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



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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think+

opinion and editorial

Acknowledging our heroes

by Paul Lewand

In the 1980s and '90s, HIV/AIDS was big news. Newspaper and magazine headlines had feeding frenzies when famous people were diagnosed with AIDS. However, the response to this new pandemic was lacklustre by those in political power, as the first wave of infections in North America was predominantly among gay males.

Many individuals, often directly affected when friends and loved ones became infected with HIV, started helping to raise awareness and funds in support of those people facing this deadly disease. On the medical front, HIV/AIDS posed new challenges and opportunities for scientists and doctors, and significant money went toward research and treatment. Throughout all the turmoil and distress, communities found ways to support one another through the health, social, and political issues associated with the disease. In those early years, many people faced horrible, lonely deaths. AIDS was ugly—but it made good press.

People who dedicate a part or, in some cases, all of their lives to AIDS work are real heroes. They identify areas of neglect and they do what they can to help, often putting their personal careers and lives on the line. They all have their own reasons, but what matters most is their willingness to stand up and make a difference in the lives of those around them.

After the introduction of advanced antiretroviral therapies and treatment options in the mid-90s, the media, perhaps with the misguided perception that the epidemic was under control, was less likely to respond to HIV-related news. In

their mind, the AIDS problem was over. But it was far from over then, and is far from over now. The dedicated people who continue to work in the HIV/AIDS movement—the activists, the scientists, the healthcare workers, the philanthropists, the volunteers, the community workers—are no less heroic than their pioneering counterparts in the 1980s and '90s. It is because of their ongoing efforts that our lives are so much better today.

When it comes to acknowledging our heroes, it's important to think of those whose contributions have gone unnoticed and unrecognized in the past. We tend to heap accolades only on those who are working in the HIV/AIDS movement today and forget about the many people whose efforts changed our lives in the early years or those who have done exceptional work throughout the last two decades.

From research and development, to the fight for access to medications, to providing food and clothing for those in need, to advocating for our rights—there are countless people who help make our lives better and our futures brighter. Because the public at large is not taking as much notice of HIV/AIDS work in recent years, it is more important than ever for our community to honour our champions. AccolAIDS is only one way — a special way — for British Columbia to celebrate their exceptional work. ⊕



Paul Lewand is the chair of the BCPWA Society.

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REALITY BITES



Nutritional disability benefit for kids

BCPWA Society, with the assistance of Oak Tree Clinic and other AIDS organizations, has secured the first monthly nutritional supplement benefit (MNSB) for an HIV-positive child in BC. Under current Ministry of Human Resources regulations, only HIV-positive adults on disability are eligible for an MNSB allotment of up to \$225 for nutritious food, bottled water, and vitamins and minerals.

“Children in BC have access to life-saving therapy, but medication alone is not enough. Nutrition is a fundamental part of HIV therapy as malnutrition can develop quickly in HIV-positive children and the consequences can be devastating,” said Dr. Jack Forbes, co-director of Oak Tree Clinic at the Children’s and Women’s Health Centre of BC.

Interaction between Reyataz and Prilosec

Bristol-Meyers Squibb (BMS) has issued a letter warning doctors and patients not to combine atazanavir (Reyataz) and ritonavir (Norvir) with omeprazole (Losec). Omeprazole is a proton-pump inhibitor for the treatment of acid-related diseases that works by suppressing gastric acid secretion.

A randomized, multiple-dose interaction study revealed that blood-based concentrations of the protease inhibitor Reyataz are significantly lowered when patients also take acid-control agents, particularly Losec. The research showed a 76 percent reduction in atazanavir area under the concentration-time curve and a 78 percent reduction in trough concentrations of atazanavir when taken with a small dose of ritonavir and co-administered with 40mg of omeprazole.

The drug maker did not know whether over-the-counter 20mg doses of omeprazole would produce similar results; therefore, it does not recommend combining the treatments.

BMS also reminded patients to be cautious when dosing medicines such as cimetidine (Tagamet) and ranitidine (Zantac) with atazanavir until further research is conducted.

Source: *Aidsmap*

Meth can worsen brain damage caused by HIV

Long-term heavy use of methamphetamine (crystal meth) can exacerbate the damage to brain cells caused by HIV, according to a study presented in the February edition of *The American Journal of Psychiatry*. Although both crystal meth use and HIV infection contributed to brain damage, the study, by researchers from Hawaii, California, and Germany, showed that their effects were additive, and not due to a more complex interaction between HIV and drug use.

Crystal meth causes the release of massive amounts of dopamine from the ends of neurones, notably in the basal ganglia. This release of dopamine often causes the ends of the neurones to shrivel and eventually die back. The researchers hypothesize that this release of dopamine can also stimulate HIV replication and worsen the damage caused by the drug.

Source: *Aidsmap*

Unsanitary conditions at St. Paul’s Hospital

Have you noticed unsanitary conditions at St. Paul’s Hospital? Have you witnessed contract staff improperly cleansing critical

medical equipment or simply not following universal hospital cleaning procedures?

Since the cleaning services at St. Paul’s Hospital was contracted out to the private sector, hospital cleaning standards may be falling below the threshold of safety for many people, especially for HIV-positive persons.

If you have personally become ill from either visiting or staying at St. Paul’s Hospital, or if you are simply concerned about this possibility, we would like to hear your concerns. Please contact BCPWA Society’s Community Representation & Engagement Standing Committee (CRE) at 604.646.5338 or email cre@bcpwa.org.

LGV spreading throughout Western Europe

The first case of the previously rare sexually transmitted infection lymphogranuloma venereum (LGV) has been confirmed in Barcelona, Spain. This brings the total number of European countries now affected to six: Holland, Belgium, Germany, France, Spain, and England.

In December 2004, a bisexual man from Colombia who had lived in Barcelona for three months tested positive for *Chlamydia trachomatis*, the bacterium that causes LGV.

LGV was first identified in 2003 in a cluster of over 30 gay men in the Netherlands. Many of these men reported sex tourism to European cities, including Hamburg, Germany, where four cases of LGV were confirmed in 2003, with more suspected.

In Belgium, over 90 percent of the men with LGV were also HIV-positive.

Source: *Aidsmap*



Warning about boosted saquinavir with rifampicin

Boosted saquinavir should not be taken with the anti-tuberculosis drug rifampicin because of the risks of drug-induced hepatitis, according to a warning issued by manufacturer Roche.

Roche issued the warning after it conducted a study involving 28 HIV-negative volunteers who were provided with 1000mg of saquinavir boosted by 100mg of ritonavir twice daily with the standard 60mg daily dose of rifampicin.

Thirty-nine percent of the volunteers developed significant drug-induced hepatitis, and one individual was admitted to hospital with mild liver failure. The study was immediately discontinued, and liver function returned to normal in all the affected individuals. Roche is advising all patients who are currently taking boosted saquinavir with rifampicin to contact their doctor immediately.

Source: *Aidsmap*

Nevirapine and liver toxicity

The US Food and Drug Administration has issued a public health advisory about recent safety-related changes to the nevirapine (Viramune) label and about appropriate use of HIV triple-combination therapy containing nevirapine. The nevirapine label has been revised several times over the last two years to include more information on liver toxicity associated with long-term nevirapine use.

The Indications and Usage section of the Viramune label now recommends against starting nevirapine treatment in women with CD4 cell counts greater than 250 cells/mm³ unless benefits clearly outweigh risks. This recommendation is

based on a higher observed risk of serious liver toxicity in patients with higher CD4 cell counts prior to initiation of therapy.

In addition, a recent study published in *The Journal of Infectious Diseases* found that women with a body mass index (BMI) below 18.5 who received nevirapine were significantly more likely to develop severe liver side effects.

Sources: *The Body*, *Aidsmap*

Web-based advocacy kit

BCPWA Society has produced a web-based advocacy kit for HIV-positive British Columbians on disability and their care providers. The advocacy kit includes 20 step-by-step guides on how to navigate through a variety of issues, including crossing the US border, emergency needs assistance, and CPP retirement. The printable advocacy guides are available on the BCPWA Society Web site at www.bcpwa.org. The kit will be updated as policy and legislation change.

Pot use does not lead to poor adherence

Smoking marijuana does not lead to poorer adherence to highly active antiretroviral therapy (HAART) in patients with mild to severe nausea caused by anti-HIV drugs, according to a US study published in the *Journal of Acquired Immune Deficiency Syndromes*. However, the investigators found that the use of other illegal drugs, and the smoking of marijuana by patients with no nausea, was associated with non-adherence to HAART, confirming previous studies.

In the recent study in Northern California, among the subgroup of

patients reporting moderate to severe nausea, 75 percent of the patients who used marijuana were adherent to their antiretroviral therapy, whereas only 48 percent of those people who did not use marijuana were adherent. The data suggests that use of marijuana specifically to ameliorate nausea may actually help adherence.

Source: *Aidsmap*

Highly resistant strain of HIV in NYC

A highly resistant strain of rapidly progressive HIV has been diagnosed for the first time in a New York City resident who had not previously undergone antiviral drug treatment. The strain of three-class antiretroviral-resistant HIV does not respond to three classes of antiretroviral medication, and appears to greatly shorten the interval between HIV infection and the onset of AIDS.

The patient is a male in his mid-40s who reported multiple male sex partners and unprotected anal intercourse, often while using crystal meth. He was first diagnosed with HIV in December 2004, and it appears that he was recently infected. Since then, the patient has developed AIDS.

Drug resistance in newly diagnosed, previously untreated patients is extremely rare. ⊕

Private & confidential

Right to Privacy Campaign in BC intensifies

by Ross Harvey

The struggle to keep your medical and other information out of the hands of the US government is heating up.

As reported in Issues 31 and 34 of *Living +*, the BC government has contracted a subsidiary of a private American company, MAXIMUS Inc., to administer all Medicare (including PharmaCare) client records. Under the terms of the American *USA PATRIOT Act*, the FBI can compel MAXIMUS to turn over their records. Under the Act, they can even obtain these records secretly, without notifying the BC government.

So, the US government could find out you're HIV-positive. The government could then bar you from entry into the country. The US legal code currently bans HIV-positive people from entering the country unless they have a hard-to-get special permit or waiver. And you wouldn't even know that you had been barred from the US until you innocently turned up at a border crossing or the US customs and immigration counter at an airport.

The implications of the MAXIMUS deal were so troubling that BC's information and privacy commissioner spent much of last summer and fall doing an exhaustive investigation and then preparing a detailed report containing 16 crucial recommendations.

When the commissioner's report was released in October 2004, the BC government said it had already implemented all the recommendations. But it hasn't, and there are still huge problems.

The BCPWA Society organized the Right to Privacy Campaign (RPC) last year to oppose the MAXIMUS deal and other threats to the privacy of British Columbians' personal information. RPC includes such important organizations as the BC Freedom of Information and Privacy Association, the BC Civil Liberties Association, the BC Seniors Network, the BC Library Association,

the BC Government and Services Employee's Union and many others. See <www.righttoprivacycampaign.com/Orgs/Orgs-FrameSet.htm> for the full list of organizations involved.

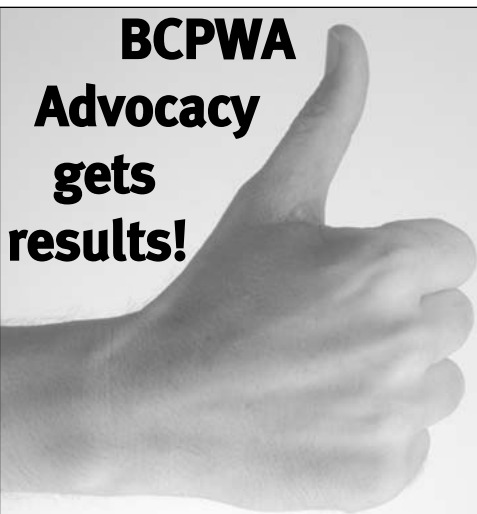
Now you can get involved. Most importantly, you can find out what information the BC government has about you that they have contracted out.

The RPC has launched phase two of the campaign: "Your Right to Know." Here's how it works:

Under BC's *Freedom of Information and Protection of Privacy Act*, you have the right to contact the appropriate government representatives and ask them to let you know what parts of your personal private information are kept by their branch or department of the government. You can also ask them to tell you what parts of your information have been included in any contracting out, where administration of that information is done by private companies that may be subject to the *USA PATRIOT Act*. The government is required to respond to your request and can't charge you a fee for this service.

RPC organizations—and the BCPWA Society—are urging you to exercise your "right to know." To do so, go to the Right to Privacy Campaign website at <www.righttoprivacycampaign.com> and click on the "Right to Know" campaign. Or, call the Right to Privacy campaign coordinator, Melissa Davis, at 604.646.5351. The RPC has prepared materials that will make it simple and easy for you to find out what parts of your personal private information are at risk. ⊕

Ross Harvey is the executive director of the BCPWA Society.



**BCPWA
Advocacy
gets
results!**

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

- ▼ **\$64,632.00** in debt forgiveness.
- ▼ **\$73,081.00** in housing, health benefits, dental and long-term disability benefits.
- ▼ **\$40,135.00** in Monthly Nutritional Supplement Benefits.
- ▼ **\$366,745.00** into members' hands for healthcare needs, from grandfathered Schedule C benefits.



British Columbia Persons With AIDS Society

Notice of Annual General Meeting

WHEN ↓

Saturday,
August 20, 2005
11:00AM

WHERE ↓

The Training Room,
1107 Seymour Street,
Vancouver

REGISTRATION ↓

10:00AM – 11:00AM

MEETING BEGINS ↓

11:00AM (sharp)

A lunch will be served

> Look for your AGM package in the mail from mid to late July 2005 <

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 2005/2006, and conduct other such business as is deemed necessary in accordance with the constitution and by-laws of the Society.

Members wishing to have business placed on the agenda for the Annual General Meeting should submit it prior to **June 13, 2005**. A letter to the Secretary of the Society containing:

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

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

Important Dates to Remember

Resolutions from the Members to be Submitted to the Secretary, BCPWA by _____ **June 13, 2005**

Mailout of AGM Packages _____ **not later than July 25, 2005**

For individuals who do not receive mail, AGM Packages will be ready for pick up from Member Services (Reception) Desk on _____ **August 2, 2005**

Last day Proxies are Mailed _____ **August 5, 2005**

Last Day Proxies May be Requested for Pick up _____ **August 12, 2005**

If you have any questions or would like to receive a copy of the Society's Annual Report, please call Robert Nickerson, Secretary, at 604.646.5315 and leave a confidential message. To ensure accuracy, please spell your last name slowly and leave a contact phone number.

What's in a name?

How we define ourselves as people with HIV

by Jeff Anderson

Why is our identity as people living with HIV and AIDS important? Looking back on our history, we belong to a group that collectively succeeded in saving lives and changing health care around the world. This success came by working together with a shared purpose. Our identity has been shaped not just by our shared vulnerability, but also by our collective and individual responses to the AIDS crisis. Over time, however, as HIV activism has become less visible, and perhaps less successful, what identifies us now is less easy to see.

A lengthy historical overview of HIV identity and influences would help us better understand the phenomenon of AIDS in the 20th Century; but, for now, we'll take a brief look at the here and now of who we are as people with HIV in BC, in Canada, and around the world.

Ironically, the term AIDS developed out of a need by governments and health insurance agencies to determine who did and did not deserve improved health care and financial assistance. In most of the world, a medical measurement still distinguishes HIV from AIDS, the simply infected to the most needy. In many cases, eligibility for health care or social assistance is still determined by a label that relates to a specific CD4 count or by a health professional's assessment that a patient has "an AIDS-defining illness."

In our early days as a disease group,

we knew that to help all people suffering from HIV—to "hit early and hit hard," as health professionals and drug companies urged us to do—we needed access to treatment at all stages of infection. We also needed to decide for ourselves when we were ready for treatment, rather than let others decide our fate. AIDS organizations and activists made sure that governments and health insurance groups included people with end-stage HIV disease, people who were newly diagnosed, and people who were asymptomatic in clinical trials and treatments. As a group, we evolved from being people with HIV to people *living* with HIV and/or AIDS. In BC, we call ourselves PWAs, while east of the Rockies we identify as PHAs. Internationally, the predominant term is persons living with HIV/AIDS (PLWHAs).

How we self-identify shapes our purpose and lends focus to our efforts.

How we self-identify shapes our purpose and lends focus to our efforts. Therefore, it is ironic that groups in Britain, such as the PWHA-Net discussion forum use the term "Aids" instead of "AIDS"—not because people with HIV demand it, but evidently because "Aids" is used by the BBC media Style Guide.

The Ontario AIDS Network has a PHA

Caucus subgroup drawn from its member AIDS organizations. In recent on-line discussions, the Caucus co-chairs shared why they dropped the term "living with" from their identity. "The two words 'living with' may not only have outlived their usefulness, but may have contributed to the HIV/AIDS complacency that has overtaken the PHA community, the gay community, the medical establishment and the community-at-large," Mike Hamilton writes. "The possibility of removing the word 'living' from the literature and leaving it to read, people 'with' HIV/AIDS... will allow people to declare and share their own life experience—whether it is fighting, living, or dying with HIV/AIDS."

The strength of our voices, our organizations, and our power vary from country to country, and even from region to region. As long as we still live, the debate about our individual and collective needs and how we self-identify will continue. Knowing what weaknesses and strengths we have in common—the sense of identity that we share—can lead the way to more effective prevention strategies as well as care, treatment, and support for people with HIV. ⊕



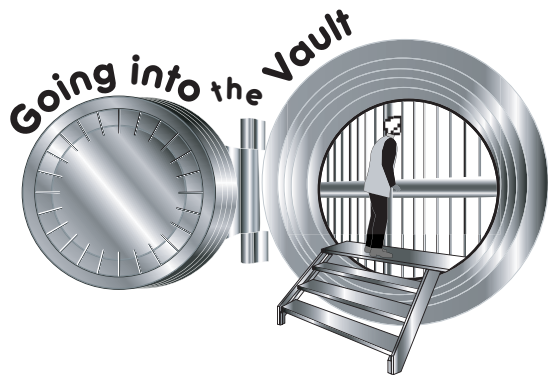
Jeff Anderson is a long-time activist and volunteer, including past treasurer of the BCPWA Society from 1997 – 2002.

Questions or concerns about your treatment or health?

BCPWA Treatment Information

You are welcome to drop by anytime Monday to Friday, 10AM to 4PM, at 1107 Seymour Street, Vancouver (down the street from St. Paul's) and you can even email us at treatment@bcpwa.org

**LOCAL 604.893.2243
LONG DISTANCE 1.800.994.2437**



The Denver Principles and the GIPA

by Sam Friedman

Since the beginning of the AIDS pandemic, people around the world who are living with HIV/AIDS have come together to form groups, networks, and organizations for self-help, mutual support, and individual and collective empowerment. Two key manifestos have fuelled the PWA self-empowerment movement. In 1983, the Denver Principles were drafted by early AIDS activists at the Second National AIDS Forum in Denver, Colorado. In addition, the principle of the Greater Involvement of People Living with AIDS (GIPA), also written by PWAs, was endorsed by 42 countries at the 1994 AIDS Summit in Paris and then by the United Nations in 2001.

It took courage, personal strength, and a proud, uncompromising, unapologetic, tenacious spirit for these HIV-positive people to stand up publicly at these early national and international events. These activists laid the groundwork for us by demonstrating the true essence and power of PWAs working together.

At the heart of these documents is the basic legal, social, and medical rights, freedoms, and empowerment of persons living with HIV/AIDS. The papers call for all people to come together, in a true spirit of collaboration, to support PWAs in their fight against stigma, discrimina-

tion, and blame. The papers further maintain that the needs and involvement of PWAs are central and essential to the success of every initiative in the fight against AIDS.

Both documents recommended that PWAs:

- ▼ be fully involved in the formation and implementation of public policy, to ensure that PWAs have equal protection under the law.
- ▼ form their own caucuses, networks, and organizations, and create and implement their own agendas and strategies.
- ▼ choose their own representatives to serve on the Board of Directors and committees of public, private, organizational, and governmental decision-making bodies.
- ▼ seek representation, with equal authority as other participants, at all AIDS forums and conferences, to share their experiences and their knowledge.

Despite the endorsements of both these documents, the active involvement of people living with HIV in decision-making is still far from universal. Many organizations, including the BCPWA Society, encourage participation and activism and greatly depend on

the commitment and courage of knowledgeable members.

BCPWA Society has many varied and challenging opportunities available for people with HIV/AIDS who wish to be involved with the organization. Building individual and collective strength and capacity through support and mentorship is key to creating effective activists. If we work together, support each other, and share our knowledge, we can truly make a difference in our lives and the lives of all PWAs. Come, listen, learn, and participate. A list of BCPWA Standing Committees is on page 36 of this magazine and on the Society's Web site at <www.bcpwa.org>.

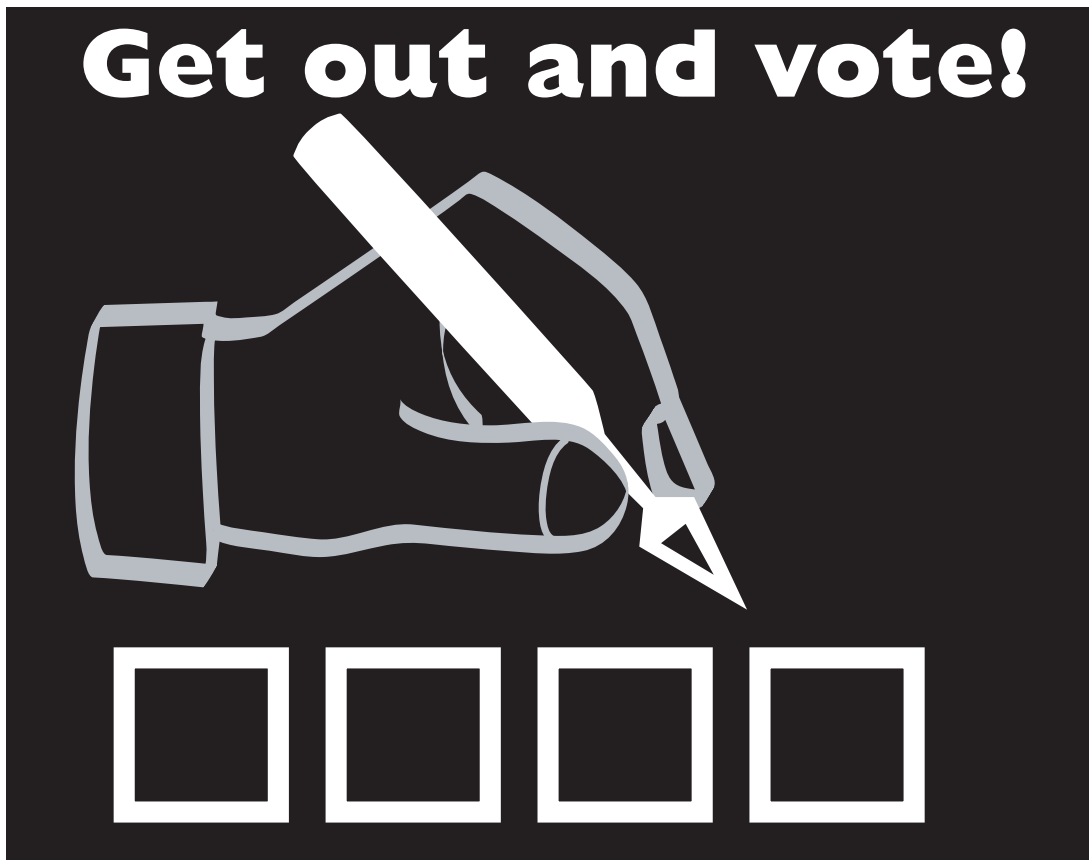
You can read *The Denver Principles and the GIPA* online at:

<www.actupny.org/documents/Denver.html>

<www.youandaids.org/Themes/EmpowermentPLWHA.asp> ⊕



Sam Friedman is a dedicated BCPWA Society member, volunteer, writer, and sits on several Society committees.



BC's major political parties respond to our questions

by Glyn Townson

On May 17th 2005, eligible voters in the province of British Columbia will exercise their democratic voice by electing local Members of the Legislative Assembly (MLAs) to govern our province for the next four years.

This is a pivotal election year in our province. The past four years have ushered in major shifts in government policy, and new directions with far reaching, long-term implications. Voters will decide if they want the province to move forward with expanded, publicly-owned and managed services, or if they prefer to pursue the current path of privatization and reform of community services, including reduced access to social programs, women's services, and legal aid.

We have been fortunate in BC to have not only publicly-funded HIV medications, but also access to the BC Centre for Excellence in HIV/AIDS, which provides some of the most cutting-edge research and best care available anywhere. HIV-positive British Columbians cannot afford to take these services for granted. Individually, we must remind our elected officials how important these resources are to us, and impress upon them that these services must be not only maintained but also expanded. Research in this province

confirms that antiretroviral medications work; the real barriers facing PWAs are social conditions—poverty, inadequate housing, and addictions—that prevent so many people from accessing HIV treatment.

To assist the BCPWA Society membership and Living+ readership in making informed decisions on election day, the Society's Community Representation and Engagement Committee (CRE) drafted five questions, directed at the electoral candidates, that deal with issues affecting quality of life for HIV-positive British Columbians. The CRE committee is currently monitoring these issues. The four major political parties in the province—the Green Party, the New Democratic Party, the Liberal Party, and the Unity Party—were invited to respond to the questions with the understanding that their responses would be published in this issue of *Living+*. The Unity Party did not provide responses.

To find out if you are eligible and/or registered to vote, contact Elections BC at tel: 250.387.5305, toll-free 1.800.661.8683, TTY/TDD 1.888.456.5448, or visit their website at <www.elections.bc.ca>. You can register to vote, as well as confirm, or update your personal information on-line.

Glyn Townson is vice-chair of the BCPWA Society.

continued on next page

Will you undertake, over the next 5 years, to double the budget for the provision by Pharmacare of antiretroviral medications through the BC Centre for Excellence in HIV/AIDS?



The Green Party supports the provision of drugs for all life threatening illnesses as part of the publicly funded Pharmacare system, at a reasonable cost to users. This would include aggressively negotiating the bulk purchase of medications to meet the requirements for all BC residents. The Green Party believes this is not just a budget issue and would support research to have a better understanding why many people with HIV are not able to access antiretroviral medications (i.e. being a member of a marginalized group or not living near Vancouver). The Green Party also supports the access of quality marijuana and alternative therapies for medical needs.



As you know, British Columbia has an excellent record of service to people with HIV/AIDS. Pharmacare provides antiviral medications at no cost to eligible persons infected with HIV (over \$37 million in 2003/2004). This will continue as required.



Since its creation in 1992 under the NDP, our party has fully supported the work done by the BC Centre for Excellence in HIV/AIDS. An NDP government will continue to work with St. Paul's Hospital and health authorities to ensure the needs of people living with HIV/AIDS are met and they have access to the medications they require. An NDP government will work to ensure more people (particularly those living in the Downtown Eastside) living with HIV/AIDS have the opportunity to access the treatment programs.

Will you undertake, in consultation with the HIV/AIDS Community, to develop and implement a province wide HIV/AIDS And Hepatitis C Strategy?



The Province has developed a framework titled "Priorities for Action in Managing the Epidemics: HIV/AIDS in BC (2003-2007)". Health Authorities and other stakeholders are currently developing plans to address the goals as set out in this document.

Ministry of Health Services, BCCDC Hepatitis Services and the regional office of the Public Health Agency of Canada are undergoing preliminary discussions looking at a renewed hepatitis strategy/framework. The BC Hepatitis Services is an integral part of the province's response to addressing hepatitis. In addition, the Ministry will be consulting with the Collaborative Circle in the renewal of the BC hepatitis strategy/framework to ensure meaningful involvement of community stakeholders.



The Green Party is committed to work with the HIV/AIDS Community to develop and implement a province wide strategy for both HIV/AIDS and Hepatitis C. This is particularly important because AIDS/Hepatitis C is now impacting intravenous drug users, prostitutes, aboriginals and other marginalized people. The Green Party believes a province wide strategy needs to take an approach that is holistic, includes a comprehensive anti-poverty component and a "four Pillar" solution similar to the current initiatives by the City of Vancouver.



Over the last several years, groups working to help those living with HIV/AIDS have struggled with growing demands but shrinking resources. The NDP is committed to developing a comprehensive strategy with the HIV/AIDS community that addresses the community's needs and the needs of individuals. A key part of this strategy would have to include a renewed focus on prevention.

Will you raise BC Benefits PWD to the level of the Statistics Canada low-income cut-off?



The NDP is committed to improving the quality of life for British Columbians living with HIV/AIDS. And we are committed to working toward ensuring that persons living with HIV/AIDS have sufficient resources.



The Green Party has a long-term commitment to implement policies to ensure all British Columbians have a guaranteed annual income that is at least equal to the Statistics Canada low-income cut-off. In the short-term the Green Party would focus achieving this for marginalized groups, seniors, children and people with disabilities. A Green Party Government would immediately implement regulations that would ensure people with HIV/AIDS qualify as a person with a disability and would ensure that any appeal process is humane and expeditious.



One of the Ministry of Human Resources' top priorities is to ensure that assistance is provided for persons with disabilities. On November 6, 2004, Premier Gordon Campbell announced a \$70 per month increase in support rates for PWD clients, the largest rate increase in history.

This increase means that a single person receiving disability assistance will receive up to \$856.42 per month, the second highest disability assistance rate in Canada. Persons with disabilities saw this increase on their January 2005 cheque, issued on December 22, 2004.

Will you double the funding provided to the Health Authorities by way of funding reserved for community based HIV/AIDS services?



With \$11M for community-based organizations and services, British Columbia is one of the few provinces with substantive investments in its response to HIV/AIDS. Community based HIV/AIDS services are managed under contracts with Health Authorities and are directed by their respective HIV/AIDS service plans. Ministry of Health Services will continue to work with provincial agencies like BC Centre for Disease Control and BC Centre for Excellence in providing support to Health Authorities in implementing their HIV service plans.



The NDP is committed to improving services to benefit persons living with HIV/AIDS and we are committed to working with community-based service organizations to ensure they are able to better meet the growing demands they face.



The Green Party is committed to increasing the funding provided by the Health Authorities that is targeted for community based HIV/AIDS services. A Green Party Government would work with the various public health agencies and non-government organizations that provide HIV/AIDS services to ensure that comprehensive and holistic programs are delivered. Again the Green Party believes this is not just a budget issue and wants to ensure that the community based programs are inclusive, appropriate and comprehensive.

Will you halt the contracting out of information management to companies subject to the USA PATRIOT Act (such as MAXIMUS) until such time as the privacy commissioner's 16 recommendations are all completely implemented?



The Green Party does not support the privatization of core health care services, including information management. In particular, the Green Party opposes the privatization of any government service that has any risk of compromising the confidentiality of the private records of British Columbians. We informed the Privacy Commission of our opposition to the Maximus contract and are on public record in this regard. The BC Green Party is committed to terminate any government service contract that does not address all concerns about confidentiality.



We assessed the MAXIMUS BC agreement against the Commissioner's recommendations and determined the contract meets or exceeds those recommendations. The Commissioner recommended the storage and access of data only in Canada, our agreement goes further — data cannot be stored or accessed outside of BC without permission. Government also has the power to take over MAXIMUS BC if there is ever a threat of unauthorized disclosure.

There is also protection for whistleblowers and a whistleblower hotline to prevent unauthorized disclosure. The Commissioner's review reinforced government's belief that administration of MSP and Pharmacare could be modernized and improved, without compromising patient confidentiality and privacy. In addition the Commissioner has stated a ban on outsourcing would not be practical or effective.



The NDP will halt all further privatization in health care and we oppose the contracting out of personal medical information to private companies, especially those subject to USA PATRIOT Act. In opposition the NDP opposed the government's move to hand over sensitive information to Maximus and supported the privacy commissioner's recommendations. Unfortunately, it may already be too late to undo many of the privatization contracts signed by the BC Liberal government.



The latest developments in microbicides

by Janet Madsen

As HIV rages on and infects more people each year, prevention continues to be a challenge. For people whose sex partners refuse to use condoms or barriers, the universal “use a condom” prevention message just doesn’t cut it.

Women are very vulnerable, as there is no prevention method truly within their control. Presently, women represent 55 percent of the world’s HIV-positive population, with young women in developing nations particularly at risk. In Ghana, for example, women with HIV outnumber men with HIV by 2 to 1. Here in Canada, women aged 15 – 29 represented 44 percent of seropositive test results reported in 2001.

Focusing HIV prevention strategies on negotiation puts anyone having receptive sex—vaginal or anal—in a difficult situation. If your partner says no, what recourse do you have?

Sexual relationships are far too complicated to simply advise someone, “Well, you just shouldn’t have sex.” Power imbalances—based on gender, cultural expectations, physical differences, emotional, and financial issues—all play a part.

When microbicides become available, that could change. Microbicides are products to be used vaginally or rectally to reduce the transmission risk of HIV and other sexually transmitted infections (STIs). Research and testing are underway, but no products are on the market yet.

Current research is focused on vaginal microbicides, with some Canadian products among those undergoing testing. Two products in Phase 3 trials include Savvy and UsherCell. Another Canadian product, “The Invisible Condom,” is currently in Phase 2 trials. After safety testing in Phases 1 and 2, Phase 3 research shifts to exploring effectiveness.

Phase 3 testing is taking place mostly in developing countries. The rationale behind conducting trials in developing nations is that Phase 3 testing requires populations that have “a high incidence of HIV, stable populations that can be followed up easily and virtually no injecting drug use or other sources of HIV risk among women,” according to the Global Campaign for Microbicides. To measure effectiveness of the product, researchers compare rates of seroconversion between groups that use placebo and groups that use the microbicide.

Large groups of uninfected women are needed for Phase 3 trials, which introduces important ethical questions.

Large groups of uninfected women are needed for Phase 3 trials, which introduces important ethical questions.

- ▼ Does the research deliberately expose women to HIV? No. All women in trials are offered free safer sex education, and plentiful, free condoms. Women are taught to use condoms and the microbicide or placebo.
- ▼ Will women receive health care during and after the trials? Yes. Women receive regular testing for STIs and HIV during the trial.
- ▼ What if a woman becomes infected during the trial? Women who become infected will have some access to antiretroviral therapy.
- ▼ How will researchers address people’s assumptions that a woman who is excluded from a trial is HIV-positive? Researchers must communicate the variety of reasons, in addition to HIV, why a woman may be excluded.
- ▼ What if a microbicide acts as a contraceptive and a woman hopes to achieve pregnancy? Researchers must advise women if the trial they are participating in is using a contraceptive microbicide.

In resource-poor areas where the trials are conducted, the well being of the whole community must be considered.

A microbicide product for rectal use is also critically needed. Because the vagina and rectum are very different both structurally and chemically, different products are required. Vaginal microbicides will likely come on the market first, and activists are aware that people may use vaginal products rectally in the hope that they may have some effect. Advocates plan to lobby microbicide manufacturers to ensure that ethics be considered in this case as well. Information on rectal use needs to be included in packaging and promotions for vaginal microbicides, including potential warnings.

Of course, money is needed for additional research, and this requires political will. Microbicide activists were pleased with the World AIDS Day announcement on December 1, 2004 from the Canadian government that awarded a \$15 million contribution to the International Partnership for Microbicides. Not only does this help product research financially, it also helps governments and the public become more aware of microbicide development.

Although progress may seem slow, let’s hope that the current Phase 3 testing will yield a marketable product within the next five to seven years. If researchers are successful, it could change the power of prevention.

For more information on national microbicide advocacy, visit the following Web sites:

- ▼ *Canadian AIDS Society* <www.cdn aids.ca> for information on *MAG-Net*. Search the phrase “MAG-Net” on the CAS Web site for numerous documents.
- ▼ *Global Campaign for Microbicides* <www.global-campaign.org>
- ▼ *Alliance for Microbicide Development* <www.microbicide.org> ⊕

Janet Madsen is the communications coordinator at the Positive Women’s Network in Vancouver.

We need people like you. BCPWA has volunteer opportunities in the following areas:

- Website maintenance* > Communications
- Administration* > Internet research, filing, database management, reception, etc.
- Special events* > AccolAIDS Awards Banquet and AIDS Walk
- Writers* > living ⊕ magazine, Communications and Positive Prevention
- Workshop development and delivery* > Positive Prevention, Communications and living ⊕ magazine

Benefits of becoming a volunteer:

- ◆ *Make a difference in the Society and someone’s life*
- ◆ *Gain work experience and upgrade job skills*
- ◆ *Find out more about HIV disease*

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



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 judgment 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, or the responsibility for, damages, costs, or consequences of any kind which may arise or result from the use of information disseminated through this program. Persons using the information provided do so by their own decisions and hold the Society's Board, staff, and volunteers harmless. Accepting information from this program is deemed to be accepting the terms of this disclaimer.



HIV + HPV = pain in the ass

The high risk of developing anal cancer

by Michael Connidis

The Human papillomavirus (HPV) is one of the most common sexually transmitted diseases among men and women in western countries. The link between HPV infection and the development of pre-cancerous cervical, anal, and genital lesions as well as cervical, anal, and genital cancer is well established. In the last ten years, there has been an increase in the incidence of anal cancer in both men and women in the general population. People who have compromised immune systems and men who have

sex with men (MSM) have a higher risk of developing anal cancer than any other subgroup in the general population.

There are over 100 different subtypes of HPV, which are distinguished by variations in their genetic code and further classified numerically. The various subtypes are associated with different abnormalities of the skin, commonly referred to as warts that appear on different areas of the body. Anogenital warts, also known as venereal warts, develop in and around the anus and or

continued on next page

genitals. HPV subtypes 6 and 11 are most often associated with visible anogenital warts but are rarely associated with anogenital cancers. By contrast, HPV subtypes 16, 18, 31, 33, 45, 51, 52, and 56 are commonly found in anogenital cancers but typically do not cause noticeable warts; as a result, HPV infection may go undetected.

Having anogenital warts does not automatically mean you are at risk for developing cancer. Often, people develop anal warts even though they do not engage in receptive anal intercourse. It is prudent to have anogenital warts treated, especially for people with compromised immune systems. Treatment modalities vary and depend upon the size and location of the warts. Cryotherapy, surgical excision, and immune modulators are the most successful forms of treatment.

HIV-positive men are twice as likely to develop anal cancer than HIV-negative men, and are 120 times more susceptible than the general population.

A lack of standard testing procedures

Infection with HPV subtypes that have a high risk for causing cancer can lead to changes in the epithelial cells of the transformation zone, a region of cells lining the anal canal between the external anus and the internal rectum. In women, similar changes occur in the transformation zone between the linings of the vagina and the cervix, where cervical cancer and precursor cell abnormalities are typically found.

Papanicolaou (Pap) tests have been crucial to the early diagnosis of cervical cancer by detecting changes in cells from this transformation zone. By contrast, there is no standardized, effective screening to identify abnormal and pre-cancerous cells in the anal canal for MSM; moreover, few technicians can accurately analyze samples. Typically, anal cancers are detected when an individual or his doctor discovers a palpable mass in the anal canal or within the rectum. Anorectal tumours are most likely to go unnoticed until there are complications such as pain or bleeding.

A recent study of 1,218 HIV-negative MSM in four major US urban centres found HPV DNA present in 57 percent of the cohort. Researchers found high-risk subtypes of HPV in 26 percent of these men. Infection with multiple subtypes of HPV was also common.

Other results from this study are relevant to MSM, regardless of HIV status. The incidence of HPV infection and the presence of high-risk types of HPV was the same regardless of age. Men who had engaged in receptive anal intercourse

were more likely to be infected with any type of HPV. MSMs who had multiple sex partners were also more likely to have HPV infection, although they were somewhat less likely to have high-risk types of HPV. (The literature does not distinguish between protected or unprotected sex.) Participants in the study had a median number of eight sex partners during the previous six months; 91 percent reported having at least one sex partner during the preceding year, while 77 percent reported having receptive anal intercourse during the preceding six months.

PWAs are particularly vulnerable to infection

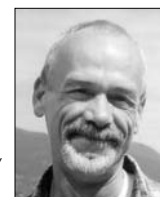
The high incidence of HPV infection in the anal canal, especially infection with high-risk types of HPV, is cause for concern amongst HIV-positive MSM. People with compromised immune systems are more easily infected with HPV and their bodies are not as effective at controlling these viral infections. Even for people with fully functioning immune systems, HPV immunity is potentially transient and repeated reinfection with the same subtype of HPV is possible. HPV vaccines currently in trials are designed to protect men against only two high-risk HPV types, 16 and 18, as well as the more common but low-risk types 6 and 11.

The incidence of invasive anal cancer in HIV-positive people, particularly MSM, has increased. HIV-positive men are twice as likely to develop anal cancer than HIV-negative men, and are 120 times more susceptible than the general population. Long-term survivors of HIV infection have a greater risk of HPV infection progressing from pre-cancerous cell abnormalities to invasive anal cancer. There has also been a higher incidence of other cancers, such as Kaposi's sarcoma (KS) and non-Hodgkin's lymphoma (NHL), among HIV-positive people; while highly active antiretroviral therapy (HAART) may lead to the regression of KS and NHL, there is no such similar correlation between HAART and anal cancer.

Condom use has not proven to be an effective barrier against the transmission of HPV. Vaccines that may reduce HPV infection are still in development and, in any event, will not protect against a number of high-risk subtypes of HPV.

HPV is here to stay. We need to protect ourselves and safeguard our health—and we need better tools and health care in order to do so.

Stay tuned for future articles in Living+ on the diagnosis, treatment and survival rates of anal cancer, as well as interviews with PWAs who discuss their experiences with anal cancer. ⊕



Michael Connidis is a member of the BCPWA Society and a member of the Living+ editorial board.

A wake-up call

Report from the 2004 North American AIDS Treatment Forum

by Michael Connidis

The North American AIDS Treatment Action Forum (NATAF) held its tenth annual conference in St. Louis, Missouri last December. NATAF brings together treatment providers and advocates to enhance skills and knowledge, and to develop inclusive strategies for the continued success of treatment advocacy. Six Canadians from BC and Ontario attended NATAF this year. We were a tight group and represented our country well. The six of us continue to work together to increase involvement from Canadian agencies for next year's conference—to co-sponsor NATAF in some capacity, participate in planning, and make presentations.

The educational workshops at the conference followed three tracks: access to treatment, care and treatments, and research. Presentations included international and multinational research projects, as well as the results of domestic and local research initiatives in both the US and Mexico. Most presenters were professional researchers and caregivers, with less direct involvement by PWAs than at previous NATAF gatherings. These demographics did not detract from the quality of information presented, but it did shift the dynamic of the conference away from being a peer-directed and delivered event.

Four plenary sessions covered broader topics: reinvigorating and strengthening AIDS activism; the shift in prevention strategies from targeting peo-

ple who are HIV-negative to focusing on HIV-positive individuals; the disparities in HIV care and treatment in communities of colour in the US; and issues affecting the integration of international and domestic access to treatment.

Overall, the reality of HIV/AIDS in North America remains discouraging. Infection rates increase while the number of pharmaceutical companies engaged in research and development of new drugs decreases. The political, institutional, and ideological hurdles persist, and are higher than they have been for a

Overall, the reality of HIV/AIDS in North America remains discouraging.

decade; these obstacles are contributing to the growing AIDS crisis everywhere. For example, positive changes in Mexico's laws and healthcare goals—intended to curb the epidemic by protecting individual rights and providing care to Mexicans who need it—are impeded by a fractured healthcare system, an inequitable legal system, and insufficient public education, information, and awareness.

For Canada, NATAF was a wake-up call and a reminder to value and protect our public healthcare system, education



system, and social services network. And it was a further reminder to keep these essential services free of ideological and political bias. Protecting these institutions ensures that Canadians will be well-informed, will make intelligent choices, and will have access to quality health care, housing, and nutrition. These are the hallmarks of Canadian life that we should strive to maintain. The US and Mexican realities are stark reminders of how important a goal this should be for all of us.

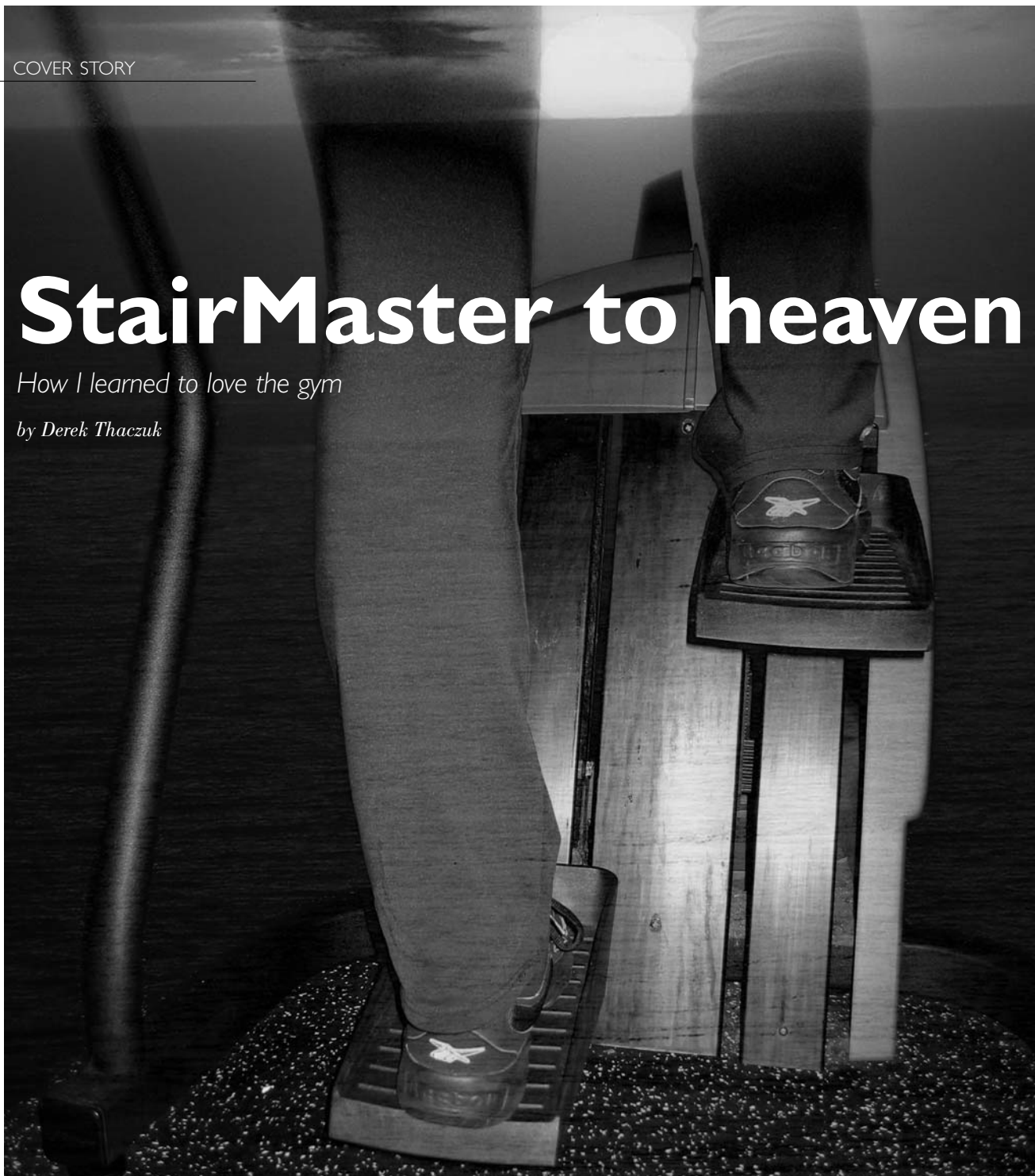
The 11th NATAF conference will be held in Oaxaca, Mexico in November 2005. This will be the first time in NATAF's history that Mexico hosts the conference; Mexican delegates were thrilled when the announcement was made in St. Louis. ⊕

Michael Connidis is a member of the BCPWA Society and a member of the Living + editorial board.

StairMaster to heaven

How I learned to love the gym

by Derek Thaczuk



To some folks, exercise is one of those pie-in-the-sky notions, one more thing on the “1,001 things to do every day if you’re HIV-positive” list. Or, it can be an all-or-nothing obsession—we all know those “perfect pec” people who never seem to leave the gym. But it doesn’t have to be that way. It can be easier than you think to find something that suits you.

Let's start with a pop quiz. What's the first thought that comes to mind?

1. The gym:

- Nice idea—like flossing, forgiveness, and world peace. Get back to me after *Oprah*.
- That Village People song.
- My second home and the centre of my social life. Got a bench with my name on it.
- It's a great place to work out, but it's not the only way to keep fit.

2. Working out:

- Yecch. So trendy. I don't do spandex.
- I get winded just taking my empties back. Need a couple of Krispy Kremes to recover.
- I work out religiously (especially before circuit parties).
- Got my weight, chest, and arm size graphed on my computer.
If you answered mostly Cs and Ds, you're already on the exercise A-list. If you ticked off As and Bs—or if this quiz ticked you off—we need to talk.

Two “case studies”

Theory Jhanes, a 38-year-old self-employed PWA, wasn't the exercise type until he tested HIV-positive seven years ago. “I hated the gym and all that stuff,” he says. “But my doctor said I should do something to build up my muscles. I've always been thin, and I've seen people lose so much weight. I didn't want to end up gaunt and sick—and sick-looking.”

Jhanes tried weightlifting, but didn't like the atmosphere at the gym and he really didn't have the strength for it, either. Then he hit on swimming. “I'm very mentally active, so I like the mindlessness of swimming. I get to just coast and not think for an hour,” he says. “I'm never going to have that pumped-up build. But that doesn't matter. I'm in great shape now.” Swimming totally energizes him even when he's feeling lousy and doesn't want to swim.

Many people share Jhanes' reservations about gym culture, especially those who remember public school gym class with a shudder. But the reality can be very different. “I wasn't thrilled about the gym at first,” says Jake Bedford (a pseudonym), a gay man who tested positive 13 years ago. “I was really self-conscious about my skinny body, my bony ribs. The last thing I needed was a bunch of gym queens giving me attitude.”

Bedford says he found just the opposite. “For the most part, everybody minds their own business. And the big buff ones—the guys who are really serious about working out—are actually easy to approach. They're really into it and they'll help you out with your routine. It seems like everybody's at his or her own level. As long as you're trying, people respect that.”

Bedford, who's had problems with HIV-related weight loss, uses weight training to keep muscle on his body. “It's a really fine line for me. I'm okay when I'm looking after myself, but once I start losing weight I can go downhill fast.” Bedford tries not to burn off too many calories through aerobic activity, because he doesn't want to lose weight. So, he stretches a lot and practices

yoga, in addition to lifting weights. “I used to try hard to bulk up,” he says, “but now I realize it's just not gonna happen. I listen to my body, do what I can, and don't push it too hard.”

Different strokes

Bedford's weight training falls into the category of resistance training. The other main kind of exercise is aerobic exercise, such as Jhanes' swimming. Many people would add a third category: flexibility training.

Resistance training means putting your muscles to work against deliberate resistance. Working with weights or weight machines builds muscle mass and/or muscle strength. Since so many PWAs tend to lose weight in the form of lean body mass, or muscle, weight training is often recommended to help rebuild muscles.

Aerobic exercise is the stuff that gets you sweating and breathing hard, and that gets your heart pumping: cycling, running, StairMaster machines, and cross-training machines. (And yes, sex can count as aerobics, at least if you're putting your heart into it!) Aerobic exercise is also called cardiovascular, or cardio for short. “Cardio” refers to your heart, and “vascular” means your circulatory system. Thus, cardiovascular exercise keeps your heart and lungs healthy and fit.

Flexibility training means stretching your muscles and joints to keep them limber and protect them against injury. Flexibility training is an important component of other forms of exercise; you should always stretch and loosen muscles before and after weight lifting or engaging in any heavy-duty form of exercise.

Naturally, these three modes of exercise overlap: for example, weight training gets your heart pumping, and you have to work your muscles to swim or run. The relative amounts of cardio, resistance, and flexibility training depend on the form(s) of workout you choose, what you're trying to achieve (Weight gain? Better endurance? Better energy and mental health?), and what kind of activity appeals to you.

Fitness tips

No matter what kind of workout you do, some common sense rules apply:

- ▼ Choose an activity that feels good and that you'll be likely to stick with.
- ▼ Before you start, get advice from your doctor and from a qualified trainer who's knowledgeable about the type of exercise you've chosen.
- ▼ Find out about proper technique and possible risks. Don't overdo it, especially at first or if you're unfamiliar with any part of the exercise.
- ▼ Drink liquids to stay hydrated while you're working out.

And make sure you eat enough food. In this world where everyone's pressured to look like a rail-thin supermodel (“Blueberry? Oh, I couldn't. I had one already!”), PWAs also have to watch their calories, but they have to make sure they get enough of them, especially when exercising.

That calorie caution applies especially to aerobics. Most of the folks sweating away on the StairMasters are trying to lose

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weight—something most PWAs are trying hard to avoid. Still, there's no harm in doing aerobics; it's good to have a healthy heart and lungs. Just give some thought to how much aerobic activity is enough. Bedford is a prime example: "I tend to be skinny and not eat much, so I have to be careful about working out," he says. "I concentrate on stretching and weights, and just spend maybe ten minutes on the cross-trainer to warm up."

Physical and mental health are intimately related. Most people who exercise find that it's about far more than just keeping fit.

Weight training comes with its own list of dos and don'ts:

- ▼ Do stretch before lifting weights, and preferably afterward as well.
- ▼ Start slowly when you're just beginning, and work with a trainer if possible.
- ▼ Choose weights so that you can do two or three sets of eight to 12 lifts (repetitions, or "reps") per set.
- ▼ Rest a minute or so between sets.
- ▼ Work your way through different muscle groups—chest, back, abdomen, arms, shoulders, legs—so that each group of muscles gets a few days rest between workouts.
- ▼ If you hurt or strain something, stop right away and see a physiotherapist if you can.

Mind and body health

Physical and mental health are intimately related. Most people who exercise find that it's about far more than just keeping fit. For Theory Jhanes, it's a huge stress relief. He used to kickbox, which he found was a great way to release anger and stress. But he prefers swimming now. "I started because I tested positive, but HIV is the last thing I think about when I'm in the pool. You have to have some other focus in your life, something besides just having HIV."

There are many forms of gentler exercise, such as yoga and Tai Chi, which can really help your mental attitude. Yoga, an increasingly popular system in the West—though thousands of years old—begins by relaxing and focusing the mind and the breath, and lets all bodily movements flow from that basic focus. "Yoga is a remarkable way to stretch and strengthen your body, but the most profound effect I've experienced in my own practice and seen in my students is that it calms the nervous system and stills the mind," says Toronto-based yoga instructor RonniLyn Pustil. "In yoga, you use your breath to create space in your body and your mind. It is a very healing practice on many different levels. There is nothing better than to see people brighten, soften, relax, and leave class feeling better than when they arrived."

Like it or not, body image is a part of mental health—and often a stressful one. The media, advertisements, and store windows constantly screech our failings to us: not thin enough, not muscled enough, not young enough, not beautiful enough.

The clothes-by-Gaultier, body-by-Cyber "norms" of so much gay culture pressure us to look like someone else's idea of perfect.

"I didn't used to like my body, but now I do," says Jhanes, reflecting on our oh-so body-conscious world. "I still complain about it like everybody else, but I'm a lot more comfortable with it than I used to be." Is that for his own sake, or for anybody else who might be looking? "Both, really. It's nice to be flattered—or cruised—but it has more to do with the way I feel about myself. Not everybody's gonna like my body but I like seeing myself in the mirror and thinking I look hot in that Speedo."

Exercise may have other benefits as well. Studies suggest that working out may help to lessen some of the metabolic complications caused by highly active antiretroviral therapy (HAART). Unfortunately, it probably won't help the visible signs of lipodystrophy (medication-associated fat redistribution), but it may at least help nudge fat and blood sugar levels back towards normal levels. Other studies suggest that regular exercise may help immune function. While it may be unreasonable to expect that mere exercise will make your CD4s skyrocket, there are plenty of other reasons to show your face at the gym.

All right, let's wrap up with one last quiz. The best kind of exercise:

- ▼ Is highly individual—it all depends on you.
- ▼ Fits comfortably into your life.
- ▼ Can add precious pounds to your lean body weight.
- ▼ Is as enjoyable as it is good for you.
- ▼ All of the above.

You got it. ⊕



After 8 years with the Toronto PWA Foundation, Derek Thaczuk is launching a solo career as a medical and science writer. He can be reached at <www.readablewriting.ca>.

Web resources

Check out the following Web sites and articles for more information and detailed exercise guides:

"Let's Get Physical" — The Positive Side, Forthcoming, Spring/Summer 2005. Should be available on the CATIE website at <www.catie.ca> after publication.

"Waste Not: HIV-related weight loss" — Toronto PWA Foundation <www.pwatoronto.org/fr_index.htm>

<www.thebody.com/dietnut/exercise.html> — A collection of articles on exercise and HIV.

<www.aidsmap.com> — Under "Living with HIV": articles on exercise, including benefits, types, steroids, as well as, planning and sustaining a program.

<www.mediobolics.com> — Devoted to weight gain and maintenance for people with HIV.

< www.aidsinfont.net/articles.php?articleID=492 > — New Mexico AIDS Infont: Exercise and HIV.

The best of both worlds

Naturopathic medicine is based in modern research but draws from healing traditions

by Dr. Jennifer Hillier

The alarm clock rings and you cringe at the prospect of another day: you just don't have the energy or motivation to eat or to take your medications. There are days when it seems so complicated and impossible that you feel you need fifteen textbooks and a team of biochemists to figure it all out. New forms of treatment seem overwhelming and daunting as you struggle with contraindications, side effects, and drug interactions.

At a time when we are all straining to see the newest drug on the horizon and battling with the limitations of treatment regimens, naturopathic medicine has slipped quietly onto the treatment scene. Focusing primarily on the individual and his or her unique circumstances, this alternative therapy is gaining popularity within the HIV-positive community.

Naturopathic doctors (NDs) are fully trained professionals. They complete a minimum of three years of university study (including several biomedical science credits), followed by four years of full-time classroom and clinic training at an accredited naturopathic medical college. To be licensed, they must complete provincial board exams. In addition, NDs in British Columbia are licensed and regulated by the College of Naturopathic Physicians of BC.

Naturopathic medicine aims to combat the side effects of various medications and to restore vitality. By addressing imbalances within the body, including nutritional, energetic, genetic, and environmental influences, this form of treatment helps to overcome discomfort and

weakness. Based in modern medical research and drawing from a wide range of healing traditions, it represents the best of both worlds, tailoring health care to the individual, not to the disease.

By looking at the entire person and his or her specific circumstances, naturopathic medicine can benefit a wide spectrum of symptoms and side effects.



The challenges of HIV are as diverse as the people who are infected with the virus. The virus causes an increased need for antioxidants and nutritional support in the body. In addition, the stress related to diagnosis and treatment can create obstacles that can worsen physical complaints. These combined factors lead to a variety of symptoms, from fatigue and anxiety to weight loss and diarrhea. Social or

emotional factors can further complicate a person's experience.

By looking at the entire person and his or her specific circumstances, naturopathic medicine can identify patterns and address not only HIV-related symptoms but also more fundamental issues; it can also benefit a wide spectrum of symptoms and side effects. Most people notice enhanced mood, better sleep, and increased energy, along with improved drug tolerance.

While some people with HIV choose to see a naturopathic physician exclusively, most have a general practitioner as their primary healthcare provider and are on a wide variety of medications and treatment protocols. Since naturopathic medicine improves the body's ability to eliminate toxins and enhance vitality, it is a good complement to drug therapies and other HIV-specific treatments.

Ideally, individuals interested in attending a naturopathic clinic should be willing to take a good look at their habits and personal health. Therapies are often simple and effective, but require active participation and commitment from both the practitioner and the individual.

The BCPWA Society now hosts a naturopathic clinic every Thursday. Services are free to BCPWA members. Appointments must be made in advance. For more information or to schedule an appointment, call Tamara Shoup at 604. 893.2244. ☎

Dr. Jennifer Hillier, ND, volunteers weekly at the BCPWA Society Naturopathic Clinic.



Having faith

The spiritual side of the AIDS Conference in Bangkok

by Jari Dvorak

Religion is not a topic you might expect to come up at an AIDS conference. In the past, organizers have tended to keep any discussion of religion out of the meetings, seeing it as counter-productive to HIV prevention and treatment efforts. It was therefore surprising to discover an interesting group of clergy at last year's Bangkok conference.

The session, called "Pledging Action," was facilitated by the United Nations Educational, Scientific and Cultural Organization (UNESCO) and interfaith organizations. The interfaith movement is a new breed of organizations working to bring different religions closer together. Among the roughly 200 workshop participants, there were many priests, nuns, and monks dressed in traditional garb. Delegates were hoping to see some influential religious leaders who have the power to change things; however, none attended this session.

Seeing religions as an underutilized asset

The speakers at the Pledging Action session were wrestling with the dire warnings of epidemiologists: efforts to halt the AIDS epidemic are not meeting targets. Asia, with its huge population, is seen as the tipping point for the epidemic; if the virus cannot be contained there, the epidemic could spiral out of control. According to epidemiologists, the emerging Asian face of AIDS is of a young woman living in a monogamous mar-

riage, with only one sexual partner: her husband.

Many believe religion is an underutilized asset that is well suited to help with AIDS prevention and to address the social factors of HIV/AIDS. In Southeast Asia, hundreds of millions of people depend on Hindu, Islamic, Buddhist, Christian, and other religious leaders in their communities for health and moral advice. This dependence is especially true in rural areas, where medical facilities are lacking.

Many of the clergy who attended the Bangkok conference expressed concern that current traditional religious practices—unequal status of women, the moral association of sex with sin, child marriages—are likely fuelling the epidemic rather than helping to contain it. They are calling for a more holistic approach to prevention.

Religions as protectors of public health

The Pledging Action session was a fresh approach to the old stalemate between religion and AIDS activism. Delegates argued that religious organizations need to be reminded about their traditional responsibility as protectors of public health.

Many religious rituals are based on the ancient wisdom of disease prevention. For example, the Islamic practice of male circumcision is praised as an infection prevention measure; clinical studies have verified this fact. Perhaps new rituals can

be developed—or rediscovered—to make HIV/AIDS prevention more comprehensive.

Speaking at the interfaith session in Bangkok, Dr. Peter Piot, the executive director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), offered an inspiring vision of the expanded role of faith-based groups in HIV prevention and care: “We hope for a day when every church engages in an open dialogue on issues of sexuality and gender difference,” he said. “Every synagogue mobilizes as advocates for a global response to fight HIV; every parish fully welcomes people who are HIV-positive, every ashram understands and undertakes study and reflection on HIV. Every pagoda is the place where young people can learn the facts of HIV/AIDS. And every mosque is a safe place for seeking honest information on AIDS and referral to services.”

This is a vision worth embracing. It could be the missing piece in the fight against AIDS—barring the discovery of a vaccine and cure.

Training religious leaders

To help propel this vision of the involvement of religious groups, the United Nations Children’s Fund (UNICEF) developed a training tool kit designed to help clergy understand and discuss AIDS prevention within their congregations. The kit is tailored to the specific doctrines, values, and beliefs of each religion, using appropriate religious language and quotations from holy books. Much of the content focuses on transcending the stigma of judgment, shame, and fear so often associated with HIV/AIDS. It highlights the particular vulnerability of women and girls to HIV infection.

Asia has already reported some success with this training. The major obstacle is a lack of acceptance at the higher levels of the religious hierarchies. As a result, much of the information is not reaching the church level, where it is needed.

Major religions still regard the condom as the Trojan horse of promiscuity and Western immorality. For Muslims, the condom is not even an issue. Sex is not talked about—period. Faced with this dilemma, imams (Islamic religious leaders) are often compelled to state the “Islamic position” before acting with compassion and discussing condoms. The official Christian position continues to be that “condoms kill.”

Nevertheless, there are encouraging signs of change. Some Catholic cardinals are recognizing that prevention of a life-threatening disease such as HIV/AIDS is not on the same moral level as the use of birth control. At least one Catholic organization, Christian Aid, has already concluded a study that proves the “condoms kill” theory to be untrue. Desmond Tutu has become one of the most vocal and influential critics of the ban on condoms.

In the Bangkok convention centre, several priests, monks, and nuns were patiently handing out pamphlets about their work in AIDS hospices and orphanages. The Christian pamphlets offered only lip service to prevention strategies. The Buddhist brochure advised people to “be faithful to your part-

ner and avoid intoxicants.” This kind of advice is a far cry from the grand vision of the Pledging Action project.

Moving forward

Some might argue that any dialogue with religious groups is futile. Yet, something new seems to be emerging. Reframing AIDS prevention from a moral private/public issue to a religious organization responsibility is a stroke of brilliance. Given the right exposure, this new emphasis on public health responsibility could be a real attention-getter for both the public and for religious groups. Despite the current resurgence of fundamentalism, religions are struggling with many internal and external pressures. They might be receptive to new approaches.

Many believe religion is an underutilized asset that is well suited to help with AIDS prevention and to address the social factors of HIV/AIDS.

We need to keep in mind that the religions, despite their conservative ways, are influential forces that can literally change history. A positive example of the transformative power is South Africa’s reconciliation movement. Another one is the role the Pope played in the downfall of the Communist regime in Poland.

Interfaith organizations understand different religions—their beliefs and their lingo. It’s a progressive and growing movement that is our natural ally. The organizers of the XVI International AIDS Conference in Toronto in 2006 need to nurture, promote, and greatly expand the participation of the interfaith movement. Here are some thoughts on how to proceed for the 2006 AIDS Conference:

- ▼ Involve the interfaith organizers in the early planning and have them to develop a wish list for the 2006 Conference.
- ▼ Promote AIDS activist involvement in the interfaith movement.
- ▼ Incorporate the spirit in the overall theme and logo branding of the 2006 Conference.
- ▼ Invite all the major religious leaders to participate, and plan appropriate collaborative events.
- ▼ Encourage the participation of progressive, spiritually inclined entertainment, sport, and science megastars to attract the interest of the media.

Such a plan probably has a better chance of succeeding than the current angry religion bashing by AIDS activists. ⊕



Jari Dvorak is an AIDS activist, spiritual seeker, and a passionate promoter of meditation. He lives happily in Toronto with his schnauzer, Dasa.

When 90 percent means failure

Maintain high levels of adherence or risk developing drug resistance

by Michael Connidis

It's been nine years since I was rescued from what felt like a slow drowning. When protease inhibitors (PIs) arrived and a lifeline of new medications was thrown to me, I wasn't about to let go. The doctors told me that I had to take the pills as prescribed every day; no one knew then how important my adherence to this life-altering daily regimen would be in my battle to survive with HIV. I have taken my pills faithfully each day, rarely missing a dose. But, all the while, I have had nagging thoughts: will the pills continue to help me more than harm me? How much time will pass before my personal colony of wild-type HIV manages to mutate so that the drugs are no longer effective? Has HIV really become a manageable chronic disease?

Over the past few years, there have been several reports from the BC Centre for Excellence in HIV/AIDS (BCCfE) on drug resistance and adherence—meaning, taking your pills when you are supposed to take them, and in the manner that they are prescribed (for example, with or without food). One study showed that 56 percent of a group enrolled in the BCCfE Drug Treatment Program, who died of non-accidental causes and who had intermittently used or prematurely discontinued antiretroviral (ARV) therapy, had no major resistance mutations.

Other international studies have indicated that high levels of adherence did not prevent HIV drug resistance. While the development of drug resistance due to HIV mutation had been considered a

significant cause of treatment failure, the relationship between adherence and drug resistance remained unclear.

Maintaining the amount of drugs in your blood

How does the level of adherence relate to the development of drug resistance? Mutations, changes in the nucleic acid sequence of the HIV genes, occur frequently when HIV reproduces because it does a sloppy job of copying its genetic code. Taking your medications as prescribed maintains the blood levels of the ARVs that keep the virus under control and undetectable. Maintaining appropriate blood levels of medications greatly reduces the chances

People taking ARV therapy must maintain a high level of adherence to suppress the virus.

that a mutated strain of the virus will emerge. The blood levels of ARVs drop over time, some faster than others, as the body metabolizes and removes them.

There must be a certain amount of the ARV drugs in your blood at all times to keep the virus in check. When you miss a dose of your medications, or take them much later than you should, the level of drugs in your blood gets too low and you give the virus a chance to repro-

duce and mutate. There is always the chance that a mutation will result in a change in the virus, enabling it to reproduce in spite of the presence of drugs in your blood. When you take your next dosage, the mutated form of the virus is no longer held in check and it will continue to reproduce. Your colony of HIV becomes drug resistant.

In January 2005, Dr. Richard Harrigan of the BCCfE reported the most recent findings regarding adherence and resistance. The study appeared in the February 1, 2005 issue of *The Journal of Infectious Diseases*. Researchers assessed individual adherence to ARV regimens by tracking the number of filled prescriptions. This information was cross-referenced with lab results from blood samples. The investigators followed over 1,000 individuals during a 30-month period between 1996 and 1999. The people in the study were treatment naive and they were starting on a wide variety of triple ARV drug regimens. This was the first study of its kind; previous studies were based on short-term clinical trials that included treatment-experienced patients.

At the end of the study, 30 percent of the cohort had developed drug resistance at the eight-month mark. Two groups within the cohort were considered and proved to be most likely to develop resistant strains of HIV: people with viral loads greater than 100,000 copies/ml when they began treatment, and people who were consistently taking most, but not all, of their ARV medication.



Taking your medication 95 to 100 percent of the time is good; taking them 80 to 90 percent of the time is a disaster in the making, and is clearly linked to developing drug resistant HIV. If you regularly miss more than two days worth of medications in a month, that could spell trouble. If you miss six days worth of drugs in a month on a regular basis, you run the highest risk of nurturing a drug-resistant strain of HIV. While study participants who adhered to their drug regimen less than 20 percent of the time did not develop drug resistance, previous studies have shown that they greatly increased their risk of dying from HIV-related causes.

Tailoring drug regimens to individual needs

Clearly, caution is in order when starting on treatment; it is also important to consider treatment before viral loads rise too high. Equally important is the need to find ways to improve adherence during treatment. If HIV/AIDS has indeed become a manageable chronic disease, maintaining a high level of adherence to treatment will be a life-long challenge.

If you regularly miss more than two days worth of medications in a month, that could spell trouble.

With an increasing number of drugs to choose from and better formulations, it is possible to tailor ARV regimens to meet individual needs. There is a better understanding of the different medications, the best combinations for each of them, and the most effective way to take them. Therapeutic drug

monitoring can be used to assess how well the medications are actually absorbed in the body. Dosages can be adjusted and medication regimens can be altered to attain optimal blood levels of the drugs. Still, the bottom line is that people taking ARV therapy must maintain a high level of adherence to suppress the virus and reduce the chance of viral mutations that may lead to drug resistance.

Keeping track of your medications and when you take them can be a huge challenge. I have a weekly ritual of counting out my pills, a task which has become easier with new drugs and new formulations. I pop the various pills into their respective compartments in 14 separate pill containers.

Each morning, I get out of bed not necessarily because I feel like it, but because it's pill time. I retrieve two containers, one for breakfast and one for dinner. Pill time means eating enough healthy calories so that my digestive system will absorb the maximum amount of the medications I am taking. Dinner is scheduled for 12 hours after breakfast and breakfast is 12 hours after dinner. When I am dining out, the pills come with me and I take them with the main course. Taking my medications has been the most dedicated and best-maintained routine I have ever managed in my life—and it's keeping me alive.

I'm one of the lucky ones. I've lived with HIV for 20 years now. My lifeline is holding and has pulled me back closer to the shore. My viral load has remained undetectable, with the occasional blip, while my CD4s have continued a gradual climb to a healthy, steady state. My physician told me my adherence is a key factor in my successful ongoing battle with HIV. Now I have a renewed hope that taking my medications will also keep my personal colony of wild-type HIV free of drug-resistant mutations. ⊕

Michael Connidis is a member of the BCPWA Society and a member of the Living + editorial board.

ZING it with ZINC

by Treena Hanson

Zinc is an essential trace mineral. It is the second most abundant trace mineral in our body. Found mainly in our muscles and bones, zinc is important for persons living with HIV/AIDS, particularly those who experience muscle wasting, because they will have lower reserves of this mineral.

Zinc plays an important role in the body's immune response, growth and development, neurological function, and reproduction. Over 100 enzymes in the body rely on zinc for vital chemical reactions. Zinc deficiencies can impair wound healing, cause chronic and severe diarrhea, decrease appetite, and reduce taste sensation. Symptoms of zinc deficiency include decreased sense of taste, dulled sense of smell, white spots on fingernails, fatigue, impotence, inability to concentrate, and hair loss.

Recent studies have shown that zinc supplementation stabilizes body weight, raises T4 cell counts, and reduces the frequency of opportunistic infections. Importantly, HIV also requires zinc to replicate, which means that excessive amounts of zinc could stimulate the progression of HIV disease.

The 1992 International AIDS Conference in Amsterdam established a recommendation of 75mg of zinc supplementation per day. Subsequent research revealed that an excess of 60mg of zinc daily (50mg from a supplement and 10mg of dietary zinc) could cause a copper deficiency. An extra 1-3mg of copper twice a week helps to balance zinc and will prevent copper deficiency. Zinc and copper should be taken at different times of the day, since each mineral interferes with the other's absorption. Ask

your doctor to regularly monitor your zinc and copper levels.

In general, recommended levels of zinc supplementation range from 40-75mg/day. Zinc citrate or zinc picolinate tend to absorb in the body most effectively. To avoid nausea and vomiting, always take zinc supplements with food.

Studies show that zinc supplementation stabilizes body weight, raises T4 cell counts, and reduces the frequency of opportunistic infections.

In terms of dietary sources, zinc is better absorbed from some foods than from others. Protein foods contain high amounts of zinc. The best sources are beef, pork, chicken, and shellfish. The dark meat of chicken contains more zinc than the light meat. Other good sources of zinc from plants include barley, legumes, and nuts. See Table 1 for plant and animal sources.

It's always best to try to get all your nutrients from food. If you require a supplement, discuss it with your doctor or dietitian. Zinc supplementation requires close monitoring since it can interfere with some medications. ⊕

Treena Hanson is a registered dietitian at St. Paul's Hospital and a member of the Vancouver Dietitians in AIDS Care.



Table 1. Food sources of zinc

PLANT SOURCES	mg	ANIMAL SOURCES	mg
Pearled barley, uncooked 1/2 cup	2.1	Oysters, 6 broiled	27
Baked beans, canned with pork	1.8	Beef shank, lean only, cooked 3oz	8.9
Cashews, 1oz	1.6	Beef chuck, arm pot roast, lean only, cooked, 3oz	7.4
Pumpkin seeds, 20g or 2/3oz	1.3	Beef cooked, 3oz	5.8
Chickpeas, cooked, 1/2 cup	1.3	Dungeness crab, cooked 3oz	4.7
Cheddar cheese, 30g or 1oz	1.2	Turkey, roasted skinless, white meat, 3oz	3.8
Tahini paste, 20g or 2/3 oz	1.1	Chicken, dark meat, 3oz	2.4
Almonds, 1oz	1.0	Yogourt, fruit	1.8

Ask the dietitian

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.

Sickly sweet

by Ágnes P. Kalmár

Question:

I've heard there is a connection between sugar and HIV. How does sugar interface with the HIV virus? For those of us with addiction issues, what role does sugar play in drug addiction, and why do so many of my friends with drug addictions eat so much sugar?

Answer:

Sugar abuse and drug addiction seem to go hand in hand, and this co-addiction is very prevalent. There is a physiological reason why this occurs. When a person uses drugs, the drugs create a sense of well being—a high. This sensation is caused by a release of certain “feel-good” neurotransmitters. Neurotransmitters are chemicals that act as messengers in the brain. Among many hundreds of neurotransmitters, the ones that cause us to feel good are serotonin and dopamine. Certain drugs that have addictive qualities cause the brain to release a large quantity of serotonin and dopamine at once, making the person feel very good. But, when the effect wears off, there is a sense of loss and depression.

After long-term drug abuse, the brain's normal function changes and the production of serotonin and dopamine decreases substantially. The body is no longer able to make itself feel good naturally. Food, sugar, chocolate, caffeine, nicotine, and aerobic exercise can also trigger the production of these feel-good neurotransmitters. For this reason, many addicts binge on sweets: it produces a chemical reaction that feels similar to the high experienced on drugs of abuse. Thus, even if you are able to quit using heavy drugs, binging on sweet foods and coffee can give you highs, which can make you vulnerable to a drug relapse.

When you eat excessive amounts of processed sugar, you consume lots of calories but not much nutrition. In order for your body to function normally, you need food that contains protein, minerals, and vitamins. These nutrients come from whole foods,

such as whole wheat breads and cereals, lean meats and fish, fresh fruits and vegetables, as well as milk and dairy foods.

If you are HIV-positive and recovering from addiction, your body needs even more vitamins and minerals in order to heal itself and have the capability to fight HIV. Yet, many HIV-positive addicts in recovery eat very poorly, consuming excessive amounts of foods containing processed sugar, which further disables the body's ability to heal itself. Although there is not a lot of information on how sugar directly affects HIV, we do know that a strong immune system requires proper nutrition.

When you are ready reduce to your sugar intake, aim for a diet of three meals and three snacks a day. Skip the white bread and go for whole wheat and brown bread. Make sure all your meals include some grains and some form of protein, such as lean meats, fish, cheese, and beans. Add a glass of milk or soy milk, as well as fresh fruits and vegetables.

Your snacks should also be balanced and devoid of processed sugar. A good snack can be fruit and cheese, crackers and cheese, peanut butter and bread, cereal and milk, or half a sandwich. Skip the donuts, cookies, and danishes. If you must have some sweets, have a small amount right after your meal so that only a small blood sugar imbalance will occur.

Cut your coffee consumption to less than two cups per day. Try to use a minimal amount of sugar, or use a sugar-free sweetener. If you drink a lot of coffee, reduce your intake slowly in order to prevent headaches from caffeine withdrawal.

It's not easy to wean yourself off processed sugars. You may benefit from one-on-one counselling with a dietitian. If you don't have access to a dietitian, try teaming up with your buddies to follow a healthy diet together. ⊕



Ágnes P. Kalmár is a registered dietitian at the BC Children's and Women's Health Centre in Vancouver.



Tropical fare

An HIV nutrition manual project in the Caribbean

by Diana Johansen

For the past two years, I have worked with the Caribbean Food and Nutrition Institute (CFNI) to develop a manual on HIV nutrition for health care workers in the Caribbean. The manual is a project of the Pan American Health Organization (PAHO), the World Health Organization (WHO) regional office for the Americas. Recently, I conducted a series of workshops in various Caribbean countries to teach HIV nutrition and disseminate the manual.

The Caribbean is famous for tropical beaches, all-inclusive resorts, pirates, Jimmy Buffett, and ganja (marijuana). However, it also has the second highest seroprevalence rate of HIV in the world, second only to Sub-Saharan Africa. As in Africa, AIDS is the leading cause of death among Caribbean adults between 15 and 44 years old.

According to the latest statistics, an estimated 440,000 adults and children are living with HIV in the Caribbean; the actual number could be as high at 780,000. The average population rate of infection in the region is 2.3 percent, but the rate varies between countries, from as low as 1 percent in Cuba to as high as 7 percent in some parts of Haiti. It is difficult to confirm numbers with any degree of accuracy, because these countries do not have reliable systems to track the epidemic,

and because many of those living with HIV have not been tested or identified.

Free access to ART

In the Caribbean, HIV transmission occurs mainly through heterosexual contact, although in some regions men who have sex with men make up a significant proportion of people living with HIV. Sex between men is heavily stigmatized and is still illegal in some countries, which remains a huge barrier to testing and treatment. Injection drug use is not a major contributor to the epidemic in the Caribbean, except in Bermuda and Puerto Rico where it accounts for almost half of the cases of infection. As with many populations around the world, female youth are especially vulnerable and make up a disproportionately high percentage of new infections.

The response to HIV/AIDS in the Caribbean has been variable. The region comprises a large number of islands, and each one is a separate country with its own government, policies, and HIV prevention and care strategies. People living with HIV/AIDS in all of the countries have free access to antiretrovirals (ART), and efforts are underway to treat as many people as possible. Funding is largely provided by The Global Fund.

According to PAHO, Latin America and the Caribbean are leading the developing world in the provision of HIV/ART treatment. The most common regimen is combivir/nevirapine, but some countries are also getting other nucleosides and even some protease inhibitors. Both people living with HIV and healthcare workers are thrilled with the response to ART and with the hope it brings. It is expected that treatment will have the effect of encouraging testing; and, through testing and early diagnosis, prevention strategies related to mother-to-child transmission (PMTCT) can be implemented.

Food security is a very real problem for HIV-positive Caribbeans because there are very limited welfare systems in place.

The general nutritional picture

HIV nutrition must be assessed in the context of overall nutrition in the region, where many people in the general population are overweight. Obesity-related diseases, especially diabetes, are prevalent. The diet consists mainly of starchy root vegetables known as ground provisions—including taro, breadfruit, plantain, and sweet potato—as well as legumes and small amounts of animal products.

People eat a considerable amount of fruit and drink fruit juices, but consume comparatively few vegetables. Most people buy their produce from local markets or trade with their neighbours, so the supermarkets have very little in the way of fresh produce, and very little of anything, for that matter. Whereas North American supermarkets are overloaded with a huge assortment of products, Caribbean only carry a small supply of each product. Specialty items are expensive.

Food security is a very real problem for HIV-positive Caribbeans because there are very limited welfare systems in place. Money spent on medicine leaves little for food and living expenses. People who cannot work must rely on their families and communities. A number of churches have food programs, but few governments run programs.

The nutrition manual project

In 2001, the CFNI realized that nutrition would be a key strategy in the treatment of people living with HIV/AIDS. At that time, ART was not widely available and people were suffering from many conditions that could be improved with nutrition therapy. The Canadian International Development Agency (CIDA) agreed to fund a project to develop two manuals. *Healthy Eating for Better Living* was designed for people with HIV and lay caregivers. *A Manual on Nutrition and HIV/AIDS for Health Care Workers in the Caribbean* contains more technical information for healthcare professionals; released last October, it is distributed in different countries at workshops for healthcare workers.

The HIV nutrition workshops take place over five days and provide a very intensive and thorough overview of the issues. Topics include the basics of HIV nutrition, social determinants of health,

nutrition assessment, body measurements and bioelectrical impedance analysis (BIA), complications and side effects of ART, HIV-infected infants and children, and PMTCT. Participants work on case studies and various interactive activities. The participants come from all healthcare disciplines, though most are nurses.

What is apparent from this region is that “resource poor” also translates into a lack of specialized healthcare professionals. Some countries do not have a dietitian at all; instead, nurses, with a range of qualifications, provide most of the nutrition counselling. The counsellors who provide care can be a nurse or a layperson with minimal training. Conducting a workshop to meet the needs of participants with such diverse backgrounds is extremely challenging. Nevertheless, the participants are all hungry for knowledge and they really engage in the process, even if the material is not relevant to their particular work.

Assessing stigmatization

Before and after the workshops, we also distribute questionnaires to the healthcare workers to evaluate their knowledge and attitudes regarding HIV/AIDS. When the attitudinal questions pertain to their work environment, participants show little evidence of stigmatization and discrimination; however, when the questions pertain to their personal life, they are more likely to answer, “I don’t know” or give a response that indicates some feelings of stigma. While this preliminary data is only from two countries, it does suggest that healthcare workers are aware of discriminatory attitudes and practices.

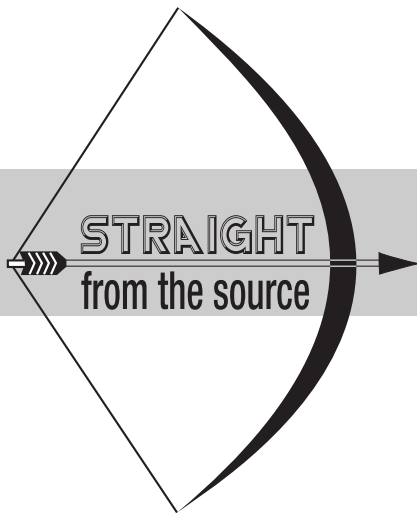
The survey does not look at discrimination against behaviours that might make people more vulnerable to HIV infection. For example, there is a strong anti-gay sentiment in many of the regions, so discrimination may occur against men who have sex with men but not necessarily against people with HIV. The majority feels that abstinence should be the main prevention message; many participants were reluctant to endorse widespread free access to condoms.

Discussions on PMPTC elicit heated discussions on the merits of breastfeeding versus replacements (formula), as the Caribbean has followed the WHO mandate to heavily promote breastfeeding. Some participants are lactation consultants who have devoted their careers to increasing breastfeeding practices and are now adjusting to the recent WHO recommendations based on informed choice, affordability, and sustainability. Countries with PMTCT programs generally provide free infant formula to women.

Spending time in developing countries is an amazing experience. The contrast between the “have” and “have not” nations is dramatic. Considering they are such resource-poor nations, countries in the Caribbean have made great strides in HIV prevention and treatment strategies. Unfortunately, stigma and discrimination are rampant, which hampers efforts to test and treat people. The education process is slow, but fortunately there appears to be commitment on the part of government and health organizations to deal with the HIV/AIDS epidemic. ⊕

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





Dealing with depression

by Anne Drummond

It is no surprise to find a high prevalence of depression among HIV-positive people. Isolation, social stigma, changes to body image, reduced ability to work, drug side effects, and chronic illness—all of these factors contribute to depression being the most common psychiatric illness observed within HIV-positive populations. Depression is a problem cited among 10 – 50 percent of PWAs, depending on the definition of depression and the particular HIV-positive population studied, compared to a range of 8 – 15 percent among the general population.

Depression has a negative effect on quality of life and contributes to the progression of disability; among PWAs, it may also compromise adherence to highly active antiretroviral therapy (HAART), which in turn leads to treatment failure and the development of viral resistance.

In an innovative research project conducted in 1999, Dr. Victoria Alfonso of the Canadian HIV Trials Network in Vancouver explored various strategies employed by HIV-positive men to deal with depression. Using an investigative approach known as the Critical Incident Technique, Dr. Alfonso asked participants simple yet probing questions about their behaviour and coping strategies since their diagnosis.

The interviews provided rich insights. The men in the study identified a variety of methods that helped them deal with depression, including: keeping busy, being physically active, learning from role models, sharing news of their diagnosis with people they trust, actively seeking meaning in their lives, learning more about HIV/AIDS, establishing and maintaining social connections, and living in a more spiritual and reflective manner.

Three distinct themes emerged from the strategies identified by research participants: proactivity, meaning, and perceived control.

Proactivity took the form of intentionally seeking ways to overcome depressed feelings. Most of the men reported becoming more attentive to the world around them and to their own

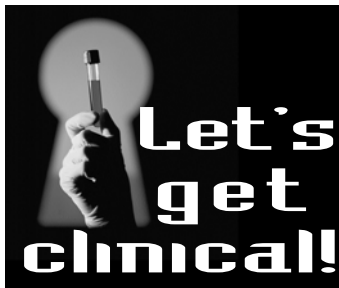
needs and wants. As a result, they reorganized their lives to give priority to those aspects of greatest importance, such as cultivating relationships, exploring self-discovery, contributing to the lives of others, and maintaining a positive attitude.

Finding meaning in their lives after their HIV-positive diagnosis was identified as an ongoing challenge for all participants. They attempted to accept their status as a part of their lives, and focused their mental and physical energy on activities that gave them a sense of purpose and meaning in each day. In general, they all regarded life as a gift, and attempted to protect themselves from actions or circumstances that threatened their emotional balance and search for meaning.

The need to feel and be in control of their lives was a common thread among all the participants. When they used inner resources—self-efficacy, organization, humour, and positive attitude—to overcome a depressed mood, they gained a sense of control, which effectively increased their feelings of resilience and confidence in their abilities to cope. Acquiring knowledge and information about their health, being present and active in their lives and relationships, and maintaining a positive attitude, all contributed to a sense of control.

Dr. Alfonso's research is valuable because it fills a gap in the HIV field by providing qualitative information on the lives, thoughts, and feelings of individuals living with HIV and related depression. The results of this study emphasize the need to enhance self-awareness in individuals living with HIV. This therapeutic approach will facilitate the conscious and unconscious cultivation of inner resources to help PWAs manage or overcome their depressed moods. ⊕

Anne Drummond is a medical writer with the BC Centre for Excellence in HIV/AIDS at St Paul's Hospital in Vancouver.



Psychologists test methods of boosting adherence

by Jim Boothroyd

Anti-HIV drugs are strong and effective, but as we all know, if you don't take your medication when and how it needs to be taken, it can lose its ability to fight off the HIV virus.

It's no wonder, then, that clinical researchers are exploring novel ways to help people feel more prepared to start and adhere to HIV medications.

Take, for example, a study that was recently approved by the Canadian Institutes of Health Research (CIHR) and the Canadian HIV Trials Network (CTN) called "Supportive Therapy for Adherence with Antiretroviral Treatments." Known as STAART (or CTN 198), it is now enrolling at The Ottawa Hospital with a target of 112 participants and aims to enroll at other sites in the upcoming months.

Funded by the CIHR, STAART is a collaboration between principal investigator Dr. Louise Balfour, a clinical research psychologist at The Ottawa Hospital, and Dr. Bill Cameron, the CTN's Ontario regional director.

STAART is the first study involving a standardized psychological intervention to be approved by the CTN. Unlike other studies, it aims to provide participants with valuable psychological readiness tools *before* they face the challenge of adhering to complicated regimens of antiretrovirals.

Study, participants must have an HIV viral load greater than 500 copies/mL, and either be starting antiretroviral therapy or be changing to a new antiretroviral regimen. Parti-

cipants will be allocated randomly to one of two groups: the first group will have four psycho-educational sessions with an HIV therapist before starting their regimens; the second (control) group will simply receive their regular regimens.

All participants will fill out psychological questionnaires monitoring mood, health beliefs, stress levels, readiness for starting HIV medications, and adherence to treatments. They will also be stratified according to their depressive symptoms upon entering the study. Outcomes will be assessed at one, six, and 12 months after starting antiretrovirals.

Another part of the study will examine methods of boosting adherence among HIV and hepatitis C co-infected patients.

STAART is one of several Canadian studies examining how psychological interventions can help in HIV treatment. Researchers at the BC Centre for Excellence in HIV/AIDS, for example, have secured funding from CIHR and other sources to launch a battery of new studies in this area. These include a trial led by clinical psychologist Dr. Josie Geller that aims to develop an empirically sound measure of readiness for highly active antiretroviral therapy, "The Antiretroviral Readiness and Motivation Scale (ARMS)." ⊕



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

Trials enrolling in BC

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

CTN 167 — OPTIMA: Options with Antiretrovirals
BC sites: Viron Health, 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 178 — Rosiglitazone maleate (Avandia)
BC site: St. Paul's Hospital, Vancouver

CTN 189 — 3TC or No 3TC for HIV with 3TC Resistance
BC sites: St. Paul's Hospital, Vancouver, and Cool Aid Community Health Centre, Victoria

CTN 190 — SMART: Strategies for Management of Antiretroviral Therapy
BC site: Downtown IDC, Vancouver

CTN P 201 — Interactions between TMC-125 and Lopinavir/Ritonavir and Saquinavir
BC site: St. Paul's Hospital.

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



La adherencia en tratamientos anti-VIH

por José Gutiérrez

La adherencia es un factor muy importante para lograr un funcionamiento eficiente en tratamientos anti-VIH. La adherencia es la forma de mantenerse al día con los medicamentos siguiendo todas las indicaciones médicas tales como número de pastillas a tomar, horarios para tomarlas y ciertas restricciones en los alimentos.

Las estrategias para la adherencia pueden variar en cada persona. Debido a las diferencias culturales, socio-económicas, de sexo, hábitos y necesidades, los tratamientos resultan ser más apropiados para algunas personas que para otras. Sin embargo, aún en las situaciones más complicadas, las personas tienen rutinas diarias que pueden usarse como recordatorios para tomar las medicinas.

La mejor manera de asegurar el éxito es su motivación y compromiso hacia el tratamiento. Muchas personas han adaptado los tratamientos a largo plazo a sus vidas normales, demostrado que sí es posible adherirse a un tratamiento. Las siguientes estrategias son herramientas útiles que han funcionado para muchas personas que utilizan terapias anti-VIH:

Integrar su régimen a la rutina diaria. Para la mayoría de las personas es más fácil acomodar los medicamentos a sus vidas cotidianas que tener que reprogramar sus horarios de acuerdo a cuándo deban tomar las medicinas. Se recomienda usar una actividad diaria como recordatorio para tomar sus medicinas.

Agrupar sus medicinas en dosis diarias, una semana a la vez, utilizando un pastillero para almacenar dichas dosis. Los medicamentos también pueden agruparse en dosis diarias y ponerse en botes separados marcados con la hora a la que se debe tomar la dosis.

Usar un pastillero electrónico o una alarma que le avise cuándo tomar los medicamentos. Lo malo es que algunos pastilleros electrónicos son demasiado pequeños y las alarmas demasiado obvias.

Usar una agenda o libreta, especialmente al comienzo de un nuevo régimen. Anotar los requisitos de los medicamentos en una agenda como si fueran citas a cumplir. Otras personas utilizan computadoras de mano o agendas electrónicas para recordar cuándo deben tomar sus dosis diarias.

Evaluar su régimen aproximadamente dos semanas después

de haberlo iniciado. Puede llevar algunas semanas de experimentación decidir cómo programar sus medicamentos de acuerdo al curso normal de su vida. A veces es conveniente hacer un ensayo “en seco” dejando tiempo para ajustar sus rutinas antes de iniciar la terapia.

Planificar con anticipación los fines de semana y las vacaciones. La gente suele omitir dosis cuando se encuentra fuera de casa. Para la mayoría, las rutinas de los fines de semana son diferentes a las rutinas de los días entre semana, por eso es importante planificar por adelantado.

Cuando viaje, se recomienda llevar todos sus medicamentos consigo, ya que el equipaje puede perderse o demorarse.

Llevar un diario. Incluya en él todo lo que sea importante para usted como cuándo tomó la última dosis, razones para haber omitido una dosis, cómo se está sintiendo, etc. Llevar un registro así le permitirá evaluar qué tan bien o mal se está adheriendo a su tratamiento.

Algunas personas tienen un *compañero de tratamiento*, quien puede hacerle recordatorios telefónicos todos los días.

Establecer un grupo de apoyo para sus necesidades emocionales. Este tipo de apoyo puede resultar de gran ayuda, ya que es difícil seguir el tratamiento y además lidiar con el estrés diario de trabajar o de enfrentar la enfermedad.

Es importante tener una buena disposición y capacidad para comprometerse con las exigencias del tratamiento. Es necesario un 95 % de adherencia para controlar totalmente la reproducción del virus del VIH y obtener todos los beneficios del tratamiento. ⊕

BCPWA Treatment Information Program (TIP)

Ofrece información sobre tratamientos del VIH/SIDA.

Todos los miércoles 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

To our Volunteers: Undisputed Champions of BCPWA This is your 2005 Recognition Dinner!

Join us for a Cabaret evening with
David Jones - Emcee Extraordinaire -
and his cast of stars

Where:
Chateau Granville Hotel, 1100 Granville St. @ Helmcken

When:
Wednesday, May 4, 2005 from 5:30PM - 9:00PM

Volunteers:
Get your tickets from your department head

Friends of Volunteers:
Tickets 25\$ — Call 604.646.5377 or
ask for Teresa at the front desk

RSVP:
Please return the RSVP form
(included with your ticket)
by Thursday April 21, 2005 to:
BCPWA info desk

*cash bar



CABARET

Upcoming BCPWA Society Board Meetings:

Date	Time	Location	Reports to be presented
April 13, 2005	1:00PM	Board Room	Written Executive Director Report — Standing Committees Director of Communications & Education
April 27, 2005	1:00PM	Board Room	Quarterly Department Reports — Financial Statements / March
May 11, 2005	1:00PM	Board Room	Written Executive Director Report — Executive Committee Director of Treatment, Information & Advocacy
May 25, 2005	1:00PM	Board Room	Standing Committees — Financial Statements / April
June 8, 2005	1:00PM	Board Room	Written Executive Director Report — Director of Prevention

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: Teresa Stancioff
t 604.646.5377 **e** teresas@bcpwa.org

Community Representation & Engagement

Contact: Adriaan de Vries
t 604.893.2298 **e** adriaand@bcpwa.org

Education & Communications

Contact: Lisa Gallo
t 604.893.2209 **e** lisag@bcpwa.org

Positive Gathering

Contact: Stephen Macdonald
t 604.893.2290 **e** stephenm@bcpwa.org

IT Committee

Contact: Ruth Marzetti
t 604.646.5328 **e** ruthm@bcpwa.org

Living ⊕ Magazine Subcommittee

Contact: Jeff Rotin
t 604.893.2206 **e** jeffr@bcpwa.org

Prevention

Contact: Paul Adomako
t 604.893.2225 **e** paula@bcpwa.org

Support Services

Contact: Jackie Haywood
t 604.893.2259 **e** jackieh@bcpwa.org

Treatment Information & Advocacy

Contact: Tarel Quandt
t 604.893.2284 **e** tarelq@bcpwa.org

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For more information visit

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email to living@bcpwa.org

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Volunteering at BCPWA

The stigma of volunteering

by Rob Gair

Volunteers are indispensable, and most organizations that rely on them like to publicly acknowledge their contributions. But how does publishing volunteer profiles in each issue of *Living +* magazine impact the people who volunteer with the BCPWA Society? Are we as volunteers reluctant to be recognized for fear of being labeled HIV-positive?

HIV has been with us for the better part of 25 years, yet the stigma remains strong. When I first learned about my own HIV-positive status, I was terrified that the wrong people would discover my secret. Now that I've had a few years to get used to the idea, I still struggle with disclosure, but I'm less worried about who knows and who doesn't. It's been a gradual process.

Are we as volunteers reluctant to be recognized for fear of being labeled HIV-positive?

When you're HIV-positive, the decision to disclose your status can be frightening. The benefits of staying silent are usually self-evident, but what about the cost? How much of our-

selves are we rejecting when we're afraid to say who we really are? And how does our silence contribute to society's denial about the seriousness of this epidemic?

To suggest that disclosure is easy, or that it is always a positive experience, would be insolent. The need for privacy is important, especially for people who are newly diagnosed. But with time, as we begin to accept what has happened to us, I think our lives are enriched when we share our experience—whether the effect is good or bad.

I sometimes wonder about all the infections that could be prevented if people were able to talk openly about HIV. But mostly I imagine a world where no one is ashamed of being HIV-positive. Finding our own personal way to confront HIV stigma will make that world a friendlier place, and it'll take us a long way toward ending the shared human crisis we call AIDS.

Dedicated to all BCPWA Society volunteers. ⊕

Rob Gair is a volunteer writer for Living+ magazine. He also volunteers in the BCPWA Prevention Department and he's a BCPWA representative on the Advisory Committee on Drug Evaluation and Therapy at the BC Centre for Excellence in HIV/AIDS.



Another volunteer speaks...

Living + magazine includes a page in each issue dedicated to a different volunteer at BCPWA. Appearing on this page does not mean that the person is HIV-positive. It means that the person is one of the special people helping the HIV/AIDS cause. But what if you were HIV-positive and your picture appeared? Do we have to hide the fact that we are positive? There are people living with cancer and other illness that

do not wish to hide their illness. Yes, there are people who do not want others to be aware of their physical situation in any way, regardless of the illness. But is it not enough to live in fear of the effects of the disease? Should we also live in fear of people being aware of our status?

If people are reading *Living +*, they probably have some involvement in the AIDS movement or at least want to be kept informed. They are probably not

concerned at all about whether or not a picture of someone in the magazine means they are HIV-positive.

We need to stop the stigma that is attached to not only this page of the magazine, but to the magazine itself.

Ryan Kyle has been a BCPWA Society volunteer for eight years.



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

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.c www.livingpositive.ca

AIDS Society of Kamloops

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

AIDS Vancouver

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

AIDS Vancouver Island (Victoria)

1601 Blanshard St, Victoria, BC V8W 2J5
t 250.384.2366
e info@avi.org www.avi.org

AIDS Vancouver Island (Cowichan Valley)

t 250.701.3667

North Island AIDS (Campbell River) Society

t 250.830.0787

North Island AIDS (Port Hardy) Society

t 250.902.2238

AIDS Vancouver Island (Nanaimo)

t 250.753.2437

North Island AIDS (Courtenay) Society

t 250.338.7400 or 1.877.311.7400

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/

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 info@friendsforlife.ca www.friendsforlife.ca

Healing Our Spirit

3144 Dollarton Highway,
North Vancouver, BC V7H 1B3
t 604.879.8884 or 1.866.745.8884
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

Okanagan Aboriginal AIDS Society

101 – 266 Lawrence Ave.,
Kelowna, BC V1Y 6L3
t 250.862.2481 or 1.800.616.2437
e 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
e 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
e erikages@pan.ca www.pan.ca

Positive Living North West

Box 4368 Smithers, BC V0J 2N0
3862 F Broadway, Smithers BC
t 250.877.0042 or 1.886.877.0042
e plnw@bulkley.net

Positive Women's Network

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

Purpose Society HIV/AIDS program

40 Begbie Street
New Westminster, BC V3M 3L9
t 604.526.2522 f 604.526.6546

Red Road HIV/AIDS Network Society

804 – 100 Park Royal South,
W. Vancouver, BC V7T 1A2
t 604.913.3332 or 1.800.336.9726
e info@red-road.org www.red-road.org

Vancouver Native Health Society

441 East Hastings St, Vancouver, BC V6G 1B4
t 604.254.9949
e 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
e 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
e 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
e info@wingshousing.bc.ca
www.wingshousing.bc.ca

YouthCO AIDS Society

205 – 1104 Hornby St.,
Vancouver BC V6Z 1V8
t 604.688.1441 1.877.968.8426
e 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.



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Butt of the joke

Having the last laugh on April Fool's Day

by Denise Becker

I think when we are dealing with hard issues like HIV and its associated problems, we sometimes need a proverbial kick in the pants to get us to ease up and not take life so seriously. And, let's face it, what would a Last Blast column be without a tribute to the greatest last blast of all—our beloved April Fool's Day. This day truly tests our sense of humour through difficult circumstances.

How did this foolish day begin? Ancient cultures, such as the Romans and the Hindus, used to celebrate New Year's Day on April 1. However, in 1582, Pope Gregory ordered a new calendar, the Gregorian calendar, and New Year's Day became January 1. April 1 then became known as All Fool's Day.

I have to admit that I am one of the most gullible people when it comes to April Fool's pranks. It always astounds me that I can be duped so blatantly, even when I have mentally prepared myself for the day.

Once, I was watching TV when it was announced that NASA had invented a pill that would convert instantly into water when placed in a certain container. There was a demonstration in a glass flask. Hikers on long treks could also use the pill. I was amazed; I told all my friends, even cleverly suggesting that this might be the end to desert droughts. I was so embarrassed when I had everyone tune into the TV show the next day to learn more!

Then there was the time that a Vancouver radio station, Rock 101.1, announced that Howard Hughes' plane, the Spruce Goose, would be circling the city and landing on the water at English Bay. I drove to work that day searching the sky for the incoming plane.

You probably have your own favourites from the media. Mine is from



I have to admit that I am one of the most gullible people when it comes to April Fool's pranks.

1995. The *Irish Times* reported that the Disney Corporation was negotiating with the Russian government to purchase the embalmed body of communist leader Vladimir Ilyich Lenin. The body had been on display in Red Square since the leader's death in 1924. Disney proposed moving the body and the mausoleum to the new EuroDisney in Paris, where it would be given the "full Disney treatment"—including displaying the body "under stroboscopic lights which will tone up the pallid face, while excerpts from President Reagan's 'evil empire' speech [would be] played in quadrophonic sound." Pure genius.

Once, when I was 21, I decided that others had made a fool of me one too many times. I devilishly concocted my own revenge. At the time, I was working as a receptionist, a sweet innocent child whom people trusted. My eyes gleamed as each

of my bosses that day picked up their message slips, requesting them to "Call Mrs. Salmon at the following number...." I snickered in the background as I listened to them unknowingly telephone the local fishing tackle shop. It was an incredibly stupid prank, since I had no idea how they would react, or if I would still have a job the next day. Luckily, they all laughed and vowed to get me back.

I hope that, like me, April Fool's Day brings out the child in you and puts a sparkle in your eye. And remember: some of the best laughs are gained at our own expense. ☺



Denise Becker is a former board member of the BCPWA Society. She lives in Kelowna.