is associated with unprotected, high-risk sexual activity and sharing needles when injecting drugs. Much is still unknown about superinfection, so there is no room for complacency. For reasons we do not know, HIV infection and disease progression varies from person to person, though it may have to do with innate genetic differences between individuals and between the strain(s) of virus.

Living positively means we must consider the available information, learn what we can, and continue the struggle of balancing the confirmed or potential risks to our lives and the lives of those we embrace with the pursuit of what makes our lives worth living. ⊕



Michael Connidis is a member of the BCPWA Society and a volunteer researcher and writer for Living + magazine.

STRAIGHT
from the source

what's new in research

Unstable housing and risk behaviours

by Laura Kuyper

Approximately 12,000 active injection drug users live in Vancouver. Five thousand live in the Downtown Eastside (DTES). Whether unstable housing conditions contributes to the explosive HIV epidemic among these injection drug users must be investigated.

The BC Centre for Excellence in HIV/AIDS (BCCfE) examined HIV-transmission rates and risk behaviours associated with unstable housing over time, armed with recent data from an ongoing study that examines personal and behavioural characteristics of injection drug users over several years. The BCCfE study compared risky behaviours of individuals living in unstable situations, such as single-room occupancies, recovery or transition houses, on the street, or with no fixed address, with individuals living in stable environments such as apartments or houses.

The research revealed that injection drug users living in unstable housing situations had a higher risk for HIV transmission, likely because they more frequently participated in risky behaviours. People who reported that they lived in unstable housing situations were more likely to use heroin, cocaine, or crack at least once a day than those living in stable arrangements. Increasing drug use can often lead many individuals to homeless or unstable housing arrangements, which may explain why individuals reporting unstable housing tended to use drugs more frequently.

People living in unstable environments were also more likely to borrow used syringes from their peers, a known HIV risk behaviour. This behaviour may reflect lack of accessibility to fixed-site syringe exchange facilities, which may have limited operating hours and inconvenient locations. It also may indicate insufficient supply of syringes in comparison to the frequency with which they inject drugs. Many of the poorly housed individuals were hard-core drug users and many high-intensity drug users often become involved in sex-trade work to fund their addictions. Consequently, many of these poorly housed individuals were more likely to report being involved in the sex trade.

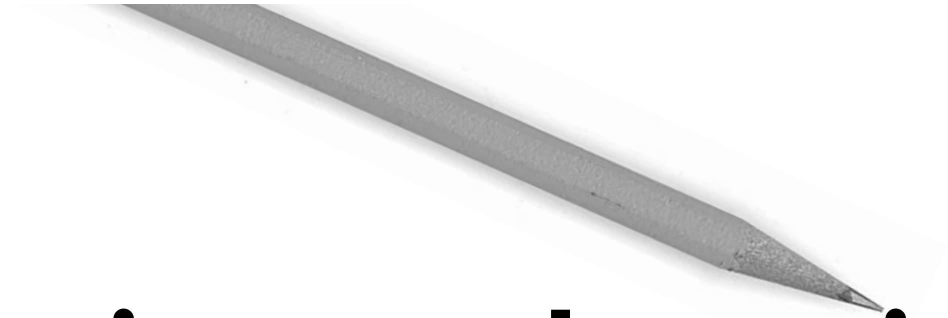
The associated risk behaviours may be a result of lack of access to addiction treatment. Many of these individuals may wish to overcome their addictions but may not be able to access the appropriate resources. Recent studies show that homeless persons with substance use problems are less likely to access social or medical services than their non-drug-using counterparts. The BCCfE study found that homeless people were more likely to have tried but been unable to access addiction treatment. The study also found that individuals reporting unstable housing were less likely to be taking methadone maintenance therapy.

Although homeless individuals have difficulty accessing primary care or preventive services, other studies have shown that they may instead use high-cost services such as emergency departments and acute care beds. Individuals living in unstable environments may find these round-the-clock services more accessible. These individuals may also require these acute care services because of neglected health problems that worsen because of lack of access to community-based care.

The higher risk for HIV infection among people living in unstable housing in the DTES is a concern in light of increasingly poor housing conditions in Vancouver. Several tent cities have been erected in the DTES in recent years. The conditions in these tent cities may lead to higher rates of HIV transmission because of the increased risk behaviours associated with unstable living arrangements.

Expanding access to addiction treatment and more funding to support safer housing environments could substantially reduce or prevent HIV epidemics like the one in Vancouver. These changes may also prove to be more cost effective in the long term if they reduce HIV risk behaviours and, in turn, limit further spread of the virus. ⊕

Laura Kuyper is a research assistant with the BC Centre for Excellence in HIV/AIDS at St. Paul's Hospital in Vancouver.



Getting to the point

Managing reactions from injectable drugs

by Kath Webster

"The old world is over; we are not just popping pills. We and the people helping us are injecting dangerous chemicals into our vulnerable infected bodies" – from the minutes of a recent meeting of T-20 users in Vancouver

Enfuvirtide (Fuzeon, formerly T-20) is a recently approved fusion inhibitor, the first in a new class of anti-HIV drugs. It has been a life saver for many who have run out of treatment options because of drug resistance or severe side effects. However, taking enfuvirtide is not a walk in the park. It must be injected twice a day because stomach acids break down the protein too quickly to be effective against HIV if taken orally. Enfuvirtide requires careful preparation by mixing the powdered drug with sterile water. Then it must be injected subcutaneously (just beneath the skin), being careful to avoid muscle, veins, nerves, and previous injection sites.

A very common side effect of enfuvirtide is injection site reaction (ISR) on the body. This reaction can include itchiness, swelling, redness, pain, hardened skin, and bumps. Each reaction varies in size and intensity and usually lasts for seven days, sometimes longer. In clinical trials, an overwhelming 98 percent of participants experienced some degree of ISR. Approximately 5 percent of people discontinued the drug as a result.

Linda Akagi, the coordinator of the outreach pharmacy at the BC Centre for Excellence in HIV/AIDS, says that 23 people in BC are currently taking enfuvirtide, and approximately ten more people are waiting for approval. So far, six people have discontinued the drug for various reasons (including ISR). Although most people can manage the injection site reactions, they are very problematic for a few, says Akagi.

Vancouver artist Joe Average has been injecting enfuvirtide for eight months and says that finding a good injection site is a huge problem. He has zero body fat because of wasting and lipodystrophy, so finding a place to inject is always a challenge. After nearly 500 injections, Average must contend with tough, leathery skin from scar tissue and numerous raised bumps or welts from previous injections that have yet to heal. He now needs to find injection sites on his back.

Treating HIV has become a two-person operation for him. His long-term friend Anne Carlson assists him with injections twice a day without fail. She has become an integral part of his healthcare. All this effort has not been in vain (no pun intended). Enfuvirtide, in combination with six other HIV drugs, is working for him. His energy has returned and he's back at the gym.

The good news is that enfuvirtide has very few side effects other than ISR. Because it's injected, it bypasses the stomach, so diarrhea and nausea are not usually issues. Some researchers also believe that because enfuvirtide works from the outside of cells, lipodystrophy and metabolic side effects may not be a problem. However, it's a very new drug, and we still do not know all the possible long-term side effects.

Some people may have emotional obstacles to injecting medications. Issues such as further loss of control, needle anxiety, isolation, poor body image, and recognition of your own mortality can be debilitating. Having a support network is crucial.

Tips for managing injection site reactions:

- Learn how and where to inject (not in muscle or veins).
- Massage the site before and after injecting.
- Apply a warm towel to area.
- Keep the area covered after injecting to prevent infection.
- Talk to your doctor about pain medication (if necessary).

For further reading on medications requiring injection, look for POZ *magazine's April 2004 special edition titled* Take your Best Shot. ⊕

Kath Webster is a treatment information counsellor for the Treatment Information Program at the BCPWA Society.

Extra helpings

Navigating through the Monthly Nutritional Supplement application

by Michele Blanchet

Living day-to-day is an extra struggle for individuals with HIV on a limited income. It's important to be informed of services and health benefit programs that can help. The BCPWA Society continues to advocate for its members. Their successful lobbying — in conjunction with other stakeholders, including community, government, and healthcare representatives — for the Monthly Nutritional Supplement (MNS), a replacement for Schedule C benefits, is no exception. This program makes it easier for individuals to apply for a monthly allowance for food, bottled water, and vitamin and mineral supplements. Although this program has been available since October 2001, confusion about it still exists.

The Monthly Nutritional Supplement is an allowance available for individuals receiving a Persons with Disabilities (PWD) benefit who have a chronic medical condition, such as HIV/AIDS or hepatitis, that causes chronic, progressive deterioration of health with symptoms of wasting. Depending on your individual need, you may be eligible for up to $165 for food, $20 for bottled water, and $40 for vitamins and minerals.

Applying for the supplement

To apply for a Monthly Nutritional Supplement

- ▼ See your Employment Assistance Worker (EAW, formerly known as a Financial Aid Worker) for an application form
- ▼ See your doctor to confirm your health status and fill out the application
- ▼ Return the completed form to your EAW

The Health Assistance Branch of the Ministry of Human Resources (MHR) in Victoria will make a decision. If you are approved, your EAW will set up monthly payments. If you are rejected, you can appeal. For questions regarding tribunal requests, call 1-866-557-0035. To contact the Health Assistance Branch, call 1-888-221-7711.

Here are some tips for helping your doctor complete the application:

- ▼ Section 3. Your doctor must tick YES in at least one of these boxes and must provide a brief description of your symptoms of wasting for each checked box. If your doctor gives the CD4 count for your compromised immune system it should be qualified if you are on antiretroviral treatment
- ▼ Section 4. Dietitian involvement is not necessary for your application to be accepted, but you should recognize that a dietitian is the most qualified professional to address your nutritional concerns. You should have a dietitian continually involved in your nutritional health.
- ▼ Sections 5, 6, and 7. To be eligible, both boxes in each section must be checked YES with a written explanation.

Vitamins and minerals, along with additional food, are crucial in helping to slow your disease progression. Micronutrient deficiencies have been associated with increased disease progression and increased risk of death. According to Michael V. O'Shaughnessy, the former director of the BC Centre for Excellence in HIV/AIDS, "Interventions that prevent wasting will prevent imminent danger to life."

Determining the issues

The following tips will help you guide your doctor in determining what issues you face in living with a chronic progressive disease.

In Section 5, nutritional products are needed to increase energy, protein, and vitamins and minerals to assist in preventing or slowing disease progression. A high protein diet is recommended to preserve lean body mass and support the immune system. If someone needs a nutritional product, such as Ensure or Boost it should be stated here.

In Section 6, bottled water is needed to prevent waterborne diseases such as cryptosporidiosis.

In Section 7, the following vitamins and minerals have shown promise in maintaining health and treating symptoms of HIV/AIDS and associated drug side effects:

- ▼ Multivitamin/mineral complex. The general consensus is that individuals with HIV benefit from this broad-spectrum vitamin once a day.

- ▼ Vitamins C and E. People with HIV require more of these antioxidants to combat the oxidative stress associated with HIV treatment.
- ▼ Calcium. More calcium is needed to prevent the development or progression of osteoporosis.
- ▼ B-complex. If you have a history of acute infection, fever, alcohol use, or malnutrition, taking these vitamins may help to slow disease progression.
- ▼ Selenium. Muscle wasting and declining CD4 counts are often associated with a deficiency of selenium.
- ▼ Zinc. Immune function may benefit from an increase in zinc, which is commonly deficient in PWAs.
- ▼ Vitamin A. Injection drug users and people with malabsorption disorders often are deficient in vitamin A.
- ▼ Glutamine. This supplement helps to maintain gut integrity and is effective in treating diarrhea.

Frequently asked questions

These frequently asked questions are adapted from an appeal guide produced by the BC Coalition of People with Disabilities:

What does the phrase "to avoid an imminent danger to life" mean?

This means that your health will probably get worse, causing a danger to your life, unless you receive the requested MNS items. For example, bottled water for a person with a weakened immune system will greatly reduce the possibility of getting a deadly bacterial infection from regular tap water.

What if I only have a short-term need for caloric supplementation, such as Ensure or Boost?

A medical practitioner must say in writing that you have an acute short-term need (up to three months) for caloric supplementation to prevent serious weight loss while you are recovering from surgery, a severe injury, a serious disease, or a side effect of medical treatment. If you are already receiving the MNS for nutritional items, you will not be eligible for this short-term allowance.

If I am receiving a diet allowance, can I receive the MNS allowance too?

If you receive another diet allowance, MHR may cancel it when you qualify for MNS.

Do I have to qualify for all three items—nutritional items, bottled water, and the vitamin or mineral supplements—to receive the MNS benefit?

No. You can receive these separately or together.

If I am eligible for part of the MNS allowance, but I file a Reconsideration Request for other parts of the supplement for which I was deemed ineligible, do I risk losing the part of the benefit that was approved?

No. There is no risk of losing the part of the MNS for which you were deemed eligible. For example, if you are eligible to receive $40 for the vitamin/mineral supplement and you file a Reconsideration Request for nutritional items, you will receive the vitamin/mineral allowance whether or not your Reconsideration Request is successful.

How long can I receive the allowance?

The MNS supplement will be provided indefinitely. However, at any time the ministry can ask for additional information from your doctor to prove you still need the supplement. The short-term supplement for an acute need can only be provided for up to three calendar months. ⊕

For more information on the Monthly Nutritional Supplement allowance and other heath benefits and programs:

Appeal Guide, Monthly Nutritional Supplement Applications and Appeals,
BC Coalition of People with Disabilities, Advocacy Access, October 2003
<www.bccpd.bc.ca/current/AppealGs/MNS_AppealGd.pdf>

Legal Services Society of BC and PovNet, Welfare Fact Sheet #7,
Welfare and Health Benefits, February 2004
<www.povnet.org/resources/7welfareandbenefitss_feb04.htm>

BC Employment and Assistance Manual,
Disability Assistance and Health Supplements, September 2003
<www.mhr.gov.bc.ca/PUBLICAT/VOL1/Part14/14-17.htm>

To find an advocate, check the following resources:

BCPWA Society Advocacy Department,
604.893.2223, Email: advdesk@bcpwa.org

BC Coalition of People with Disabilities,
604.872.1278 or 1.800.663.1278, Email: advocacy@bccpd.bc.ca,
<www.bccpd.bc.ca>

Visit PovNet at <www.povnet.org> and click on "Find an Advocate."

Michele Blanchet is the registered dietitian at Gilwest Clinic, a Richmond clinic that specializes in HIV and hepatitis treatment and methadone maintenance.

Thank you to The Loving Spoonful

The Oak Tree Clinic would like to express our appreciation to The Loving Spoonful for the support they give all people living with HIV, but especially to pregnant women and new mothers. Providing formula to infants of lower income HIV-positive mothers improves food security for the whole family, and ensures the infant has access to proper breast milk replacement. Your work and support make a huge difference, and on behalf of all the families who have benefited from this service, thank you so much.

Loving your liver

Part II of a review of Canada's new hepatitis C nutrition guidelines

by Diana Johansen

In the last issue of Living+, we reviewed the first part of the national nutrition guidelines for hepatitis C. Now we discuss the nutritional issues at different stages of HCV infection, as well as complementary and alternative medicine (CAM) to treat symptoms and side effects.

The various stages of HCV

Acute HCV infection is the initial infection period of the hepatitis C virus. Most people will develop few or mild symptoms, but some will experience fatigue, nausea, vomiting, and loss of appetite. The goal of nutrition therapy during this stage is to provide adequate nutrition to help the liver cells heal and regenerate. This means getting enough calories, protein, and micronutrients (vitamins and minerals) to maintain weight. In some cases, a low fat diet is helpful. Avoid alcohol.

Chronic HCV infection (pre-cirrhotic) can extend over many years, during which mild or intermittent symptoms may occur. Chronic inflammation can ultimately result in liver damage, fibrosis, steatosis (fatty liver), cirrhosis, or cancer. Eating a nutritious diet with moderate physical activity is recommended. No specific dietary modifications are required unless symptoms are present, which should be addressed individually (see Part I of this article).

Chronic HCV infection (cirrhosis) develops as fibrosis and irreversible scarring that progressively damage the liver. Most people with cirrhosis have compensated disease with few symptoms, in which case nutritional guidelines do not change. However, cirrhosis can gradually become decompensated, which results in numerous metabolic and nutritional complications.

Malnutrition can have an independent negative effect on disease progression and survival. The principle causes are metabolic abnormalities (glucose intolerance and breakdown of the body's proteins), inadequate dietary intake because of loss of appetite and gastrointestinal symptoms, and maldigestion or malabsorption, especially of fat.

Hepatic encephalopathy (HE), or impaired mental function, may occur in advanced liver disease when scar tissue prevents normal flow of blood through the liver. The damaged liver has difficulty processing the products of protein metabolism, especially ammonia, leading to protein intolerance. Prolonged low protein diets are no longer used to treat HE, but they may be used briefly in conjunction with medications. Lactulose is often prescribed to induce two to three soft bowel movements daily, which help clear the ammonia.

Ascites, the build-up of excess fluid in the abdomen, is the most common complication. It develops because the body is unable to regulate fluid and sodium balance. Dietary treatment involves restricting salt intake and sometimes fluid intake, in conjunction with diuretic medications.

Hepatic bone disease, or loss of bone mass density, occurs more frequently and with more severity as liver function declines. The development of osteoporosis is likely a result of decreased bone formation and increased bone breakdown, which may be influenced by calcium, vitamin D, or vitamin K deficiencies.

End-stage liver disease is an indication for liver transplant, although not everyone will qualify. Nutritional problems and wasting are common at this stage. The role of nutrition is to alleviate symptoms and create the best possible nutrition status to withstand the stress of a transplant. Poor nutrition status at the time of transplant is associated with increased risk of complications and poor survival. After a transplant, nutrition therapy deals with common health problems related to transplant surgery and immunosuppressive drugs.

Using CAM to treat symptoms

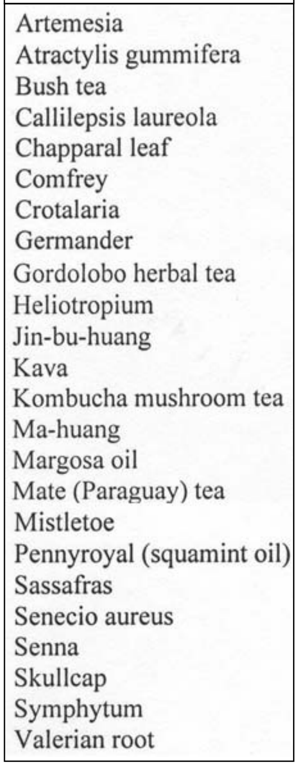
The HCV nutritional guidelines define CAM as "medical and healthcare practices that are not an integral part of conventional (Western) medicine." The guidelines suggest asking the following questions to evaluate a therapy:

- ▼ Has the therapy been proven to be more effective than providing no intervention?
- ▼ Is the therapy as safe as doing nothing?
- ▼ Does the potential for benefit exceed the potential for harm to the patient and family?
- ▼ Have proponents of the therapy demonstrated its efficacy and safety?
- ▼ What is the cost of the therapy and what are the financial implications for the patient?

Because oxidative stress appears to play a role in the progression of liver damage, nutritional antioxidants are often promoted to protect the liver. In particular, vitamin E and selenium have shown promise. However, the guidelines still recommend that supplementation be restricted to clinical trials.

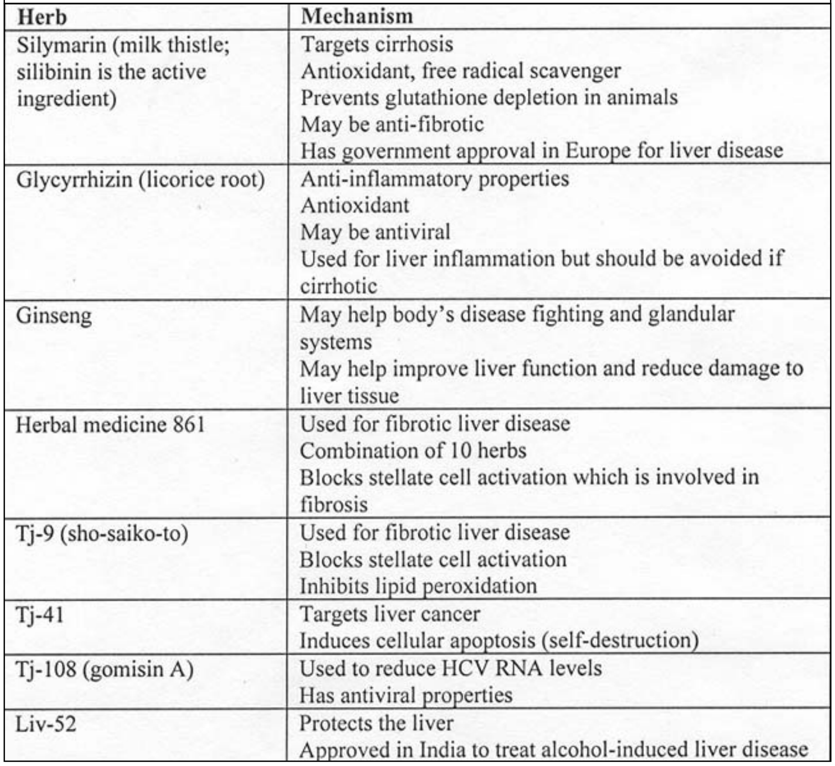
Herbal remedies are often used to heal the liver or deal with the side effects of HCV treatment. Several therapies have demonstrated potential benefit, but some can actually be toxic to the liver or interfere with other medications such as HIV drugs. See tables 1, 2, and 3.

Table 1.
Herbs that are toxic to the liver



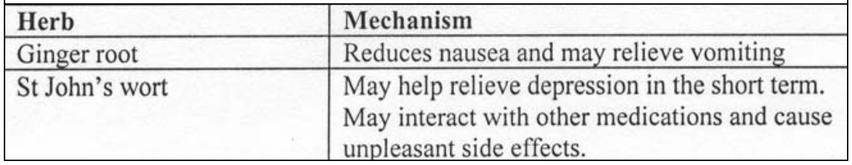
Artemesia
Atractylis gummifera
Bush tea
Callilepsis laureola
Chapparal leaf
Comfrey
Crotalaria
Germander
Gordolobo herbal tea
Heliotropium
Jin-bu-huang
Kava
Kombucha mushroom tea
Ma-huang
Margosa oil
Mate (Paraguay) tea
Mistletoe
Pennyroyal (squamint oil)
Sassafras
Senecio aureus
Senna
Skullcap
Symphytum
Valerian root

Table 2.
Herbs that may improve liver functions



Herb	Mechanism
Silymarin (milk thistle; silibinin is the active ingredient)	Targets cirrhosis Antioxidant, free radical scavenger Prevents glutathione depletion in animals May be anti-fibrotic Has government approval in Europe for liver disease
Glycyrrhizin (licorice root)	Anti-inflammatory properties Antioxidant May be antiviral Used for liver inflammation but should be avoided if cirrhotic
Ginseng	May help body's disease fighting and glandular systems May help improve liver function and reduce damage to liver tissue
Herbal medicine 861	Used for fibrotic liver disease Combination of 10 herbs Blocks stellate cell activation which is involved in fibrosis
Tj-9 (sho-saiko-to)	Used for fibrotic liver disease Blocks stellate cell activation Inhibits lipid peroxidation
Tj-41	Targets liver cancer Induces cellular apoptosis (self-destruction)
Tj-108 (gomisin A)	Used to reduce HCV RNA levels Has antiviral properties
Liv-52	Protects the liver Approved in India to treat alcohol-induced liver disease

Table 3.
Herbs that may help alleviate the side effects of interferon



Herb	Mechanism
Ginger root	Reduces nausea and may relieve vomiting
St John's wort	May help relieve depression in the short term. May interact with other medications and cause unpleasant side effects.

***Note:** Herbal medicines are not regulated in Canada, and it is difficult to know if the products contain the stated amounts of the medicinal ingredient. Based on random sampling, some products on the market contain very little of the desired component. Health Canada's Natural Health Products Directorate has more information. Monographs for specific therapies can be found at*
<www.hc-sc.gc.ca/hpfb-dgpsa/nhpd-dpsn/monograph_compendium_list_e.html>

Nutritionally at-risk groups

Other determinants of health can influence nutritional health in vulnerable groups. People with other medical conditions such as HIV, hepatitis B, diabetes, and renal disease are at high risk of developing nutritional problems because of the additive nature of complications. People with HCV who drink alcohol or use street drugs are also more likely to experience nutritional deficiencies and may have a more rapid disease course. Poverty severely limits food security and is strongly linked to nutritional vulnerability. Aboriginal people have a much higher rate of HCV infection than non-aboriginal Canadians. They may also experience other negative determinants of health such as poverty, substance use, alcohol use, and other diseases such as HIV and diabetes.

People with HCV infection are susceptible to a wide range of nutritional complications, with increasing prevalence and severity as the disease progresses and liver function declines. Nutrition therapy may help to slow liver damage, and well-nourished individuals may have a better clinical course. A number of complementary therapies, including antioxidants and herbs, have shown promise, but these should be evaluated carefully before embarking on long-term use. Many aspects of a person's life impact nutritional status and must be considered holistically when developing nutrition care plans. *More details on the national nutrition guidelines for HCV can be found at <www.dietitians.ca/resources/HepatitisC_Guidelines.htm>* ⊕

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

Ask the dietitian

Ask the Dietitian is a new Living+ feature. If you have a diet or nutrition question, email it to ***dietitian@bcpwa.org*** or mail it to *Living* +, BCPWA Society, 1107 Seymour Street, 2nd Floor, Vancouver, BC V6B 5S8.

Whet your appetite

by Ellie Schmidt

I have no appetite! I want to eat, I know I need to eat, but every time I sit down to a meal, I feel ill just looking at it. Help!

Wow, I hear this so often! Loss of appetite is a common complaint from people living with HIV. Factors such as disease state, depression, fatigue, fever, medication side effects, co-infection with hepatitis C, and addiction can seriously interfere with your ability to eat.

The following strategies have helped others regaining their appetite.

- Consume small frequent meals at regular intervals. Don't put too much on your plate. I've seen clients filling their plate, only to be overwhelmed by the volume of food in front of them. Often they can't eat any of it. Try only a few spoonfuls of each item. You'll likely have success with a more manageable amount of food on your plate.
- Make every bite count. Eat calorie and protein-dense foods. Make high calorie/protein shakes that you can sip on slowly.
- Enhance your eating environment. Relax, share meals with friends, eat favourite foods.
- Use community or family supports such as meal delivery, assistance with shopping, cooking, and clean up.
- Ask your doctor about appetite stimulants. Even fresh air prior to meals can stimulate your appetite.
- Don't eat and drink at the same time, because fluids can fill you up. Instead, try drinking fluids between meals.
- Cook when you have the energy. Package the meals into small single servings and freeze them for consumption at a later time. Sometimes the smell of cooking will turn you off from eating.
- Sneak food in between meals. Have lots of ready-to-eat snacks on hand. You'll be amazed at how much you can consume when you're not thinking about it. Nibble on a piece of fruit or a muffin when you're walking down the street. Eat peanuts, cheese, cut vegetables, or what ever you like while watching television.
- Take a daily multivitamin/mineral supplement so your body gets some micro-nutrients even when you can't eat enough.
- Remember, a poor appetite can be a vicious cycle. The less you eat, the less you want to eat. Start slowly and eat a little bit every few hours. With every attempt, you will be able to eat more; as your stomach enlarges and your body readjusts to having food in it, your appetite will return. The more you eat, the more you will want to eat. ⊕

Ellie Schmidt, RD, is a community nutritionist with the Vancouver Coastal Health Authority and the dietitian at the Dr. Peter Centre in Vancouver.

Let's get clinical!

Updates from the Canadian HIV Trials Network

Canadian therapeutic vaccine trial begins

by Jim Boothroyd

After a three-year delay, enrollment has begun for the first Canadian designed and developed clinical trial of a therapeutic HIV vaccine that aims to reduce dependence on toxic antiretroviral (ARV) drug combinations.

The 12-month phase I and II study called "Vaccination before treatment interruption" (CTN 173) will enroll 60 patients at Ottawa Hospital, Centre hospitalier de l'Université de Montréal, and McGill University Health Centre.

The purpose of the study is to determine if vaccination before structured treatment interruption (STI) improves immune function by causing a delayed and reduced rebound in the amount of virus in the blood. Volunteers must be taking at least three ARV drugs, including a protease inhibitor, and have had an undetectable viral load for at least two years.

Participants will be randomly assigned to one of three arms of the study. Those in the first arm will receive Remune and ALVAC. Those in the second will receive a Remune placebo and ALVAC. Those in the third will receive matching placebos.

Remune is made from whole HIV particles, stripped of the envelope layer and sterilized. It is used to mimic an infection to boost the immune system. ALVAC is a preparation of a modified recombinant canarypox virus, used to transport HIV gene products into the body to stimulate protective immunity.

Participants in all arms will interrupt their ARV therapy at week 24. Viral load and CD4 counts will be monitored frequently before and after the STI.

The study was designed and is led by Dr. Jonathan Angel of the University of Ottawa and the Canadian Network for Vaccines and Immunotherapeutics (CANVAC).

In 2000, the study was awarded funding by the Canadian Institutes of Health Research and the Ontario HIV Treatment Network. But troubles securing supplies of the vaccines from the manufacturers—Immune Response Corporation in the US and Aventis Pasteur in France—delayed the study.

Most HIV vaccine research focuses on the search for a preventive (or prophylactic) vaccine, but demand is also strong for vaccines that could help seropositive individuals. At present, there are none.

"An effective therapeutic vaccine would help the person's immune system control HIV infection, potentially without the use of medications, and provide important insights into the development of an effective preventative vaccine," said Dr. Angel. ⊕

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

Trials enrolling in BC

CTN 147 — Early Versus Delayed Pneumococcal Vaccination
BC sites: St. Paul's Hospital and Downtown Infectious Disease Clinic (IDC), Vancouver

CTN 157 — Fenofibrate & L-Carnitine for Elevated Triglycerides
BC sites: St. Paul's Hospital and Downtown IDC, Vancouver

CTN 164 — STI (Structured Treatment Interruption)
BC sites: Downtown IDC, Vancouver and Cool Aid Community Health Centre, Victoria

CTN 167 — OPTIMA: Options with Antiretrovirals
BC sites: Viron, Downtown IDC, and St. Paul's Hospital, Vancouver, and Cool Aid Community Health Centre, Victoria

CTN 169 — DAVE:: D4T or Abacavir plus Vitamin Enhancement
BC site: St. Paul's Hospital, Vancouver

CTN 171— CellCept (Mycophenolate Among Patients with HIV Receiving Abacavir)
BC site: St. Paul's Hospital, Vancouver

CTN 178 — Rosiglitazone Maleate (Avandia)
BC site: St. Paul's Hospital, Vancouver

CTN 183 — Continuous versus Intermittent Treatment
BC site: St. Paul's Hospital, Vancouver

CTN 189 — 3TC or No 3TC for HIV with 3TC resistance
BC site: St. Paul's Hospital, Vancouver

To find out more about these and other trials, check out our trials database at <www.hivnet.ubc.ca/ctn.html> or call Sophie at the CTN (1.800.661.4664).

Light at the end of the tunnel

The 2004 Microbicides Conference reveals promising developments

by Tamil Kendall

Not yet on the market, microbicides are jellies or lubes that could be used in the vagina or rectum to reduce HIV transmission. But before you get ready to ditch your condoms, consider that phase 3 trials begin this spring, meaning that the earliest a product will be available is about five years. The first generation of microbicides is expected to be between 30 percent and 50 percent effective, much less effective than correct condom use. Also, vaginal microbicide research is much further ahead than the development of a rectal microbicide.

These "buts" may make a microbicide seem a little less promising; however, in terms of the global epidemic, a cheap and acceptable microbicide is a very exciting prospect indeed. Ninety percent of people living with HIV/AIDS are in the developing world. The vast majority of them don't know they are infected. Furthermore, almost half of the infections globally are among women: in Africa, infection rates stand at 58 percent, rising to 67 percent between the ages of 15 and 24. Young women are particularly vulnerable. In urban areas of Kenya and Zambia, where overall infection rates are 26 percent and 28 percent respectively, HIV prevalence in women is six times greater than in men among sexually active 15 to 19 year olds, and three times greater than men among 20 to 24 year olds.

The 2004 conference

At the conference, Stephen Lewis, the UN Secretary-General's Special Envoy for HIV/AIDS in Africa, noted that inertia and sexism have plagued the response to AIDS, delaying our realization that globally AIDS has a woman's face. He said that gender equity is one of the hardest and longest fights on the planet. We are fighting, he said, to change the underlying causes that make men and women vulnerable to HIV/AIDS, but we also need prevention alternatives.

"People say to me, Stephen, what about the men? We have to work with the men," Mr. Lewis said. "Of course we do. But please recognize that it's going to take generations to change predatory male sexual behaviour, and the women of Africa don't have generations."

A microbicide is not going to be a magic bullet, but even a partially effective microbicide could stop 2.5 million HIV infections over three years. The 2004 conference didn't announce a marketable microbicide, providing instead basic, clinical, and social science information that shows the way forward to making microbicides a reality.

Basic science

Scientists presented animal models demonstrating the safety and efficacy of several microbicides, as well as novel mechanisms for preventing HIV transmission vaginally. Between 1996 and 2000, UNAIDS co-sponsored a trial of a microbicide called N-9 among sex workers in Africa and Thailand. The trial was a disaster. Because N-9 is a detergent, repeated use irritated the vagina and increased HIV transmission. The lesson for us is to avoid condoms or lube with N-9 for vaginal or anal sex. The lesson for microbicide scientists is to study vaginal irritation.

Cellulose acetate phthalate did not irritate monkeys in the long or short term, and several studies showed that it was effective. In one study, it protected three of the four animals from infection. Researchers found that polyamine inhibitors (dextrin sulphate and PRO 2000) hindered the formation of a bridge (“virological synapse”) between the effector and target cell, preventing cell-cell HIV transmission in a test tube.

Scientists also presented new ideas for microbicides. One researcher showed that hormones used topically thicken the “skin” or epithelium of the vagina, possibly reducing transmission. Dr. Mark Wainberg of McGill argued in favour of using non-nucleoside reverse transcriptors (NNRTIs) that bind tightly to the RT enzyme in microbicides because they are active against HIV without being metabolized and because binding to the RT enzyme stops new cells from getting infected.

Clinical science

The clinical science section of the conference also provided advances in microbicide development. Based on early safety studies, a number of microbicides look promising: dextrin sulphate, PRO 2000, cellulose sulphate, Carraguard, and tenofovir. Dextrin sulphate plus PRO 2000, BufferGel plus PRO 2000, and Carraguard are all ready for phase 3 trials this year.

> **When a vaginal microbicide is developed, people will use it for anal sex. Do you license a vaginal microbicide that isn’t safe for anal use?**

Public-private partnerships took an important step forward when Tibotec, a Johnson & Johnson pharmaceutical research and development company, gave the International Partnership for Microbicides (IPM) the right to develop TMC-120, an NNRTI, as a microbicide. If the product works, IPM gets the right to market the drug in the developing world, making sure that it is accessible to poor men and women, and Tibotec keeps the rights to sell the product in Europe, Canada, and the US. Tibotec is the first big pharmaceutical company to get actively involved in microbicide research, and we can only hope that this model encourages other companies to get on board.

Rectal microbicides

A controversial issue in the clinical science section of the conference was the rectal safety of a vaginal microbicide. Interest is increasing in rectal microbicides, but up until now, research has focused on vaginal microbicides.

Rectal microbicide development is even more challenging than vaginal microbicides. First, instead of being a closed pocket like the vagina, the rectum is part of the long tube of the digestive system. So, making sure that the product covers enough of the tube to be effective is a concern. Second, the epithelium (internal skin or lining) of the rectum is more delicate than the vagina and it has more cells that are part of the immune system and susceptible to HIV infection right below the surface. Thus, irritation caused by a microbicide is even more potentially dangerous than in the vagina.

On the upside, almost everyone uses lube for anal sex, so if a product could be developed, it would be used widely. However, when a vaginal microbicide is developed, people will inevitably use it for anal sex. Do we license a vaginal microbicide that isn’t safe for anal use? The consensus at the conference and the position of the US Food and Drug Administration is that we can’t wait for a microbicide that is safe for both vaginal and rectal use. Information about anal use must be collected during phase 3 trials, and packaging of vaginal microbicides should share this information.

Social science

The social science section told us that microbicides are acceptable to women and their male partners and provided some evidence that microbicides are not going to reduce the use of other prevention alternatives, such as condoms. Researchers also noted that it is important to educate decision-makers and the community about microbicides, so that when a microbicide becomes available, it is acceptable and accessible.

Analysis of the economic benefits of microbicides is an important tool in this advocacy effort. There was also widespread recognition that horizontal relationships between outside and local researchers and communities need to be developed and that communities need to be ready to support authentic participation.

The participation of HIV-positive individuals in clinical trials is another pressing issue. Currently, clinical trials are recruiting HIV-negative women because they want to know whether the microbicide works to prevent HIV infection. It is crucial, however, that microbicides are also safe for HIV-positive people and effective for preventing transmission to an HIV-negative partner or transmission of a different virus. PWAs and AIDS activists need to get more involved in microbicides to make sure that this happens. ⊕

International Partnership for Microbicides
<www.ipm-microbicides.org>

Global Campaign for Microbicides
<www.global-campaign.org>

Alliance for Microbicide Development
<www.microbicide.org>

Tamil Kendall is an associate researcher at the UNAIDS Collaborating Center located in the National Institute of Public Health in Cuernavaca, Mexico.

INFORMACIÓN EN ESPAÑOL

Que es esa cosa llamada masculinidad?

por Sergio Plata

En nuestra sociedad la masculinidad es un conjunto de características y normas de conductas, es un proceso social donde los hombres aprenden, asimilan y rechazan. En algunas culturas la imagen paterna esta presente y desde pequeños se les enseña a los niños a reprimir sus emociones, a no llorar. se les educa a ser violentos, repitiendo que la hombría se demuestra con poder.

Desde temprana edad al niño se le ensena a manipular la violencia a través de los deportes la socialización y los juegos, es la misma sociedad que les va construyendo la imagen del hombre. En los juegos se les remarcan status de respeto, control y de poder, favoreciendo a los mas fuertes y marginando a los debíles a través del miedo. es así como los niños van aprendiendo a ser violentos y mas hombres, incluso el niño muchas veces se separa de la madre para sentirse mas hombre. La religión, el arte, la ciencia y la tecnólogia promueven y sostienen el poder masculino , donde ser hombre esta basado en la heterosexualidad, desvalorizando y descualificando lo femenino

Para Shopenhauer la voluntad de vivir es la voluntad de poder y de dominio y exigen la creación del superhombre: aquel en quien se revela esa voluntad con toda su fuerza, situado mas alla de la moral, que vive en constante peligro, desprendido de los productos de la cultura decadente, en esfuerzo y lucha permanente cuya moral es la del señor, del dominador y del fuerte.

Los hombres sin saber negociar, descargan su irá contra las mujeres y los homosexuales. El miedo es para ellos sinónimo de débilidad, les afecta lo femenino y cualquier signo de homosexualidad se transforma en cólera o violencia, porque ser masculino va asociado a todo lo que hacen los hombres, les da miedo intimar con otros hombres, estructurando su masculinadad en actos de dominio y control, incluso cuando el ego masculino se ve amenazado pueden ser hostiles a los homosexuals y antipáticos como una forma de dar a conocer su masculinidad Lancaster en su “libro life is hard” habla de la bipolaridad; dominante-dominado, masculino-femenino es decir los hombres demuestran su control y poder arriba y la mujer abajo.

Las manifestaciones que se consideran masculinas ponen en desventaja a los hombres, la misma presión social provoca el suicidio entre adolescentes varones poniendolo como una de las tres principales causas de mortalidad, es dos veces mayor que en las mujeres, y en pa?ses desarrollados el riesgo se triplica entre varones homosexuales jovenes.

A los hombres se les fomenta muchas veces el inicio temprano de las relaciones sexuales y la promiscuidad en cuanto al número de parejas sexuales como formas de afirmar la masculinidad , se reduce la fidelidad y se provoca el consumo del alcohol y drogas lo que facilita comportamientos de riesgos, en la cultura del hombre se valora la penetración y el contacto con los genitales y fluidos, incluso se llegó a difundir que el vih/sida era una enfermedad de hombres, es hasta los 90s cuando comienza el proceso de heterosexualización del vih/sida

Finalmente el riesgo de la masculinidad tiene un costo y se refleja en la salud fÍsica y mental de los hombres. No olvidemos que el principio activo del hombre debe radicar en una unidad desarrollada sociocultural, histórica y psicológica. Para ser hombre debemos aprender a feminizar la masculinidad. ⊕

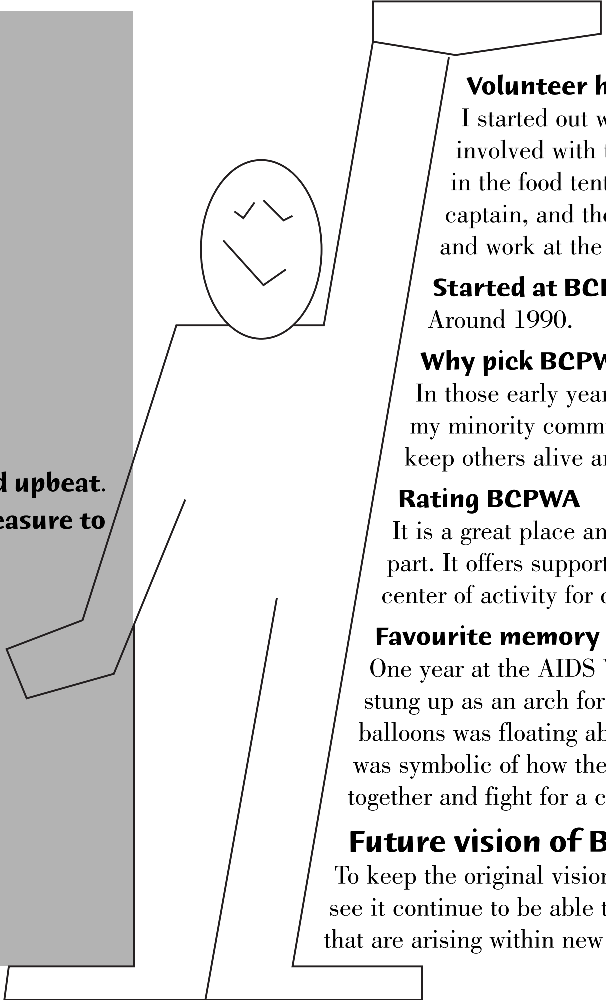
BCPWA Treatment Information Program (TIP)
Ofrece información sobre tratamientos del VIH/SIDA.
Todos los miercoles 1:00PM a 5:00PM.
1107 Seymour Street, 2nd Floor, Vancouver, BC V6G 5S8
Llame a la línea directa: 604.893.2243
email: treatment@bcpwa.org

Volunteering at BCPWA

Profile of a volunteer: Terry Soper

Always funny, warm and upbeat. A real trooper. It is a pleasure to work with Terry!

Jackie Haywood
Director, Support Services



Volunteer history

I started out working at BCPWA doing office work. I then got involved with the AIDS Walk: truck driving, set up, cooking in the food tent, volunteer party team captain, security team captain, and the volunteer tent. I also do taxes for members and work at the info desk in the member's lounge

Started at BCPWA

Around 1990.

Why pick BCPWA?

In those early years, so much was not known and peers within my minority community were dying. I wanted to do something to keep others alive and at the same time honour my lost friends.

Rating BCPWA

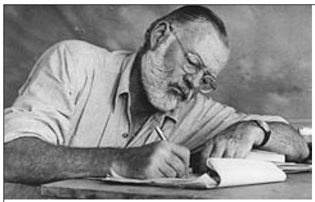
It is a great place and the energy that flows is positive for the most part. It offers support and comfort when things are tough. It is the center of activity for change, which is priceless.

Favourite memory

One year at the AIDS Walk, a huge string of purple balloons was stung up as an arch for the finish line. Later in the day, the string of balloons was floating above Denman Street...what a fantastic sight! It was symbolic of how the AIDS Walk is a way for community to come together and fight for a cause that affects so many.

Future vision of BCPWA

To keep the original vision of the founders who gave birth to BCPWA. To see it continue to be able to grow with new vision to meet the challenges that are arising within new discoveries about the HIV virus.



Interested in writing?

We need articles on HIV-related prevention, advocacy and treatment. Volunteer for living+ magazine...

Volunteers should possess the following skill sets:
— Ability to analyze and distill information
— Excellent research and writing skills
— Ability to work independently

Here's what one of our writer's had to say: "I find the whole process challenging and rewarding, not to mention the "feel good" feeling after finishing a piece."Volunteering for living+ provides the flexibility to work from home.

If you are interested in becoming a volunteer writer and/or to obtain a volunteer application form, please email volunteer@bcpwa.org, call 604.893.2298 or visit www.bcpwa.org.

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
e info@bcpwa.org www.bcpwa.org

A Loving Spoonful Location
Suite 100 – 1300 Richards St,
Vancouver, BC V6B 3G6
604.682.6325
e 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
e info@aidsmemorial.ca www.aidsmemorial.ca

AIDS Prince George
1–1563 2nd Ave,
Prince George, BC V2L 3B8
t 250.562.1172 ***f*** 250.562.3317
e ogodwin@bcgroup.net; www.AIDSPG.ca

Living Positive Resource Centre Okanagan
101–266 Lawrence Ave.,
Kelowna, BC V1Y 6L3
t 250.862.2437 or 1.800.616.2437
e lprc@lprc.ca; www.livingpositive.ca

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
t 250.753.2437 ***f*** 250.753.4595

AIDS Vancouver Island (Victoria)
1601 Blanshard St, Victoria, BC V8W 2J5
250.384.2366
info@avi.org; www.avi.org

ANKORS (Nelson)
101 Baker St, Nelson, BC V1L 4H1
t 250.505.5506 or 1.800.421.AIDS
f 250.505.5507 **e** 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
f 250.426.3221 **e** gary@ankors.bc.ca
http://kics.bc.ca/~ankors/

AIDS Vancouver Island (Cowichan Valley)
1 Kenneth Place, Duncan, BC V9L 2Y9
t 250.701.3667 ***f*** 748.3509

Asian Society for the Intervention of AIDS (ASIA)
210 – 119 West Pender St,
Vancouver, BC V6B 1S5
t 604.669.5567 ***f*** 604.669.7756
e asia@asia.bc.ca; www.asia.bc.ca

Dr Peter Centre
1100 Comox St,
Vancouver, BC V6E 1K5
t 604.608.1874 ***f*** 604.608.4259
e info@drpeter.org; www.drpeter.org

Friends for Life Society
1459 Barclay St, Vancouver, BC V6G 1J6
t 604.682.5992 ***f*** 604.682.3592
e ffl@radiant.net www.friendsforlife.ca

Healing Our Spirit
3144 Dollarton Highway,
North Vancouver, BC V7H 1B3
t 604.879.8884 or 1.800.336.9726
e info@healingourspirit.org
www.healingourspirit.org

McLaren Housing Society
200 – 649 Helmcken St,
Vancouver, BC V6B 5R1
t 604.669.4090 ***f*** 604.669.4092
e mclarenhousing@telus.net
www.MCLARENHOUSING.com

North Island AIDS (Campbell River) Society
684B Island Hwy,
Campbell River, BC V9W 2C3
t 250.286.9757 or 1.877.650.8787
f 250.830.0784

North Island AIDS (Courtenay) Society
355 6th St, Courtenay, BC V9N 1M2
250.338.7400 or 1.877.311.7400

North Island AIDS (Port Hardy) Society
8635 Granville St, Ground Floor,
Port Hardy, BC V0N 2P0, **t** 250.902.2238
niac@island.net ; www.island.net/~niac

Okanagan Aboriginal AIDS Society
101 – 266 Lawrence Ave.,
Kelowna, BC V1Y 6L3
250.862.2481 or 1.800.616.2437
oaas@arcok.com; www.oaas.ca

Outreach Prince Rupert
300 3rd Ave. West
Prince Rupert, BC V8J 1L4
t 250.627.8823
f 250.624.7591
aidspr@rapidnet.net

Pacific AIDS Network c/o AIDS Vancouver Island (Victoria)
1601 Blanchard St.,
Victoria V8W 2J5
t 250.881.5663 ***f*** 250.920.4221
erikages@pan.ca; www.pan.ca

Positive Living North West
Box 4368 Smithers, BC V0J 2N0
3862 F Broadway, Smithers BC
250.877.0042 or 1.886.877.0042
plnw@bulkley.net

Positive Women's Network
614 – 1033 Davie St, Vancouver, BC V6E 1M7
604.692.3000 or 1.866.692.3001
pwn@pwn.bc.ca; www.pwn.bc.ca

Red Road HIV/AIDS Network Society
804 – 100 Park Royal South,
W. Vancouver, BC V7T 1A2
604.913.3332 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 Resource & Community Service Society
1284 F Gladstone Ave, Victoria, BC V8T 1G6
t 250.388.6620 ***f*** 250.388.7011
varcs@islandnet.com
www.varcs.org/varcs./varcs.nsf

Victoria Persons With AIDS Society
#330-1105 Pandora St., Victoria BC V8V 3P9
t 250.382.7927 ***f*** 250.382.3232
support@vpwas.com; www.vpwas.com

Wings Housing Society
12 – 1041 Comox St, Vancouver, BC V6E 1K1
t 604.899.5405 ***f*** 604.899.5410
info@wingshousing.bc.ca
www.wingshousing.bc.ca

YouthCO AIDS Society
205 – 1104 Hornby St. ,
Vancouver BC V6Z 1V8
604.688.1441 1.877.968.8426
information@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 Resources section of the BCPWA Society website at www.bcpwa.org.

Upcoming BCPWA Society Board Meetings:

Date	Time	Location	Reports to be presented
August 4, 2004	1:00	Board Room	Quarterly Department Reports — Written Executive Director Report — Standing Committee — Financial Statements / June
August 18, 2004	1:00	Board Room	Director of Development
September 1, 2004	1:00	Board Room	Written Executive Director Report — Executive Committee — Financial Statements / July
September 15, 2004	1:00	Board Room	Standing Committee
September 29, 2004	1:00	Board Room	Written Executive Director Report — Financial Statements / August Director of Prevention

The BCPWA Society is located at 1107 Seymour St., 2nd Floor, Vancouver.

For more information, contact: Alexandra Regier, Office Manager Direct: 604.893.2292 Email: alexr@bcpwa.org

BCPWA Standing Committees and Subcommittees

If you are a member of the BC Persons With AIDS Society, you can get involved and help make crucial decisions by joining a committee. To become a voting member on a committee, please attend three consecutive meetings. For more information on meeting dates and times, please see the contact information on the right column for the respective committee that you are interested in.

Board & Volunteer Development

Contact: Adriaan de Vries
t604.893.2298 e adriaand@bcpwa.org

Collective Advocacy

Contact: Lisa Gallo
t604.983.2298 e lisag@bcpwa.org

Education & Communications

Contact: Lisa Gallo
t 604.983.2298 e lisag@bcpwa.org

Fund Development

Contact: Alasdair Hooper
t604.893.2264 e alasdairh@bcpwa.org

IT Committee

Contact: Ruth Marzetti
t604.646.5328 e ruthm@bcpwa.org

Living+ Magazine Subcommittee

Contact: Jeff Rotin
t604.893.2206 e jeffr@bcpwa.org

Prevention

Contact: Peter Hall
t604.893.2225 e peterh@bcpwa.org

Support Services

Contact: Jackie Haywood
t604.893.2259 e jackieh@bcpwa.org

Treatment Information & Advocacy

Contact: Tarel Quandt
t604.893.2284 e tarelq@bcpwa.org

Yes! I want to receive living+ magazine

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address ______________city ______________province/state______

postal code/zipcode ________country______________________

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I have enclosed the following for 6 issues of *living*+

○ $40 USA ○ $45 International

○ I want to donate the above subscription to a PWA who can't afford it

○ Enclosed is my donation of $______ for *living*+

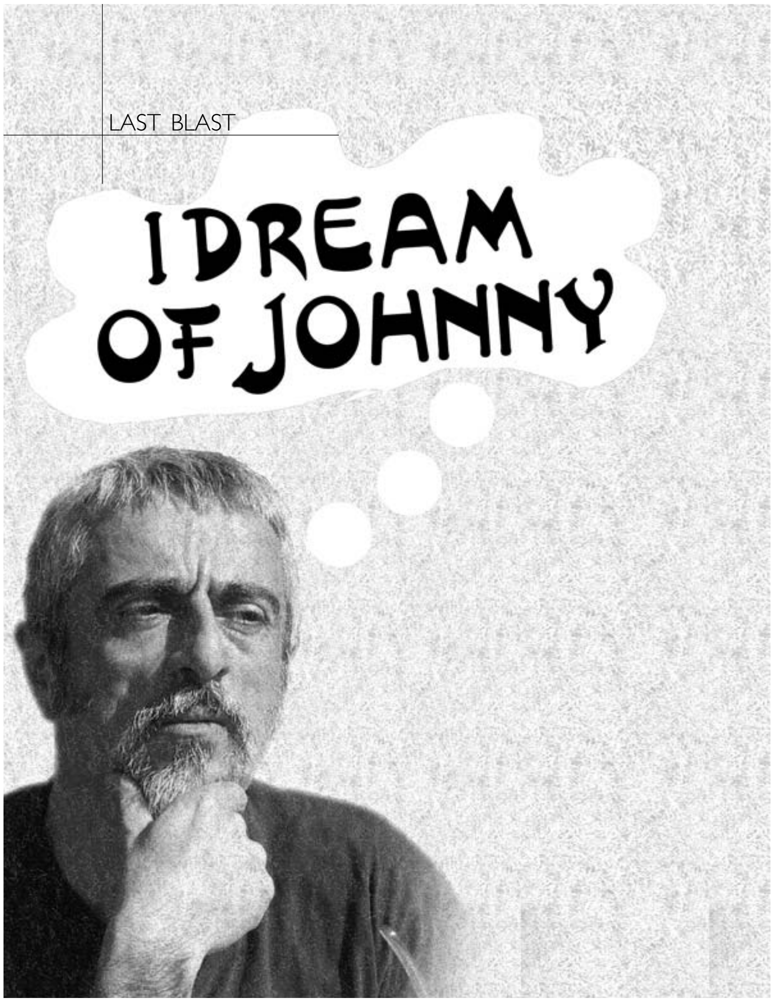
○ Please send me more information about Planned Giving

Cheque payable to BCPWA

living+

1107 Seymour Street, 2nd Floor
Vancouver, BC
Canada V6B 5S8

I DREAM OF JOHNNY



by Francisco Ibáñez-Carrasco

I dream of Johnny, but Johnny does not want to marry me. If marriage is now available to gay men, why not use it the way we use Botox, crystal, or Cialis? Brand new laws are like shiny new tools and when we have a hammer, everything begins to look like a nail. Ugly can be the divorce between nail and wood, those who are fastened together by a house, a life insurance, purchased appliances and pets (and sometimes children), or because they afforded the wedding pageantry, the multi-million dollar assembly line of social pages portraits, bridesmaids in pink taffeta prancing around an erection of fruit cake and royal icing.

In 2004, marriage is a choice on a Wal-Mart shelf of designs for good living. I want to have my cake and eat it too, live my own reality show, be the spectacle.

We marry to have a family. We have a motley crew of friends who recognize us as a family. Under Canadian laws, we live in common-law, and the government recognizes us as a couple. The stretch is that "marriage" demands that the community at large recognize us as a family.

I should have worn something prettier that hot summer day we moved in together. We were dusty and sweaty and horny at the end of that day. What was I thinking? Together to pool resources, fight, and clean our cat's litter, we married a mob—dead or alive—whose DNA signature is inscribed under our nails, in my warts, in my herpes outbreaks, in the HIV of my bloodstream. If one in the community feels joy, envy or pain, we all do. If we get married happily ever after, shouldn't we all be happy? By marrying, do we queers show care for each other and not for an archaic covenant that envelopes us in a Champagne bubble?

Historically, marriage preserved bloodlines and wealth, a social tool akin to the suffrage to elect civic representatives. If practice makes perfect, or at least it improves us as citizens, we should marry to reshape marriage as a viable queer social institution.

On second (and more sober) thought, I would marry because I care. However, I may care for too many. I give myself fully when I share myself with one man or many men, and this I say under considerable social scorn and biological risk. If not a virtue, promiscuity among queers is a practice of caring for oneself and others, in each body and its rivers of saliva and tears and fluids that entails consensuality and maturity.

Reportedly, monogamous marriage is equally caring so promiscuity and marriage should not be at odds; they sleep in adjacent rooms. Is carnal sex the only measure of promiscuity? Is having sex with one single body the measure of monogamy?

> **In 2004, marriage is a choice on a Wal-Mart shelf of designs for good living. I want to have my cake and eat it too, live my own reality show, be the spectacle.**

Marrying is giving oneself to one man in body and soul. To marry is to have someone to call "my own." Ah! Such contrived stereotypes hovering like fairies around the heads of our dicks. Such great expectations; that one man could abate my sexual, emotional (and financial) cravings.

Maybe I had little self-esteem to embrace Mr. Right when he came my way. Horror! Do I think of Johnny as a second choice, a compromise, and a lesser evil? My first choices, Justin Trudeau, on cold days, or Ashley MacIsaac when I was feeling randy, never knocked at my door. Hell, I was HIV-positive and scared. Was I only looking for anyone to take care of me at the end of the antiretroviral cocktail party when the night ahead was dark and voracious? Is Johnny a serotriage casualty in the cruel battlefield of epidemic gay love?

I stop writing, I look down the window onto our garden and I see Johnny tending his flowers in his worn-out Dickies, the spring sun shining on his fair face, aging beautifully, I see Lucy the cat circling him mischievously, and I see that my second choice is not even close to a fairy tale prince but is so real that I could burst into laughter and tears and melt at his feet every single time. ⊕

Francisco Ibáñez-Carrasco's collection of short stories (many of them about living with HIV) will be published in August 2004 by Suspect Thoughts Press, San Francisco.