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## features



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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.

British Columbia Persons With AIDS Society

The British Columbia Persons With AIDS Society seeks to empower persons living with HIV disease and AIDS through mutual support and collective action. The Society has almost 4000 HIV+ members.

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# think+

## opinion and editorial

# Get involved at BCPWA

*by Paul Lewand*

Many of our members may not be aware of how unique the BCPWA Society's committee structure is and how it differs from other agencies. Our standing committee structure guarantees an HIV-positive voice in every decision the Society makes. Only full voting members of the Society, represented on the standing committees, are entitled to vote; associate members and staff are invited to contribute their opinions, but do not have voting privileges.

Presently, the BCPWA Society has nine operating standing committees: board and volunteer development (BVDC), community representation and engagement (CRE), education and communications (which includes the *Living* + magazine subcommittee), information technologies, prevention, treatment information and advocacy (TIAD), finance, fund development (which includes both the AIDS Walk and AccolAIDS subcommittees), and support services. A tenth standing committee is currently in the developmental stages and will be called Membership Engagement.

Each committee is chaired by a member of the board, or a designate, who is responsible for reporting on the standing committee's work and presenting recommendations to the BCPWA Society's board of directors. Most committees meet once a month, with representatives, staff, key volunteers, and committee members reporting on the progress of its operations. Some committees, such as CRE, meet every second week, as there are often time-sensitive issues that need to be researched and monitored closely. If it is deemed necessary to expand or otherwise change the mandate of a standing committee, that committee will make recommendations to the Society's board of directors.

An important distinction of our Society is that it operates from the bottom up, rather than from the top down as in many other organizations: all actions undertaken by the Society are a direct result of work generated by the standing committees, not the Board. Our Board members are active in all of the standing committees.

As in any peer-driven organization, we require our membership's participation in order for the standing committee structure to operate effectively. Our Society is a direct reflection of how the members of these committees view the scope and direction of their work.

Most standing committee meetings are open to any full voting member in good standing; there are a few exceptions to this rule in areas involving confidential information. Otherwise, for all regular standing committees, any member is welcome to participate and attend meetings without voice or vote. A member must attend two previous meetings and be nominated at the third in order to be granted full voting privileges.

If you are a member of the BCPWA Society, you can get involved and steer the direction of our agency. There are listings of the standing committees on page 38 of this magazine, with contact information as well as location and times of upcoming meetings.

Members living outside of the Lower Mainland may participate in committee meetings by teleconference, where available. ⊕

*Paul Lewand is the chair of the BCPWA Society.*

# Reality Bites


## Interaction between tenofovir and ddI

According to a warning letter sent to European clinicians from drug manufacturers Gilead Sciences and Bristol-Myers Squibb, the nucleotide tenofovir (Viread) should not be taken in combination with the nucleoside ddI (Videx).

The letter was issued after a high rate of virological failure and resistance was observed in several clinical trials where tenofovir and ddI were taken, in combination with a non-nucleoside reverse transcriptase inhibitor (NNRTI), by patients with low CD4 cell counts and high viral loads. Similar findings were reported when the same two drugs were taken in combination with a nucleoside reverse transcriptase inhibitor (NRTI). Based on these findings, the companies reasoned that it is possible that combining these drugs may produce similar effects if taken with a protease inhibitor (PI).

The letter advises against the coadministration of these drugs unless absolutely necessary and recommends close monitoring of patients who are prescribed both drugs in combination.

*Source: AIDSmap*

## Call for cast and crew

Theatre Positive, the BCPWA Society's unique and creatively expressive support program, was developed in 1996 by playwright and founding director Jake Thomas, and BCPWA Society's director of support services, Jackie Haywood.

This year, the troupe is producing an original play based on the life experiences of people living with HIV/AIDS. The play will be performed at the Roundhouse Community Centre during the week around World AIDS Day.

Theatre Positive is looking for writers, actors, stagehands, costume designers, technical support staff, and front of house volunteers. If you've always wanted to be on stage or involved with a fabulous live production, now is the time. Meetings, casting, and rehearsals start soon. For more information, contact Jake (phone: 604.893.2285 or email: jakejamesthomas@yahoo.ca).

## Shortage of antiretrovirals to developing world

Bristol-Myers Squibb and Merck, manufacturers of antiretrovirals stavudine (d4T) and efavirenz (Sustiva) respectively for the developing world market, confirmed in a recent *Wall Street Journal* report that they anticipate temporary difficulties meeting the unusually high demand for these drugs in the coming months. The problem is attributed to the increasing volume of orders from treatment programs funded by US President George W. Bush's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, TB, and Malaria.

There is some concern that supply shortages could last longer as a result of changes to Indian patent law, limited availability of raw materials, and fluctuations in the dollar exchange rate.

*Source: AIDSmap*

## BC Transplant Society relaxes criteria for PWAs

Owing largely to advocacy efforts initiated by the BCPWA Society's community representation and engagement (CRE) committee, the BC Transplant Society recently revised its guidelines relating to transplants for people living with HIV/AIDS. Organ transplants are now assessed on a case-by-case basis, in consultation with the BC Centre for Excellence in HIV/AIDS. Although the expanded eligibility criteria have enabled one PWA to receive a new kidney, the guidelines require further revision to be inclusive. The CRE committee continues to advocate against discriminatory guidelines and practices surrounding organ transplants for HIV–infected people as well as other issues of interest and relevance to PWAs.

The CRE committee invites community participation in its activities. Volunteers are needed to write articles, conduct legal/policy research, organize campaigns, and join the committee. Visit CRE's Web page, subscribe to the list serve (www.bcpwa.org), or phone the coordinator (604.646.5376) for more information.

## Kaletra maintenance therapy safe

The results of a small pilot study published in the March issue of *AIDS* indicates that the lopinavir/ritonavir PI combination known as Kaletra is an effective maintenance therapy for both treatment - naïve and treatment - experienced individuals.

Investigators in Miami, Florida conducted a 24-week pilot study to determine the effectiveness of Kaletra as a maintenance drug once suppression of viral load has been achieved through combination highly active antiretroviral therapy (HAART). Kaletra was

# REALITY BITES


prescribed in combination with zidovudine (AZT) and lamivudine (3TC). Results of the study indicate that most patients on the Kaletra monotherapy maintained viral suppression for up to six months following the combination HAART protocol.

*Source: AIDSmap*

## New statistics on HIV occupational exposure

According to a paper that recently appeared in *Eurosurveillance Weekly*, there have been six confirmed and an additional 18 possible cases of HIV transmission through occupational exposure reported internationally. Most cases involve needle stick injuries sustained by healthcare workers. Cases were reported in France, Germany, Australia, Brazil, Trinidad and Tobago, the UK, and the US. Two cases involved HIV infection even after post-exposure prophylaxis was administered.

Worldwide, there have been 108 confirmed cases of HIV transmission through occupational exposure and 238 possible cases reported since the AIDS epidemic began. Investigators warn that the data likely greatly underestimates the actual incidence of occupational exposure, since researchers depend chiefly on surveillance procedures and reporting practices. Also, information related to occupational exposure is not available from Africa, South East Asia, and South Asia.

The report concludes that healthcare workers should receive information and training on the prevention and management of occupational exposure, including a detailed review of universal precautions, and appropriate procedures for the disposal of sharps.

*Source: AIDSmap*

## Medical marijuana survey

Results from a nationwide survey on the medicinal uses of marijuana in the UK were published in the March 2005 issue of the *International Journal of Clinical Practice*. According to the lead author of the paper, Dr. Mark Ware of McGill University in Montreal, findings surrounding the use and effectiveness of marijuana, particularly for the purposes of pain management, "lend support to the further development of safe and effective medicines based on cannabis."

Forty-five percent of survey respondents indicated that marijuana was more effective for their purposes than their prescribed medication. And 76 percent of respondents claimed that their symptoms returned or increased in severity when they discontinued cannabis use.

The most common reported uses of medical marijuana were for the management of chronic pain, multiple sclerosis, depression, arthritis, and neuropathy.

*Source: Medical News Today*

## Unusual eye lesion may signal HIV infection

A group of Scottish doctors are recommending that clinicians consider the possibility of HIV infection in young people presenting with atypical conjunctival lesions.

Conjunctival intraepithelial neoplasia (CIN), formerly known as Bowen's disease, is rare pre-cancerous lesion located on the surface of the eye. Although the lesion usually affects the elderly, there have been an increasing number of cases reported among young HIV-positive Africans. Risk factors include solar ultraviolet light, petroleum products, heavy cigarette smoking, and infections with particular strains of the human papillomavirus (HPV).

*Source: AIDSmap*

## Epidemic acknowledged in Russia

After years of denial and silence, the government of Russia has publicly acknowledged the reality of the AIDS crisis in its country.

"The numbers have exceeded all the estimates of experts," said Russia's deputy prime minister, Alexander Zhukov, at a recent AIDS conference. "The growth of AIDS has gone beyond being a medical problem, and has become an issue of strategic, social, and economic security of the country…."

There are presently 312,000 confirmed diagnoses of HIV in the country. However, estimates project 100 new infections daily, with roughly 860,000 people currently infected.

The Russian government is turning increasingly towards the private sector, particularly the pharmaceutical industry, for financial support in its fight against a rapidly expanding epidemic. The government has allocated only modest resources towards prevention and treatment programs and is depending on the business community for additional financial assistance.

*Source: PWHA-Net* ⊕

# Eat this

*A private member's bill aims to reclassify natural health products as "food"*

*by Ron Rosenes*

If a private member's bill now going through the House of Commons is successful, all of the work to date of the Natural Health Products Directorate (NHPD) of Health Canada may come to nothing. Bill C-420 proposes to amend the definition of "food" to include natural health products (NHPs). This amendment would move the regulation of NHPs to the Food Directorate of Health Canada. While it may be easy to dismiss this situation by claiming that private member's bills rarely succeed, this one might be different if we don't sit up and pay attention. So far, the bill is flying quite low on Canadian radar screens. That may be about to change.

Why should we care? Before I answer that, I must declare my bias: I sit on the Management Advisory Committee of NHPD where we provide advice to the Directorate on various aspects of implementation of the regulatory regime. My involvement is in the capacity of consumer advocate, and I sit alongside representatives of the manufacturers of such NHPs as vitamins, minerals, herbs, homeopathic remedies, and Traditional Chinese Medicine (TCM). The industry representatives are in favour of compliance with the new regulations, to be phased in over the next five years, but also want to ensure that the process is fair and expeditious.

We should care because it is essential to ensure access by maintaining competition and low prices for the products we use. I am personally in favour of regulating NHPs, which so many of us use in our daily self-care management of HIV. I want to know that what is on the label is also in the bottle, and that Canadian products use good manufacturing processes (GMPs), in facilities that are regularly inspected. I also want assurance that there is a consumer-centred system of post-market surveillance to monitor adverse events.

## An anti-drug legislation

Dr. James Lunney, Conservative MP for Nanaimo-Alberni, originally introduced Bill C-420 to the House of Commons in March 2003. Dr. Lunney is a chiropractor who says on his Web site: "Most Canadians are shocked to learn that vitamins, minerals, and other food products are drugs under Canadian law, and that any product can be reclassified as a drug just by making a claim that it has health benefits." Dr. Lunney would have us believe that classifying NHPs as "drugs" limits our choice as consumers. While the original Bill C-420 died during the last session of parliament, it was reintroduced this year by another chiropractor, Dr. Colin Carrie, Conservative MP for Oshawa.

Proponents of the amended legislation are both anti-regulation and anti-drug. They wish to reopen the whole debate held by the Standing Committee on Health that decided that NHPs need their own appropriate regulatory regime. It was only due to the complexities involved in passing major new health legislation — creating a separate, "third" category — that it was decided to regulate NHPs as a subset of the drug regulations under the existing Food and Drug Act. The new NHP regulations were given their own regulatory administration within Health Canada.

According to the NHP Directorate Web site, its mission is "to ensure that all Canadians have ready access to natural health products that are safe, effective, and of high quality, while respecting freedom of choice and philosophical and cultural diversity." This means prioritizing the regulation of NHPs based on their likeliness to cause harm, while respecting tradition and the patient-provider relationship. It also means not regulating herbs or compounds that are made for individual use, as for TCM or traditional Aboriginal medicine.

What would happen if parliament votes, as reflected in Bill C-420, to amend the definition of "drug" to exclude "food" and to amend "food" to include "any article grown, manufactured, sold or represented for use as food or drink for human beings, chewing gum, and any ingredient that may be mixed with food for any purpose whatever, *including dietary supplements, herbs and other natural health products* [emphasis added]?" There would be two possible outcomes: either NHPs would fall under food regulations, or the Food Directorate would administer the current NHP regulations.

## The problem with classifying NHPs as food

If NHPs were regulated as food, there would be major inconsistencies in critical areas such as health claims, labeling, GMPs, routes of administration (topical versus ingested), and adverse event reporting. Many common self-care products that have been on the market for decades with evidence-based claims, such as Metamucil, Tums, and Hall's cough drops, would have to be removed from the market in order to meet food regulations.

Bill C-420 does not address these inconsistencies. Dosages of vitamins and minerals, as we know them, might have to become "serving sizes." Food labeling would not require the listing of medicinal ingredients by quantity, but only in descending order of presence. The result would be market and consumer confusion about the different ingredients and levels of active components in a given product. Simply migrating the NHPD into the Food Directorate is not the intention of the bill's proponents, as that would only lead to more legislative confusion.

## Revoking subsections of the Food and Drug Act

Bill C-420 also proposes to repeal two subsections of Schedule A of the Food and Drug Act. This is a good idea. First introduced in 1934, these regulations were designed to curb advertising of medicines for diseases that had no known treatments at the time. The diseases listed in Schedule A include cancer, arthritis, diabetes, depression, and hypertension. Today, we know that there is a strong body of evidence for the use of glucosamine in the treatment of arthritis, and St. John's wort for the treatment of moderate depression. But people with HIV want more than the evidence base alone; we also need to know the potential for interactions with our medications.

**Food labeling would not require the listing of medicinal ingredients by quantity, but only in descending order of presence.**

The NHPD regulations presently allow manufacturers to make a full range of claims, including structure, function, risk reduction, treatment or cure, provided there is sufficient evidence—including thousands of years of traditional use—to support the claims. These subsections of Schedule A prevent Canadians from learning more about natural remedies.

Bill C-420 in its present form must be defeated. However, the outdated provisions in Schedule A should be revoked. We need to call for the amendment of the bill to remove any definition changes and get on with revoking Schedule A to finally allow proper and complete labeling information, including health claims for the products we use.

People with HIV increasingly face out-of-pocket expenses to maintain health. The use of NHPs and other self-care products is on the rise. Regulations undoubtedly create costs that are passed on to the consumer, but the costs may be controlled if there is meaningful competition on a level playing field. ⊕

*Ron Rosenes is vice-chair of the Canadian Treatment Action Council, secretary of AIDS2006 Toronto Local Host, on the board of the Sherbourne Health Centre, and an honourary director of the AIDS Committee of Toronto.*

### More information and making your voice heard on the issue

*The NHPD Web site can be found at: <www.hc-sc.gc.ca/hpfb-dgpsa/nhpd-dpsn/index_e.html>*

*The anti-regulationists can be found at: <www.friendsoffreedom.org/article.php?sid=2284>*

*Dr. James Lunney can be reached at: <http://www.jameslunneymp.ca>*

*Dr. Colin Carrie can be reached at: <www.colincarriemp.ca/home.htm>*

# Winning one for the kids

*by Jane Talbot*

We've all heard the expression "it takes a village to raise a child," thanks to the Hillary Clintons and Dr. Phils of the world. While that may sound cliché, every now and then it does indeed require the strength of a village to provide the best possible care and support for our children.

On February 9, 2005, the fruits of one village's labour was celebrated with the announcement that, through the collaborative efforts of BCPWA Society's Advocacy program, the Oak Tree Clinic, and other AIDS organizations, the first Monthly Nutritional Supplement Benefit (MNSB) had been secured for an HIV-positive child in British Columbia. While it may have been a governmental oversight originally, the regulations of the Ministry of Human Resources nevertheless stipulate that only HIV-positive adults receiving provincial disability benefits are eligible to apply for a MNSB health benefit of up to $225 for nutritional food, purified drinking water, and vitamins and minerals.

Because PWAs under 19 years are not eligible for MNSB benefits, a number of HIV-positive children in the province are receiving inadequate levels of nutrition necessary to slow disease progression, prevent further wasting, and alleviate symptoms of moderate to severe immune suppression. "Children in BC have access to lifesaving therapy, but medication is not enough," said Dr. Jack Forbes, co-director of the Oak Tree Clinic at Children's and Women's Health Centre of BC. "Nutrition is a fundamental part of HIV therapy, as malnutrition can develop quickly in HIV-positive children and the consequences can be devastating." Dr. Forbes is the pediatric infectious disease specialist who provides care for all 40 HIV-positive children in BC.

Recognizing the importance of proper nutrition, AIDS Vancouver and Oak Tree Clinic initially approached the BCPWA Society in July 2004 for advocacy and legal expertise to help change governmental procedure in order to obtain nutritional benefits for a seven-year-old HIV-positive child. After six months of research, a legal submission, and continued consultation with Oak Tree Clinic and AIDS Vancouver, the BCPWA Society submitted a hand-delivered application to the Ministry of Human Resources. The Ministry designated the application a priority and rushed it to the Health Assistance Branch in Victoria, which granted the benefits within 13 days.

While delighted with the outcome of securing the first MNSB benefit for a child, the individuals and organizations behind the effort are quick to point out that much work is still required in order for the law to change. "We're very pleased our efforts will improve the life of an HIV-positive child," said BCPWA Society chair Paul Lewand. "While a precedent has been set, disability legislation still excludes children from receiving MNSB. The provincial government must recognize children as equal citizens and immediately amend disability legislation to include children."

Our village is powerful, productive, and proud; together we will continue to ensure our HIV-positive children receive the best care and nutrition possible. ⊕

*Jane Talbot is currently on contract with the BCPWA Society's treatment information and advocacy department.*

# Study shows Vancouver facility reduces needle sharing

Vancouver's pilot supervised injection site has reduced needle sharing among high-risk drug users, according to a new study published in the international medical journal *The Lancet*. The paper, authored by the BC Centre for Excellence in HIV/AIDS (BCCfE), represents the first published findings on the impact of a supervised injection site on syringe sharing.

The supervised injection site, known as InSite, attracted high-risk injection drug users who had a history of needle sharing behaviour. The first government sanctioned facility of its kind in North America, it was opened in September 2003 by Vancouver Coastal Health in partnership with the Portland Hotel Community Services Society.

Findings from the paper—entitled "Safer injection facility use and syringe sharing in injection drug users"—reveal that InSite positively influenced behaviour. InSite attracted people who previously were at high risk of sharing syringes. However, after the facility opened, there was reduced needle sharing.

Researchers surveyed 431 active injection drug users between December 2003 and June 2004. Of those, 90 users reported that all, most, or some of their injections were at the safer injection facility. An earlier study showed that site users were particularly high-risk drug users.

Individuals who used the supervised injection site for some, most, or all of their injections were 70 percent less likely to report syringe sharing. Even when all other risk factors were considered, use of the site was independently associated with reduced syringe sharing. The study also revealed that drug users who need help with injecting and engage in binge drug use were more likely to report syringe sharing.

The paper follows a BCCfE study published in the *Canadian Medical Association Journal* last year that revealed InSite's opening was associated with improved public order by reducing injection drug use and syringe disposal in public spaces. ⊕

# The high co$t of aging with HIV/AIDS

*by Melissa Davis*

When 51-year-old Walter unexpectedly fell ill while vacationing on the west coast in the spring of 1991, he went to the emergency department of a nearby hospital in White Rock, BC. The last thing he expected, following a series of routine questions, blood tests, and a physical examination, was an HIV diagnosis. "My first reaction was total shock," he said. "Back then, things were different with AIDS. I thought I'd be dead within a year." So Walter did what others in his position did at that time: he put his affairs in order. He cashed in his life insurance policy, wrote a Will, arranged and prepaid his funeral expenses, and made the most of the time he had left.

Fourteen years later, Walter still makes the most of his time. His CD4 cell count hovers near 320, his viral load remains undetectable, and in late February, he and his partner of almost 15 years celebrated Walter's 65th birthday together.

*continued on next page*

## Facts, figures, and factors associated with HIV and aging

Walter's story reflects an emerging trend in North America: the experience of aging with HIV. Statistics from the US-based National Institute on Aging (NIA) show that the cumulative number of AIDS cases in American adults aged 50 and older has more than quintupled, from 16,200 to over 90,600 between 1990 and 2003; the NIA further claims that 19 percent of Americans living with HIV are over the age of 50. Canadian statistics are similar. According to Public Health Agency figures, although the actual number of reported *new* HIV diagnoses among older Canadians is not statistically significant and has, in fact, declined slightly in recent years, the proportion of HIV-positive people over the age of 50 has increased from just over 11 percent in 1994 to slightly more than 20 percent in 2002.

"This isn't really unexpected," says Suzan Krieger, an individual advocate with the BCPWA Society. "Although we're just beginning to see the trend reflected in our membership." Presently, 12 members out of slightly less than 2,500 in the advocacy department's database will reach the age of 65 this year. However, an additional 769 are currently between the ages of 50 – 63, indicating that the membership demographic—and the need for age-appropriate treatment information and advocacy services—will shift significantly over the next several years.

Until recently, the entire notion of aging with HIV was unfathomable. Twenty years ago, the stretch of time between diagnosis and death could be a matter of weeks or months. Even a decade later, in spite of a handful of AIDS drugs and improved management of opportunistic infections, quality of life and life expectancy for PWAs were still diminished by severe drug toxicity and disease progression. But for the survivors who lived to witness the advent of antiretroviral therapies (ART) in the late 1990s—and those diagnosed thereafter—AIDS has evolved from a devastating, terminal illness into a chronic, manageable disease. Since then, people with HIV have been living longer and healthier lives.

In addition to widespread availability of ART, several other factors have contributed to the increasing numbers of older people living with HIV/AIDS in North America. Targeted HIV prevention efforts neglect older men and women and, consequently, ignorance and misinformation about the disease are common for people over age 50. And while sex education appears restricted to a younger demographic, sexual activity most definitely is not. In fact, this population group has experienced something of a second wave sexual revolution in recent years due to the popularity of Viagra for men, coupled with greater sexual freedom without the worry of unwanted pregnancy, for post-menopausal women. Nevertheless, cultural assumptions and prejudices desexualizing older people have resulted in inadequate targeted HIV prevention education and support services, as well as numerous cases of undiagnosed or misdiagnosed HIV infection by healthcare providers.

As one might expect, socio economic issues affecting seniors are exacerbated for older people living with HIV and AIDS. About a year ago, Walter began wondering about how his monthly income might be affected once he reached the age of 65. Realizing that provincial income assistance would be discontinued, he made some inquiries through Social Development Canada (formerly HRDC). "When I started making calls, it was like going from pillar to post. No one could give me a straight answer," Walter said, exasperated.

## Disability benefits for PWAs in BC

In BC, an HIV-positive single person under the age of 65 receives income assistance as a Person With Disability (PWD). Disability benefits pay $856 per month ($10,272 per year) and entitle recipients to enhanced provincial healthcare coverage, including medical services, prescriptions, vision care, dental care, and related health costs. Individuals on PWD assistance who experience excessive weight loss or wasting may be eligible for an additional Monthly Nutritional Supplement Benefit (MNSB), paying up to $225 per month, to purchase essential food items, vitamins, and bottled water. MNSB recipients on disability benefits support themselves, then, on $1,081 per month ($12,972 per year).

**"Many of these people never expected to live this long. Now, edging their way to 65, they're wondering what they're going to live on."**

Prior to the implementation of the MNSB, hundreds of PWAs and other people with disabilities in BC applied separately for a monthly health allowance known, under the provincial legislation, as Schedule C. The amount awarded varied in each case, based on the applicants' circumstances, but recipients of Schedule C received monthly allowances in the $200 to $500 range, and continue to receive these benefits.

This was Walter's situation. "Before I turned 65, I'd get my disability cheque and my Schedule C [allowance] every month. It wasn't a lot of money, but I managed. Subsidized housing really helps. And I stick to my budget." In spite of living on very limited resources, Walter claims the provincial system provided for his basic needs. "I can't really complain. I'm not someone who takes advantage of things. And when I've really needed something—like my scooter to get around, or home care when I couldn't do certain things for myself—I've always received the help I need."

## Inadequate federal income support for seniors

Unfortunately for Walter, the same does not appear to be true with respect to the federal system. Older PWAs face a decrease in income when responsibility for their financial support is transferred from provincial to federal jurisdiction. Yet the federal government's most recent statistics on disability in Canada suggests otherwise. Social Development Canada reported that the average annual household income for seniors with disabilities in 2001 was a remarkable $46,708 and, evidently, only slightly less ($800) than the average household income for seniors without disabilities. Persons living with HIV or AIDS, under the disability umbrella, are more likely to find their experience reflected in the statistic of 18 percent of Canadians with disabilities whose incomes place them below the low income cut-off amount.

Federal income security programs for seniors provide slightly less financial support than provincial income assistance for persons with disabilities. For people entirely dependent on these government programs, with no additional sources of revenue, the maximum annual income for a single person remains between $12,000 – $15,564—a far cry from the $47,000 national average (thanks to independent retirement savings plans) that the federal government boasts.

Eligibility for federal programs is based not on financial need or medical requirements, but on factors related to length of residency and/or employment in Canada. For example, the maximum monthly allowance for Old Age Security (OAS)—an abysmal $471—requires a minimum ten year prior residency in Canada. The Canada Pension Plan (CPP) is directly related to the applicant's employment history and the amount contributed to the plan during the individual's employment; even so, the maximum monthly CPP payout is only $826. The Guaranteed Income Supplement (GIS) is a top-up fund for individuals whose combined OAS and CPP revenue totals less than $1,000 per month. Finally, OAS and CPP revenue are both considered taxable income according to Canada Customs and Revenue Agency, an additional financial burden that has seniors like Walter extremely concerned.

"In hindsight, I wish I had been more prepared and put some money away for myself," Walter says, reflecting on his predicament. BCPWA Society advocate Suzan Krieger sympathizes. "Many of these people never expected to live this long," she explains. "For health reasons, they left their jobs years ago so they haven't contributed to CPP for a very long time. Now, edging their way to 65, they're wondering what they're going to live on."

## Making a case for additional support

As the situation stands now, Walter is entering his golden years in the red. His present income, under the federal system (including a modest GIS top-up) still remains 20 percent less per month than he was receiving through his provincial disability benefit and Schedule C health allowance. And without that additional money to purchase essential health-related nutritional items, his health could be seriously compromised.

Teaming up with the BCPWA Society advocacy department, Walter submitted a request to his provincial Employment Assistance Worker (EAW) seeking approval to receive a portion of his Schedule C monthly allowance to make up for the shortfall in income paid under the federal system. His request was denied.

Presently, Walter's case is being reviewed at a higher level, with the reconsideration officer at the Ministry's health assistant branch. "It takes time to get an answer," explains Cheryl Colborne, another advocate with the BCPWA Society. "They're looking at this case carefully, I'm sure, because we all know that the outcome will set a precedent for similar appeals in the future." And with at least 769 current BCPWA members expected to qualify for seniors benefits over the next decade or so, that's a lot of unplanned paper work for the provincial government—and a lot more money than they had budgeted for.

Let's hope the government does the right thing and respects their elders. ⊕

*Melissa Davis is a Vancouver-based communications consultant and the interim managing editor of living+.*

### *Information*

- ***Social Development Canada — Income Security Programs:***
  www.sdc.gc.ca/en/gateways/nav/top_nav/program/isp.shtml
- ***Government of Canada — Online Publication: Services for Seniors Guide:***
  www.communication.gc.ca/guides/seniors_aines/index_e.html
- ***Public Health Agency of Canada — HIV/AIDS Epi Update (HIV/AIDS Among Older Canadians):***
  www.phac-aspc.gc.ca/publicat/epiu-aepi/epi_update_may_04/6_e.html

### *Advocacy*

- ***BC Persons With AIDS Society Advocacy Department***
  *Email*: advdesk@bcpwa.org
- ***Vancouver HIV-Positive Peer Advocacy Action Group***
  *Email*: vhpaag@yahoo.ca

### *Support*

- ***Association on HIV Over Fifty:***
  www.hivoverfifty.org
- ***HIV Wisdom for Older Women:***
  www.hivwisdom.org

ACCOLAIDS

# Honouring our heroes

On April 24, the BCPWA Society and GlaxoSmithKline, in partnership with Shire BioChem, held the fourth annual AccolAIDS awards gala at the Pan Pacific Hotel in Vancouver. This fundraising event honours community achievements of individuals and organizations in the BC AIDS movement.

## ABOVE AND BEYOND

### WISH (Women's Information and Safe House)

The WISH Drop-in Centre, in Vancouver's Downtown Eastside, has become a trusted first point of contact for Vancouver's most marginalized women. The Drop-in Centre provides hot meals, clothing, referrals to shelters, and a safe place to rest in a caring, non-judgmental environment. It is a hub that helps connect women to the supports they need in order to maintain their health, or to transition off the streets.

In partnership with the Prostitutes Alternatives Counselling and Education Society (PACE), WISH also operates a Mobile Access Project—a van that drives through existing and emerging "strolls" to offer respite and immediate response to women working on the streets at night.

WISH is the only area Drop-in Centre for women involved in street-level survival sex. It serves roughly 500 women each month, helping this hard-to-reach group by connecting them with the means to stay safe, healthy, empowered, and alive.

## HEALTH PROMOTION & HARM REDUCTION

### Portland Hotel Society and Vancouver Coastal Health for InSite

InSite is a revolutionary approach to the use of illicit injection drugs and the associated vulnerability to disease. The site offers drug users a clean, safe, and supportive space to prepare and inject drugs. As many as 500 injection drug users use the facility each day. All injections are supervised by a team of nurses, health care professionals, and peer workers.

The InSite nursing team creates a safe and hygienic environment, providing medical assistance and ensuring that users do not share equipment. A team of peers from the Downtown Eastside, program assistants from the Portland Hotel Society, and nurses and addiction counsellors from Vancouver Coastal Health make the service community-oriented and accessible to a diverse client base. The result of this collaborative approach has been street-level trust and, consequently, a high-use success.

## INNOVATIVE PROGRAMS

### Fire Pit

The Fire Pit is a cultural drop-in centre that is helping to address HIV/AIDS among the Aboriginal populations in the Prince George community. People living with HIV/AIDS and those at risk gather at the Fire Pit for food and coffee. While there, they can also engage in a variety of activities that help them reconnect to their culture: art making, drum making, drumming, singing, storytelling, beading, making bannock, preserving food, and sharing knowledge and skills. Organizers believe participants can discuss the impact of colonization and learn about culture while engaged in social activities.

Fire Pit offers drug and alcohol counsellors, an outreach nurse, and a social worker. HIV/AIDS education and support services are open and flexible, to meet the needs of street-involved individuals. Creativity, adaptability, and accessibility are the keys to the Fire Pit's success.

KEVIN BROWN PWA HERO

## Brenda Loyie

Brenda was a peer counsellor at Positive Living North. She provided a strong voice for Aboriginal women and for those struggling with addictions. Most notably, Brenda became a local, provincial, and national advocate for people co-infected with HIV and hepatitis C. She shared her story with others in the video *Hospital Curtains Are Not Walls*, and served on the Canadian HIV Trials Network's Community Advisory Committee.

Her peers note that Brenda supported clients, staff, and the community through her perspective on the epidemic in a way that was sometimes raw and painful, but always from the heart. Such was her commitment that she continued to guide them from her hospital bed in the last years of her life.

Brenda's partner, Blondie, continues the work of Brenda's legacy to make HIV/AIDS services readily accessible to anyone who needs them.

PHILANTHROPY (TIE)

## Chainlink

Since 1997, a dedicated group of inmates at Mountain Institution, a medium-security federal prison in Agassiz, has provided palliative care, peer counselling, treatment information, and prevention education on the inside. Many members of the group are HIV-positive or co-infected with hepatitis C. Whether educating inmates on the dangers of high-risk activities, or supporting fellow prisoners whose physical needs have increased due to AIDS-related disabilities, the men of Chainlink have created a community of dignity at Mountain Institution.

In addition, each year, the Chainlink members organize their own AIDSWALK event, raising funds from the general inmate population to contribute to the BCPWA Society's annual fundraising event.

## The PumpJack Pub

Since opening in December 2000 with the goal of providing a comfortable gay neighbourhood pub, the PumpJack in Vancouver's West End has become a successful and integral part of the community, and a support to local organizations, sporting teams, and community groups.

The PumpJack has been a significant supporter of the HIV/AIDS community. To date, the pub's fundraising activities have raised over $30,000 for various organizations. Contributions have been raised by individual organizations who run the PumpJack's coat check, and at special events such as The Prairie Fairies Fowl Supper, Homos-A-Carolin', and the Fire & Ice New Year's Celebration in support of the Dr. Peter Centre. The PumpJack Pub also hosted the launch of BCPWA Society's *Sex Positive Guide* and assisted in the promotion of *Outlooks* magazine's AIDS-related events calendar.

SCIENCE, RESEARCH AND TECHNOLOGY

## BC Centre for Excellence in HIV/AIDS

The BC Centre for Excellence in HIV/AIDS (BCCfE) is Canada's largest HIV/AIDS research and treatment facility. The Centre develops, conducts, and disseminates comprehensive research and treatment programs in HIV and related diseases. The BCCfE provides educational support programs to healthcare professionals and monitors the impact of HIV/AIDS in BC, analyzing the effectiveness of programs for investigating and treating HIV and related diseases. The Centre's Drug Treatment Program distributes antiretroviral medications to eligible HIV-infected individuals at no cost; to date, over 7,400 British Columbians have enrolled in the program.

The BCCfE is continually working to better the health outcomes of individuals living with HIV/AIDS. Its *Therapeutic Guidelines* provide recommendations for best practices in treating HIV disease and form the basis of treatment strategies.

SERVICE DELIVERY

## Liz James

Liz has worked with the BC Centre for Disease Control's Street Nurse Program since its inception in 1988. Throughout her career, Liz has remained a firm and determined activist.

In 1990, Liz teamed with other community members to purchase 400 needles from a sympathetic pharmacist. This was the beginning of the DEYAS Needle Exchange program. Liz was also a member of the original working group that initiated Oak Tree Clinic for Women, Children, and Families with HIV and AIDS. In the spring of 2000, Liz was adamant that nurses should advocate for safe injection facilities for drug users; she joined the Harm Reduction Action Society.

Liz is known by the community and her co-workers as a warm, caring, humble, and visionary nurse. Her work in community development, her holistic approach to health and wellness, and her remarkable ability to motivate clients, is an inspiration.

SOCIAL, POLITICAL & COMMUNITY ACTION

## James C. Johnstone

An AIDS Vancouver staff person coordinated Vancouver's first AIDS Candlelight Memorial and Vigil in 1985. In 1988, James Johnstone, Martin Laba, Pei Hsien Lim, and Loree Rose were asked to take over the event. James had been involved in Vancouver's first buddy support group for PWAs, active in the Coalition for Responsible Health Legislation, and had co-chaired two BC gay and lesbian conferences. But it was the spiritual as well as the political aspects of the AIDS Vigil that appealed to him.

James has been passionately committed to the Vigil for the past sixteen years. He has emceed the Vigil, ensuring that it is a safe, healing, empowering, and meaningful event that is accessible to all attendees, whatever their background. He is proud to be part of this dedicated group of people, and he believes that this award honours not only him, but also the work of all involved. ⊕

With thanks to all participating event partners, sponsors, suppliers, committee members, nominees, nominators, award recipients, attendees & volunteers for making AccolAIDS a resounding success for the fourth year in a row.

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# Becoming blasé

*Is there a relationship between HIV/AIDS complacency and treatment optimism?*

*by Paul Adomako*

Recent studies have linked HIV/AIDS complacency, a phenomenon defined as minimizing, discounting, or discrediting the threat of HIV/AIDS, to an increase in or relapse into unsafe sexual behaviours. This complacency also impacts people's perceived risk of HIV exposure.

One contributor to HIV/AIDS complacency is the attitude of treatment optimism arising out of the effectiveness of highly active antiretroviral therapy (HAART) in improving quality of life. Research in this area reflects the ongoing debate surrounding the availability of HAART and the resurgence of unsafe sexual behaviours.

A 1998 US study by Kelly, Hoffman, Rompa, and Gray sampled 379 men who have sex with men and found that ten percent of respondents agreed or strongly agreed with the statement, "AIDS is now very nearly cured." Overall, eight percent of the men indicated they practiced safer sex less often, in light of new AIDS treatments. Moreover, among respondents who were HIV-positive and on HAART, 18 percent claimed they were practicing safe sex less often.

Related to the notion of treatment optimism is the perception that HAART decreases the chance of transmission. While not a consistent finding, several studies identify an association between HAART, undetectable viral load, and perceptions of decreased sexual transmission risk. In a 2001 survey of 472 men attending a gay pride festival in the midwestern US, researchers found that sex with an HIV-positive partner taking HAART who had an undetectable viral load was not consistently viewed as riskier than sex with an HIV-negative partner or a partner with an unknown HIV status.

The issue of decreased viral load resulting in reduced HIV transmission does have some validity at a population level. Since studies have shown that viral load is a main predictor of risk for heterosexual transmission of HIV, one could reason that HAART may contribute to decreased transmission of HIV. However, at an individual level, people on HAART with undetectable levels of viral RNA in their blood might still have virus present in their semen. Some researchers have warned that any prevention advantages gained from decreased viral load in a population of individuals on HAART could easily be surpassed by an increase in the frequency of unsafe sex.

If increases in unsafe behaviours can be partly attributed to HIV complacency, we need to place greater emphasis on prevention efforts targeted at HIV-positive people. Prevention strategies must address the relationship between treatment optimism and risk behaviour. The challenge lies in ensuring that such prevention efforts do not inadvertently stigmatize, blame, or unfairly judge people living with HIV.

**If increases in unsafe behaviours can be partly attributed to HIV complacency, we need to place greater emphasis on prevention efforts targeted at PWAs.**

While most of the research findings on this issue have been from industrialized nations, some evidence suggests that similar dynamics could evolve in developing nations where efforts to increase access to antiretroviral treatment are ongoing. Globally, living longer and healthier with HIV may be an indicator of quality of life, but it may also be a catalyst for unexpected attitudinal and behavioural shifts at the individual and community level, requiring more complex and integrated positive prevention approaches. ⊕

*Paul Adomako is the director of prevention for the BCPWA Society.*

# Multiple Choice

*Are preventive messages effective or counterproductive?*

**A. Yes**
**B. No**
**C. None of the above**
**D. All of the Above**

A | B | C | D

*by Lucía Terra*

As rates of HIV infection among women continue to rise, specialists worry about the effectiveness of some of the strategies employed, to provide prevention information to this population group.

One-time prevention messages, such as a single counselling session conducted after an HIV test or an information brochure, tend to present multiple prevention options at the same time. The messages are usually listed hierarchically, from most to least effective alternatives. For example, a typical AIDS prevention brochure would say something like: "Use a male condom. If you don't use a male condom, use a female condom. If you don't use a male condom or a female condom, use spermicide."

Although male condoms have proven very successful at protecting women against HIV and sexually transmitted diseases (STDs), they don't enjoy great popularity among women with high risk for contracting HIV. Among other problems, the use of male condoms can be difficult to negotiate with male partners.

Unfortunately prevention options that offer women more control are somewhat less effective. Scientists have yet to fully determine the effectiveness of female condoms to prevent HIV infection and other STDs. Similarly, there is very little research on the usefulness of vaginal spermicides as a protection from HIV (a marketable microbicide is at least five years away).

The problem of hierarchical messaging is that by proposing multiple options for HIV prevention methods, women may forego the most effective device, male condoms, in favour of less effective alternatives, such as female condoms or spermicide, thus increasing their risk of infection.

**We need to examine how people process HIV prevention messages in order to avoid unforeseen effects of hierarchical healthcare messages.**

In a recent US study, researchers tested the current hierarchical prevention approach by using two different messages: one that promoted the use of male condoms only, and another that presented the traditional hierarchy of options. The study was conducted among heterosexual minority women, 18 to 32 years old, a group considered to be at high risk for contracting HIV and other STDs. Each group saw a different message.

The results revealed that when hierarchical messaging was used, male condoms were perceived as less effective at preventing HIV than when exclusive male condom messaging was used; this finding was observed whether or not the women were currently using male condoms (though it did not influence male condom usage among women currently choosing that method). Women currently not using male condoms who received the hierarchical message were less willing to use condoms in the future.

Researchers argue that we need to examine how people process HIV prevention messages in order to avoid unforeseen effects of hierarchical healthcare messages. They suggested a possible alternate approach: first promote the use of one method, male condoms, then offer alternatives to women who are unable or unwilling to use the principal method. Another approach would involve the repetition and reinforcement of the prevention messages through various communication channels, since repeated exposure to messages is more likely to create positive behaviour change. ⊕

*Lucía Terra is a Vancouver-based freelance writer.*

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

# Highlights from CROI

*by Enrico Mandarino*

The 12th Conference on Retroviruses and Opportunistic Infections (CROI), held in Boston from February 22 – 25, once again brought together up to 4,000 researchers in HIV/AIDS from around the world to discuss the latest in scientific and clinical information on how to better understand and deal with the HIV/AIDS pandemic.

The news story of a multi-resistant HIV strain found in New York City prompted CROI organizers to add an unprecedented "special session" to the conference program. Dr. David Ho, director from the Aaron Diamond AIDS Research Center in New York City, and a group of researchers presented the most recent data on the case of a man with a rapidly progressing, multi-drug resistant (MDR) form of HIV. The man, in his late forties, had previously tested negative for HIV antibodies on five occasions since September 2000. He had unprotected sex with "countless" partners over the years while using crystal methamphetamine. When he was diagnosed in January 2005, his HIV infection had progressed to full-blown AIDS and his virus was resistant to most of the drugs used to treat HIV.

Rapid progression to AIDS is not a new phenomenon. One study involving over 10,000 participants looked at seroconverters within four to five months of infection; the medium time to AIDS-defining illness was 8.3 years. However, of the 10,000 participants, seven progressed to AIDS in ten months, 45 progressed to AIDS in one year, and 242 progressed to AIDS in 24 months. As well, transmission of drug resistant HIV has been well documented.

What remains unanswered about this case is whether it is truly an aggressive MDR strain of HIV rather than a genetic disposition of the host, and whether this is a single case versus a cluster. Dr. Mark Wainberg from McGill University in Montreal said that the circumstances of this case suggest that the host, not the virus, drove to rapid disease progression. "Maybe his immune system was completely destroyed," he said.

The debate about this case continued long after the session ended, with many questions remaining unanswered.

## New antiretrovirals at CROI

Among protease inhibitors (PIs), the agent that is closest to licensing which is currently available in Canada and other developed countries through expanded access programs is the non-peptidic PI, tipranavir. RESIST-1 and RESIST-2 are two large multi-centre Phase III studies in which 1,483 patients were randomized to receive either tipranavir boosted with low dose ritonavir (Norvir) twice a day or

another ritonavir-boosted PI. There was heavy previous exposure to antretrovirals in both arms, with a medium exposure of four to five protease inhibitors. Treatment response at 24 weeks showed that 41 percent of the patients on tipranavir/ritonavir achieved a treatment response versus 19 percent in the control arm. Another abstract examining quality of life showed significant improvement in general health and mental health scores in the tipranavir arms compared to the control arm.

Another PI undergoing Phase II large-scale dose study to treat late-stage HIV disease in experienced patients is ritonavir-boosted TMC114/r. Most of the patients in this study were heavily pre-treated with extensive antiretroviral exposure (medium 11 drugs). Planned interim analysis at week 24 showed a significant reduction in viral load in the TMC114 arms compared to the control arm. The proportion of patients with more than a 1.0 log reduction in viral load was 72 percent versus 16 percent in the control arm; the corresponding T4 cell increase was 75 and 15 respectively. No significant changes were seen in liver function or lipid markers.

**The news story of a multi-resistant HIV strain found in New York City prompted CROI organizers to add an unprecedented "special session."**

The most promising new non-nucleoside reverse transcriptase inhibitor (NNRTI) presented at the conference was TMC278, which appears to work against multiple NNRTI resistant mutants. A seven day randomized, double blinded, dose-ranging monotherapy study showed a median viral load fall of 1.2 log in all doses studied. No significant adverse reactions were reported and a multinational phase II dose-finding study in antiretroviral-naïve patients is set to start this spring.

## Novel sites: maturation, integrase, and RNase H

During the "new agents" session of the conference, researchers unveiled KMMP05, which may be a prototype for a new class of anti-HIV drugs. HIV uses two enzymatic activities, polymerase and Ribonuclease H (RNase H), to convert the single-stranded viral RNA into double-stranded DNA. RNase H is essential for HIV replication, and RNase H inhibitors can interfere with the replication process. This study suggests a novel binding site that should have little or no cross-resistance with existing NRTIs.

For the first time at the CROI conference, there was a public report of a precursor compound to the integrase inhibitor. Integrase is the third enzyme required for HIV replication. A ten day study of L-000870810, a novel HIV integrase inhibitor, showed a 1.8 log reduction in viral load using two different doses, and it was well tolerated in patients. This study was determined to be a proof of concept for the antiviral activity of HIV integrase strand transfer inhibitor (ISTI) as a new therapeutic class.

A proof of principle and first time data was presented on PA-457, the first in a new class of antiretrovirals called maturation inhibitors. This drug specifically blocks the conversion of HIV precursor CA-SP1 (p25) to mature capsid protein (p24), therefore blocking the spread of infection to new CD4 cells. The drug shows potent activity against HIV resistance to currently available drugs. Phase I and II dose studies have been completed with PA-457 administered as a single oral dose to patients both on and off antiretroviral therapy. A significant reduction in viral load of 0.7 log was seen in patients receiving higher dose levels. ⊕

*Enrico Mandarino is secretary of the board of the Canadian AIDS Society and a board member of the Canadian Treatment Action Council.*

# TB or not TB

*by Sam Friedman*

Years ago, tuberculosis (TB) was referred to by the term consumption since, without treatment, it consumed patients until they simply wasted away. *Mycobacterium tuberculosis* is characterized by its potential virulence and casual mode of transmission. PWAs, especially those with CD4 counts below 200, are particularly vulnerable to contracting TB.

When a TB-infected person coughs, sneezes, shouts, or spits, microscopic sputum droplets containing TB become airborne, extending into a radius of several square feet. Simply inhaling air that is contaminated with TB can cause infection. Though TB normally only affects the lungs, often causing pneumonia, if left untreated it can spread to the lymph nodes, kidneys, bones, lining of the brain, and spinal cord.

**Simply inhaling air that is contaminated with TB can cause infection.**

When exposed to TB, our bodies create antibodies through a cell-mediated immune response. This reaction ultimately leads to the encapsulation of TB bacteria in scar tissue, which normally contains the infection in a latent or inactive state. However, when CD4 counts fall below 200, especially below 100, the immune response is often insufficient to control the infection from spreading and becoming active.

Tuberculosis can cause a more rapid progression of HIV disease and an increased risk of opportunistic infections, so if you are HIV-positive, you should be screened for TB, even if you tested negative in the past.

A simple skin test generally reacts to the presence of TB antibodies, producing either a negative or a positive result. False negative results can occur in people with less than 200 CD4 counts. The TB vaccine, *Mycobacterium bovis*, can also produce false negative results. Both positive and negative skin tests should be followed up by an X-ray as well as sputum and blood testing to confirm or rule out infection; where a positive result is confirmed, these tests also indicate whether the infection is latent or active and if it is a resistant form of the TB bacteria.

For people co-infected with HIV and TB, who have CD4 counts below 200, the risk of TB progressing from latent to an active state is very high. Therefore, even though latent TB may present no symptoms and may be non-infectious, daily treatment with isoniazid, for the prescribed nine month period, is highly recommended.

Active TB infection is highly contagious. Symptoms include cough, fever, night sweats, chills, fatigue, and weight loss. Immediate aggressive treatment is required using a combination of isoniazid, rifabutin, pyrazinamide, and ethambutol daily for two months, after which only isoniazid and rifabutin are taken daily for the following four to eight months. Avoid missing doses, since this can rapidly lead to multi-drug resistant TB.

Research cites many complex adverse drug interactions between TB antibiotics and highly active antiretroviral therapy (HAART). It is highly recommended that both an HIV and a TB specialist supervise your treatment. If your CD4 count is above 350 and stable, discontinuing HAART during the first two months of treatment is recommended to avoid the drug reactions. Using rifabutin instead of rifampin will also reduce adverse drug interactions. Do not discontinue HAART during treatment if your CD4 counts are below 100.

Research on supplements of vitamin A and zinc as part of TB therapy reveal that they help more rapid elimination of TB from sputum and more rapid resolution of lung lesions. The amounts of supplements used in the study were less than PWAs usually use for supplementation; higher doses may possibly yield better results.

The *Mycobacterium bovis* vaccine has little effect when CD4 counts are below 200. A genetically engineered *Mycobacterium tuberculosis* vaccine is in early human trials, but further trials are required to ascertain if this approach has any benefit.

Knowledge is empowerment. Get tested and treated if necessary. ⊕

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

# Just say 'no'

*HIV-positive gay men don't need routine anal pap smears for anal cancer*

*by Tom Lampinen*

Anal cancer in HIV-positive gay men has been a hot topic lately. Since anal cancer is quite rare, occurring in fewer than ten men in BC each year, the major concern is prevention rather than treatment of invasive anal cancer. At the top of some prevention lists is screening for anal cancer and pre-cancer, as a form of early intervention.

Surprisingly, most people discuss anal cancer screening from only two vantage points: first, from the rare experience of an anal cancer diagnosis or, second, advocating for anal Pap smear screening programs (noting the success of Pap smear programs in reducing cervical cancer deaths by 80 percent). However, the question of whether or not to implement routine anal cancer screening is best considered by applying the same criteria used to decide whether or not to introduce any new medical screening test or procedure. It is crucial to assess the extent to which screening meets these standard criteria, because inappropriate screening can potentially cause more harm than good, both individually and collectively.

It is important to understand the actual purpose of screening. A screening test does not diagnose illness. It is used only to distinguish individuals with a high likelihood of having the disease from those with a low likelihood. People classified with a high likelihood are referred for more invasive diagnostic testing. Clinical epidemiologists consider four key questions when evaluating any newly proposed screening program:

- Is the disease a significant problem for a specific population group (i.e., HIV-positive individuals), because of either its frequency or severity?
- Is the natural course of the disease such that it is present in a person for a reasonable length of time before symptoms develop?
- Is an effective treatment available that can favourably alter the usual course of the disease?
- Is a suitable screening test or procedure available—one that is reasonably accurate, amenable to prospective patients, reasonably safe, and inexpensive?

## Is anal cancer a significant problem?

Anal cancer is rare in the general population, occurring in less than one in every 100,000 men annually. However, among gay men, both, HIV-negative and HIV-positive, the annual incidence of anal cancer is estimated to be much higher, around 40 per 100,000 in the former and 80 per 100,000 in the latter. These rates among gay men exceed the rate of cervical cancer recorded before the implementation of cervical cancer screening programs. In this regard, gay men appear to be an appropriate population for anal cancer screening.

Unfortunately, what gets lost in just about every discussion of these statistics are the actual counts, which provide gay men with an estimate of their absolute, personal risk for developing anal cancer. If 80 of every 100,000 HIV-positive gay men develop anal cancer, that translates to only six such cases in BC each year. Thus, an HIV-positive gay man's risk for developing anal cancer this year appears to be well below one in 1,000; an HIV-negative gay man's risk is less than one in 2,000.

## Is the natural course of the disease understood?

Available evidence indicates that HIV-positive individuals with high-grade anal dysplasia can carry such cells for prolonged periods without developing invasive anal cancer. Interestingly, many follow-up studies where anal Pap smears are performed on HIV-positive gay men discovered high-grade dysplastic cells in the majority of those tested repeatedly (because two or more Pap tests are better than one at detecting them). There appears to be ample opportunity to detect high-grade anal dysplasia before the development of invasive cancer. And it is reassuring that despite long-term use of potent antiretroviral therapy with longer survival and an extraordinary prevalence of high-grade cellular abnormalities, absolute risks for invasive anal cancer among HIV-positive gay men remain very low.

However, the fact that the vast majority of HIV-positive gay men will ultimately require treatment for high-grade dysplasia indicates vast program costs and personal burdens (physical discomfort and psychological distress) greater than has been previously suggested. BC advocates for routine anal cancer screening will have to grapple with the issue of treating so many HIV-positive gay men to prevent so few cases of cancer, in the absence of proof of treatment efficacy. Moreover, the millions of dollars required for screening is likely to affect delivery of other health care services.

## Is an effective treatment available?

As with many other cancers, treatment of earlier-stage anal cancer brings better outcomes than treatment of late-stage cancers

that have spread. However, during two decades of research, investigators have not shown that treatment of high-grade cells in the anal canal prevents development of anal cancer. More importantly, a San Francisco study that attempted surgical elimination of high-grade cells in 29 HIV-positive men reported a 79 percent recurrence rate, mostly within one year.

The most important current limitation to proposed screening programs for HIV-positive gay men appears to be the lack of an effective treatment for high-grade dysplasia. This is a high priority item for clinical Human Papillomavirus (HPV) research.

## Is a suitable screening test available?

The anal Pap smear is certainly an easy, safe, and relatively inexpensive procedure to perform. However, there is unlikely to be any significant role for anal Pap tests in anal cancer screening programs for HIV-positive gay men since the vast majority of tests conducted from this population show abnormal results; consequently, referrals for further examination and/or biopsy of the anal canal will be needed by practically everyone.

The anal Pap smear provides practically no useful distinction among HIV-positive men who are screened. Screening programs might well begin with high-resolution anoscopy, an expensive procedure that was not intended for such widespread use.

## The future of anal cancer screening

The current conundrum is that screening might well benefit the very few HIV-positive individuals in whom anal cancer is detected early. However, this number appears to be very small compared to the large number screened and subsequently treated for anal dysplasia. In fact, the resulting cost, inconvenience, and discomfort caused by the screening process itself is likely to far outweigh the benefit of such a large-scale program. Of note, the widely cited cost-effectiveness of anal Pap screening is too optimistic, having assumed a high cure rate for high-grade dysplasia and an implausibly high rate of progression from high-grade dysplasia to invasive anal cancer.

At present, available evidence does not support widespread, routine anal cancer screening of HIV-positive gay men however, there is a role for such screening in research contexts. High research priorities include improving our understanding of prevalence and progression rates in more representative samples of HIV-positive men, uniform and systematic follow-up of men already treated for high-grade dysplasia to assess the effectiveness of treatments already rendered, and the clinical evaluation of alternative approaches to eradicate high-grade cells from the anorectal canal.

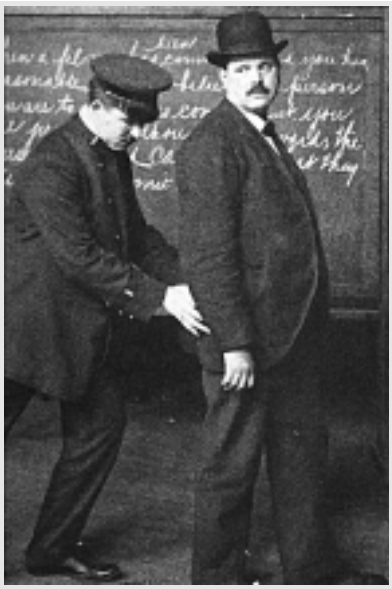
Researchers are now hunting for better molecular markers to identify that tiny percentage of people who will have anal cell abnormalities and who are much more likely to develop invasive anal cancer. An even more attractive approach to anal cancer prevention in HIV-positive gay men is the development of a therapeutic HPV vaccine. The aim would be to stimulate stronger immune control over HPV infection among persons already infected with selected cancer-associated strains of HPV. Such a trial began in the autumn of 2004. Others are in various phases of planning. ⊕

*Dr. Thomas Lampinen is a clinical assistant professor with the University of British Columbia's department of health care & epidemiology and the BC Centre for Excellence in HIV/AIDS.*

# A bum deal

*Diagnosing and treating anal dysplasia*

*by Michael Connidis*



Scientists have established a clear link between infection with subtypes of the human papillomavirus (HPV) and anal dysplasia and anal cancer. The prevalence of HPV infection, the most common of all sexually transmitted diseases (STDs), is highest among HIV-positive individuals, especially among men who have sex with men (MSM). There has also been an increase in the incidence of anal cancer, which began before the HIV epidemic.

How to best screen for, diagnose, and treat tissue abnormalities in the anal canal has emerged as a pressing issue in the standard of care for people living with HIV/AIDS. Another important question is whether early detection and treatment of

*continued on next page*

anal dysplasia reduces the risk of developing invasive anal cancer (see the preceding article for an in-depth evaluation of routine anal Pap smears). A concerted effort is underway to establish an optimal standard of care and treatment for anal dysplasia and anal cancer.

## What's happening here in Vancouver

The Anal Dysplasia Clinic (ADC) at the BC Centre for Excellence in HIV/AIDS (BCCfE) has become one of Canada's leading clinics involved in research into anal dysplasia, as well as in the diagnosis and treatment of the condition. Under the direction of Dr. Robert Taylor, a colorectal surgeon at Mount St. Joseph Hospital, the clinic opened in 2003 at St. Paul's Hospital in downtown Vancouver. People are referred to the clinic when anal Pap smear results are abnormal or when other symptoms are present, such as anal bleeding, itching, or a detectable mass.

If you are referred to the clinic, the first appointment takes approximately one hour. Dr. Taylor is personable and takes time to learn all the pertinent details of each patient's medical history. He makes an effort to put all patients at ease and to make the procedures as comfortable as possible. First, he conducts another anal Pap test to ensure that there is a screening standard. This procedure is very quick and involves inserting a Dacron or polyester tipped swab into the anal canal and gently rotating it, collecting cells from the lining of the canal in the swab fibres. The collected cells are sent for cytology analysis.

The next screening is a digital examination of the anal canal. Since the anal canal has many nerve endings and is very sensitive, Dr. Taylor uses a lubricant containing a topical anesthetic during this procedure. He checks for any surface irregularities, lumps, or hard spots along the anal canal. High resolution anoscopy (HRA) is the best way to visually assess the condition of the tissue lining the anal canal. Next, an anoscope—a clear, smooth plastic cone that is two centimetres in diameter—is gently inserted a few centimeters into the anal canal. Using a binocular microscope, Dr. Taylor examines the anal canal. A mild solution of acetic acid is swabbed over the lining of the anal canal, which turns the tissue a milky white colour; areas with irregular growth appear more opaque. It is also possible to distinguish changes in the blood vessels underlying these abnormal areas; rather than having a branch-like appearance, abnormal blood vessels will exhibit a spotted pattern.

What happens if they find dysplasia?

Any detected areas of dysplasia are first biopsied. The biopsy helps determine the nature of the abnormal tissue and confirms whether or not it is cancerous. The areas of dysplasia are then treated with a topical application of a solution containing 80 percent trichloroacetic acid (TCA); this procedure takes about 10 minutes. Because there is limited room to maneuver, treatment options are similarly limited. Doctors can also perform an electrocautery using a local anesthetic. Laser treatment is another option; however, Vancouver's ADC clinic does not have the equipment to perform this procedure.

The applied TCA chemically burns off the layer of affected tissue, and is replaced by healthy tissue within roughly two weeks. Typically, there is minimal discomfort from this treatment. Additional treatments may be required to eliminate all of the dysplastic tissue. Follow-up anoscopy is routinely conducted to ensure that the treatment has been successful and to screen for new areas of dysplasia. If a non-invasive (*carcinoma in situ*) growth is discovered during this procedure, it is typically removed and sent for analysis.

The ADC conducts screening and treatment for anal dysplasia, as well as some early-stage *carcinoma in situ*; they do not treat anal warts, since this procedure is routinely performed by physicians or through STD clinics. If the ADC clinic observes invasive anal cancers during the screening process, the patient is referred to the BC Cancer Agency. The invasive growth may be biopsied at ADC to confirm the diagnosis, but the treatment is managed through the BC Cancer Agency.

If you are HIV-positive, the odds are likely that you may have some form of HPV-related anal dysplasia. Nevertheless, statistically speaking, the chance that you will develop anal cancer remains very low. Pap screening for anal dysplasia and treatment of affected areas have not been shown to prevent anal cancer. The digital examination is a more effective form of screening to detect palpable anal cancers, with the added benefit, for men, of allowing examination of the prostate gland at the same time. While digital examination of the anal canal is not a preventative approach, it can lead to earlier detection of cancerous growths before they become invasive.

If you have reason to be concerned about anal dysplasia and/or anal cancer, discuss the matter with your doctor and together decide how to most effectively address your concerns. ⊕

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

# Easier Access to Medicinal Marijuana

**Wednesday, June 29th**
**6:00 - 8:30 PM**

**Location:**
**West End Community Centre,**
**870 Denman Street**

**Speaker:**

Kirk Tousaw,
Marijuana Party BC

Rielle Capler,
Compassion Club

**Topics:**

- statistics in BC
- the application procedures
- problems with current laws and the procedures for application
- the proposed amendments to the current laws
- problems faced by HIV + British Columbians
- treatment benefits & side effects

Volunteers will help you apply to legally use medicinal marijuana. Join our efforts to change the laws to make medicinal marijuana more accessible.

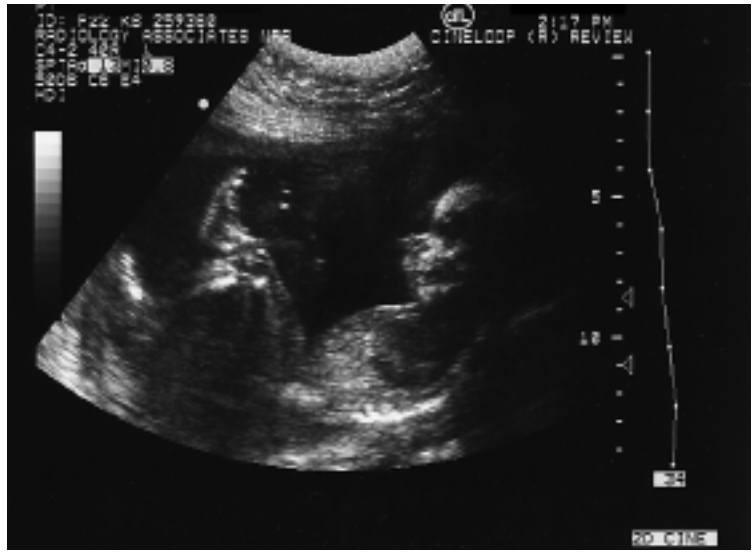
**RSVP:**
**604.646.5338 by June 25th**

Presented by: British Columbia Persons With AIDS Society

# Positively pregnant

*Prevention of mother-to-child-transmission in the age of HAART*

*by Sabine Huss*



Pregnancy in HIV-positive women and the risk of mother-to-child (or vertical) transmission is becoming an increasingly critical issue. HIV infection is spreading quickly among women in Canada and throughout the world. The Joint United Nations Program on HIV/AIDS (UNAIDS) estimates that, this year, 7,000 women worldwide will become infected each day. The Public Health Agency of Canada reports that women represent an increasing proportion of HIV-positive cases nationally; in 2002 women accounted for 25 percent of all positive test results, climbing from about 12 percent in the years between 1985 and 1997. Additionally, nearly 80 percent of the newly infected women are in their prime childbearing years, between the ages of 15 to 39.

In the age of antiretroviral therapy (ART), PWAs are now living longer, and many HIV-positive women are choosing to have children. This requires successful management of these pregnancies and the prevention of mother-to-child transmission.

Without treatment, up to 25 percent of children born to HIV-positive mothers will become infected before or during birth, depending on the mother's viral load and the circumstances of birth. This risk increases by 14 percent if the baby is breastfed—something that doctors in Canada advise against (see article on page 28 of this issue)—though it is often the only option for women in developing countries who lack infant formula or clean water.

With treatment, however, the picture is brighter: of the 106 mother-infant pairs who received full ART in BC between 1994 and 2003, no newborns were infected. By utilizing available treatment options, vertical transmission seems to be preventable.

## Treating HIV-positive mothers-to-be

Treatment of HIV-positive pregnant women focuses on the care of the mother and prevention of transmission to the fetus. Doctors try to use ART that will not limit a woman's future treatment options. (Since there is little long-term research to date, this approach remains unproven. So far, doctors know that even a single dose of nevirapine will lead to resistance in 20 percent of patients, but it is uncertain what this will mean for a woman's future treatment.) Many countries, including Canada, have guidelines for the prevention of vertical transmission, which help healthcare providers offer the best treatment options based on all available information.

**Of the 106 mother-infant pairs who received full ART in BC between 1994 and 2003, no newborns were infected.**

Knowing one's HIV status as early as possible is crucial to preventing vertical transmission. To ensure that all pregnant women have access to HIV testing, Canadian provinces and territories have incorporated the test into prenatal care. Alberta, Newfoundland and Labrador, Nunavut, and the Northwest Territories all include HIV testing in routine prenatal blood tests for pregnant women; if the test is not wanted, the woman must opt out. All other provinces offer testing with informed consent during routine prenatal check-ups; women opt in if they want the test.

Research suggests that pregnancy and childbirth *per se* have no negative influence on the progression from HIV to AIDS, but doctors will always take a woman's treatment history into account to avoid negative consequences that may arise in her future therapy. If treatment is required, a woman should start regardless of her pregnancy; if she is currently taking HIV medications, she should continue to do so, although a change in her regimen may be recommended in order to avoid drugs that are potentially harmful to the fetus. Efavirenz (Sustiva), hydroxyurea (Hydrea), a helping agent

taken with ddI, delavirdine (Rescriptor), and nevirapine (Viramune) are all contraindicated during pregnancy due to high risks for adverse events in either the mother or the fetus. Fusion inhibitors are also not recommended because of insufficient research on their effects during pregnancy.

## Reducing the side effects

Pregnant women need drug regimens with few side effects, because side effects may be especially difficult to manage during pregnancy. In the first trimester, nausea and vomiting need to be monitored since they can cause lower drug levels in the blood, leading to resistance. If a woman's own health does not require ART, she can consider starting a regimen to suppress her viral load and lower the transmission risk. She can stop taking the medications after giving birth. This kind of treatment should start at 18 weeks into the pregnancy to minimize the risk of drug-related effects on the fetus.

All antiretroviral treatment should continue as long as possible throughout labour. During labour, doctors will suggest treatment with zidovudine (AZT), plus a single dose of nevirapine (Viramune) if the woman's viral load is not suppressed or she has not had ART throughout her pregnancy. Most HIV-positive women can give birth through vaginal delivery; doctors may suggest a Caesarean section only if the mother's viral load is not sufficiently suppressed.

In keeping with Canadian guidelines, newborn infants should also receive zidovudine and nevirapine. Nevirapine is only given in cases where either the mother is at high risk for HIV and has not been tested prior to labour, or if she is HIV-positive with a viral load over 1000 copies/mL—even if she is on therapy. The newborn should be in the care of an HIV specialist for ongoing treatment and testing.

In BC, a multidisciplinary team of doctors, pharmacists, nurses, social workers, dietitians, researchers, and other staff and volunteers specialize in the care of HIV-positive women and children at the Oak Tree Clinic in Vancouver. The care of HIV-positive women before, during, and after pregnancy and childbirth is an area that incorporates innovation, hope, and support—being sensitive to women's experience of marginalization while emphasizing their dignity and right to make their own decisions. *Information about Oak Tree Clinic can be found at <www.oaktreeclinic.bc.ca>. The Canadian consensus guidelines for the prevention of vertical transmission can be found on their Web site.* ⊕

*Sabine Huss is the treatment outreach coordinator for the BCPWA Society.*

# Butt out

*Need more reasons to quit smoking? Here you go*

*by Diana Johansen*

Cigarette smoking is the largest preventable cause of death in the US, according to the Centers for Disease Control and Prevention. That grim statistic probably holds true for Canada, too. Tobacco is a toxin that causes illness, debility, and premature death. Yet, smokers have great difficulty quitting, because tobacco dependence has the same characteristics as any drug addiction: nicotine is psychoactive, tolerance develops with use, and people experience withdrawal symptoms when they stop.

When a person tries to quit and then lights up again, nicotine enters the brain within seconds, connects with nicotine receptors, and alters the brain chemistry. The brain releases neurotransmitters such as dopamine, causing feelings of well-being and relief from withdrawal symptoms. Concentration and memory sharpens, anxiety decreases, and appetite is suppressed.

Most smokers make several attempts to quit before they finally succeed. The on-again, off-again cycle makes some individuals reluctant to try to quit again; but considering the health risks associated with smoking, people trying to give up the habit should receive all the encouragement and support they need.

Lung cancer is the leading cause of death from cancer for men and women, and most people who die from lung cancer are cigarette smokers. There is a causal relationship between lung cancer and both the amount of cigarettes smoked and the number of years as a smoker. People who smoke are also more likely to develop cancer of the mouth, throat, esophagus, pancreas, bladder, kidney, and cervix. The good news is cancer risks decrease after quitting smoking and decreases further over the course of additional smoke-free years.

## The adverse effects of smoking for PWAs

Smoking is one of the major risk factors for heart disease in both men and women, and smokers who suffer heart attacks have a lower survival rate than non-smokers. Moreover, PWAs who smoke may be at even greater risk. Elevated cholesterol and triglycerides, very common problems with current antiretroviral medications, are also major risk factors for heart disease; there have been reports of heart attacks among persons on antiretrovirals. The combination of these potent risk factors could dramatically increase the risk of heart disease.

Smoking has other negative effects for HIV-positive persons. Tobacco affects the immune system and may hasten HIV disease

progression to AIDS. HIV-positive smokers are more likely to develop respiratory infections, especially Pneumocystis carinii pneumonia (PCP) and tuberculosis (TB; see article on page 19). Smoking decreases the local immunity in the lungs so that there is less protection against respiratory infections, faster decline in CD4 cells after infection with HIV, and more active viral replication in the lungs of smokers. One study also suggested that antiretroviral therapy might be less effective for people who smoke daily.

Emphysema—a disease where lung tissue is destroyed, making it increasingly difficult to breathe—progresses more rapidly in HIV-positive individuals. Almost everyone who dies from emphysema is or has been a smoker. Other lung disorders such as asthma and chronic obstructive pulmonary disease also occur more often in smokers.

Smokers are also more susceptible to a variety of oral diseases, and HIV-positive smokers in particular are more likely to develop oral candidiasis, or thrush. Tobacco smoke is also associated with acute and chronic rhinitis and increased rates of nasal and sinus cancer.

**Tobacco affects the immune system and may hasten HIV disease progression to AIDS.**

Smoking and HIV infection both increase oxidative stress and the production of free radicals. Oxidative stress is thought to be a contributing factor in aging, disease processes, and viral replication. People living with HIV may experience more negative consequences of oxidative stress because they have low levels of protective antioxidants in the body. Smoking also depletes antioxidant levels in the blood, especially vitamin C.

Cigarettes decrease appetite, making it harder to overcome loss of appetite caused by illness or side effects of medications. One large study showed that smokers had a lower intake of beta-carotene, vitamins C, E, A, E, B12, and B6, thiamine, folic acid, iron, and potassium. Many of these nutrients are required for healthy immune function and antioxidant protection. Moreover, smokers tend to weigh less than non-smokers and usually gain weight when they quit, an important consideration for those who need to gain weight.

## Other general adverse effects

Among other negative effects, cigarette smoking is associated with peptic ulcer disease; smokers' ulcers heal at a slower rate because of a decreased ability to fabricate new cells and mucus in the stomach lining, both of which are necessary for healing. Cigarette smoking also aggravates diarrhea, and can cause reflux (heartburn) and delayed gastric emptying, meaning that food stays in the stomach longer than usual.

Cigarette smoking is also associated with lower bone mineral density and an increased fracture rate, especially in men and post-menopausal women. This effect is a result of different mechanisms, including a direct toxic effect on the bone, decreased serum vitamin D levels, and altered hormonal metabolism. Smokers also tend to have lower body weight and be less active which also influence bone health.

While smoking may give the sensation of relieving stress, tobacco actually increases stress levels overall, possibly due to its effects on the endocrine system and altered levels of various regulatory hormones. Pregnant women who smoke tobacco have higher rates of miscarriage, stillbirth, premature birth, and pregnancy complications. Finally, smokers in drug treatment programs are more likely to crave cocaine and heroin than non-smokers.

## The benefits of quitting

Aside from the obvious health benefits and potentially longer life, think of the money you would save, which can add up to as much as $200 a month! Food tastes better, your appetite improves, and you no longer have to go outside in cold, rainy weather to smoke. Skin doesn't wrinkle or age as quickly, and you can say goodbye to nicotine-stained fingers.

Quitting smoking is difficult because of its highly addictive qualities. You need to embrace a certain readiness for change, and you need an action plan. You are more likely to succeed if you use appropriate aids and supports. Some people can quit cold turkey or rely solely on a support group or buddy system, but many need nicotine-replacement therapy. In BC, these therapies are not covered by PharmaCare. However, you can use the money you save from not purchasing cigarettes to pay for the smoking cessation aids.

Nicotine gum is good for a first line of therapy if you use it properly. You should take it with nothing else except water; chew it slowly and keep in your mouth long enough to release all the nicotine. People usually need one piece every one or two hours, at least during the first few months after quitting.

Among other therapies, people generally use the nicotine patch for about eight weeks, although this depends on the degree of tobacco addiction. Bupropion, also know as Zyban or Wellbutrin, is a medication used during the quitting process as well as for long-term maintenance; it is also prescribed as an antidepressant, in which case it is covered by PharmaCare. If you are considering nicotine-replacement therapy, talk to your doctor about the best and safest option.

The bottom line is that smoking is bad for you. If you have ever considered quitting, now is a good time. If you have tried and failed, keep trying—you are bound to succeed eventually. If you need assistance, find the right tool for you with the help of your doctor. ⊕

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

# The formula for feeding

*Infant feeding for mothers with HIV*

*by Sarah Fielden*

Despite health promotion messages that encourage breastfeeding—including messages like "breast is best"—breastfeeding is not suitable for all women. When a mother has HIV, she has a high risk of transmitting the virus to her newborn through her breast milk. Therefore, in Canada and around the world, different strategies are recommended for feeding infants of HIV-positive mothers. In Canada, the best two feeding options available for HIV-positive parents with newborns are banked human milk and commercial formulas.

Research has shown that breast milk is the most complete form of nutrition for infants, providing increased protection against illnesses such as allergies and infections. The good news is that there is a way for babies of HIV-infected parents to get nourishment from breast milk. The BC Women's Milk Bank operates out of the Children's and Women's Health Centre of BC in Vancouver and provides human breast milk to sick and premature babies, as well as to some infants of adoptive or HIV-infected parents.

For those who cannot use or access breast milk, commercially-sold formulas are the best available substitute until infants reach the age of nine to 12 months, according to Health Canada, the Canadian Pediatric Society, and Dietitians of Canada in its position papers, *Nutrition for Healthy Term Infants and Nutrition for a Healthy Pregnancy*.

Recommendations for formula feeding include:

- cow's milk-based, iron-fortified formulas
- soy-based formulas for infants who cannot consume dairy-based products due to health, cultural, or religious reasons
- whey or casein-hydrolysate formulas for infants with milk allergies
- lactose-free, cow's milk-based formulas for infants with lactose intolerance
- specialty formulas only for infants with specific medical conditions such as premature birth
- pasteurized whole cow's milk, which can be introduced for infants at nine to 12 months.

Powder formula should be mixed with the amount of water as specified in the instructions; do *not* water the formula down. Substitutes that are not recommended in the first two years of life include skimmed milk, soy and other vegetarian beverages, and homemade formulas.

Although many other fluids will not harm a baby directly, they can limit an infant's nutrition by filling them up so they are not hungry for breast milk or formula. For example, aside from calories, fruit juices do not give additional nutrients to a baby and may also cause diarrhea and contribute to cavities. Water that can be given to infants to drink or to mix with formula must be municipally treated, non-carbonated, or commercially-sold underground spring water.

Recognizing that most parents want to feed their babies well, certain social factors contribute to a family's ability to access and choose good nutrition for all of its members. Infant formulas and banked breast milk are very expensive and can cost over $1,000 per year. Fortunately, if the parent is receiving social assistance, the Ministry of Health should cover the cost of formula. If not, additional support is available through social workers and dietitians at the Oak Tree Clinic for women and families with HIV and the Downtown Eastside's Sheway project, both located in Vancouver.

In terms of other social factors, poverty, literacy, language, family health, and isolation are just some of the issues facing many HIV-positive parents. It is not only a lack of knowledge or information that impacts the health of infants born to parents living with HIV, but also limited financial resources and support from government, institutions, and communities. Being able to provide a child with the best possible nutrition and health is a human right, and families deserve to be empowered and enabled to make the most informed choices about infant feeding.

Consult with a registered dietitian to help determine the best feeding options for you and your infant, how to access services, and when and how to introduce solid foods. ⊕

*Sarah Fielden is a student in the Individual Interdisciplinary Studies Graduate Program with the Institute of Health Promotion Research at UBC. She is also a Michael Smith Foundation for Health Research graduate trainee.*

# 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.

# Mixed messages about milk thistle

*by Kristen Yarker*

**Question:**
**I am HIV-positive and co-infected with hepatitis C. I've heard that milk thistle is good for the liver. Should I take it?**

**Answer:**
First, I want to congratulate you for consulting a medical practitioner before starting an herbal product. When considering complementary therapies, particularly combining powerful modern drugs with powerful traditional medicines, it is important to keep your healthcare team—including nurses, doctors, dietitians, and pharmacists—in the loop. Most people don't. In a recent US study involving 118 PWAs, 67 percent of participants taking herbal products had not informed their doctors. Although traditional medicines come from natural sources, they can be very potent. Way back when, people used herbal remedies with the utmost respect; nowadays, many people take herbal products without giving them a second thought.

People have used milk thistle since ancient times to treat and protect the liver. The active ingredient in milk thistle is silymarin. Some commercial tablets claim to contain up to 80 percent silymarin. Typically, people take 100 – 200mg, up to three times a day, but some brands of milk thistle recommend up to 500mg three times per day. Few side effects have been noted when individuals are not taking other medications (either modern or traditional).

Studies conducted to date reveal mixed results on silymarin (milk thistle) for people living with hepatitis C. The herb does seem to improve some of the markers of liver activity found in the blood. However, it is not clear whether silymarin slows or reverses the damage done to the liver by hepatitis C or whether or not it improves people's quality of life.

What is most uncertain is silymarin's safety for individuals co-infected with HIV and hepatitis C. People with HIV/AIDS have not been included in any of the studies examining how silymarin affects hepatitis C. Furthermore, we know that the liver plays a key role in metabolizing medications. If silymarin affects the liver, it raises questions about its effect on the liver's interaction with medications.

Silymarin also seems to be active in other areas of the body involved in medication metabolism, such as the intestine. Biochemistry enthusiasts may be interested in knowing that silymarin potentially interacts with the enzyme cytochrome P450 and the protein P-glycoprotein, both of which are involved in the body's use of medications such as antiretrovirals. Scientists are just beginning to conduct research into this possible interaction.

The bottom line is that not enough evidence supports the benefits of milk thistle for hepatitis C. There is no evidence that milk thistle is safe when combined with highly active antiretroviral therapy for people co-infected with HIV and hepatitis C. If you want to try it anyway, be sure to notify everyone on your healthcare team regardless of how you think they might respond. Once informed about your use of the herb, they can watch out for signs of medication interactions. ⊕

*Kristen Yarker, BASc, MSc, RDN, is a nutritionist/dietitian working with the ADAPT (Aboriginal Diabetes Awareness, Prevention, and Teaching) Program at Vancouver Native Health Society.*

# Giving women sex workers a voice

*Steps towards HIV prevention, treatment, and care in the Downtown Eastside*

*by Kate Shannon and Vicki Bright*

Women engaged in survival sex work in Vancouver's Downtown Eastside (DTES) face multiple vulnerabilities, including violence, entrenched poverty, mental illness, and high-risk sexual and drug-related harms. The social contexts of these women's lives create multiple barriers that place them at high risk for HIV infection. Stigma is also a major barrier faced by HIV-positive sex workers, forcing them to conceal their status. In addition, for many of these women, essential needs for food and shelter take priority over health care, including HIV. The illegal nature of sex work in Canada increasingly pushes street-entrenched women to the outskirts of society, limiting their access to and uptake of supportive health services. Despite significant advances in once-daily antiretroviral therapy (ART), survival sex workers have remained largely outside of HIV treatment and care.

The Maka Initiative is a recently established collaboration between Women's Information and Safe House (WISH) Drop-In Centre and the BC Centre for Excellence in HIV/AIDS (BCCfE). In operation since 1987, WISH provides hot meals, showers, personal hygiene care, and a point of safety and respite for women sex workers. The BCCfE, established in 1992, is a state-of-the-art HIV/AIDS research and treatment facility located at St. Paul's Hospital in Vancouver. Maka was created to engage all levels of the community in addressing the barriers faced by female sex workers and seeks to give women a voice in developing an HIV prevention, care, and treatment program.

Between September and December 2004, a baseline needs assessment was conducted among WISH participants through peer-administered interviews and supportive HIV testing. HIV prevalence among participants was 26 percent and hepatitis C prevalence was 71 percent. The average age of initiation into sex work was 19 years. The majority of study participants reported having clients from outside the DTES; many women worked along strolls in other parts of Vancouver. All women indicated daily struggles with addiction, particularly crack cocaine smoking. According to the women, drug use with clients occurred frequently. Women also cited low condom use with intimate partners, many of whom were injection drug users. Inconsistent condom use with clients was largely related to offers of more money to not use condoms and the power dynamics of pimps and dates in safer sex negotiations.

Among ART options, women responded favourably to medication distribution through women's-only clinics and services such as street delivery; they responded less favourably to current ART distribution models. Women in this community have consistently underutilized conventional primary care services, due to concerns about disclosing their HIV status as well as fears about encountering clients, bad dates, and previous aggressors.

Health and social programs targeting street-based sex workers need to develop more tangible programs that reach women where they are, recognizing the unique vulnerabilities and transient nature of this population. Perceptions of women sex workers as vectors of disease need to shift, and we need to take a closer look at the social context of women's lives that place them at high risk for HIV infection. Pairing HIV prevention and health care will help remove some of the existing barriers surrounding stigma, privacy, and disclosure.

The next phase of Maka includes community-based research, as well as a peer prevention program and wellness nights on related issues such as violence, harm reduction, safe sex negotiation, and emotional and mental well-being. The hope is that through innovative, participatory research, this initiative will allow women sex workers to play active roles in the development of a relevant and sustainable model for HIV prevention, treatment, and care. ⊕

*Kate Shannon (l) is a researcher with the British Columbia Centre for Excellence in HIV/AIDS in Vancouver. Vicki Bright (r) is a case manager with AIDS Vancouver.*

# Contributions

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British Columbia Persons With AIDS Society

# Rays of hope in Kenya

*The scale-up of antiretrovirals in Africa*

*by Kath Webster*

In December 2003, the World Health Organization (WHO) and the Joint United Nations Program on HIV/AIDS (UNAIDS) announced the "3X5" initiative. The goal of the initiative is to provide guidelines and support the scale-up of antiretroviral (ARV) treatment programs in developing countries: the "3" represents the target of three million people and the "5" represents the target year of 2005. If three million people in the identified countries begin taking ARVs by the end of this year, the 3X5 initiative will be deemed a success. It's important to note that this is only half the number of those who are currently in need of treatment.

By the end of last year, approximately 700,000 people in developing countries were receiving ARVs, a number which more than doubled in less than a year. The WHO has reported that, at this rate, the 3X5 target is realistically attainable.

Médecins Sans Frontières (MSF, or Doctors without Borders) doesn't agree. In a statement released in response to a January 2005 3X5 progress report issued by WHO, the MSF said: "Treatment expansion is moving at a snail's pace. From the perspective of a medical humanitarian organization working in resource-poor countries to treat people with AIDS, the global picture is bleak. Instead of celebrating, the WHO, UNAIDS, and other organizations should be sounding the alarm."

Regardless of the pace, much more funding is needed from affluent countries so that the scale-up and flow of ARVs continues without interruption.

The greatest need for treatment remains in sub-Saharan Africa, where just over ten percent of the world's population lives but where more than 60 percent of all people with HIV reside. In many of these countries, the prevalence of HIV in the adult population is hovering near 30 percent and life expectancy at birth has dropped below 40 years of age. AIDS is threatening to rob Africa of its future.

In response to the severity of the problem, many governments—supported to varying degrees by non-governmental organizations, faith-based organizations, and other global funding agencies—are working towards the 3X5 goal. As we sit sipping our non-fat soy lattes, they are undertaking the monumental task of ARV rollout.

## Barriers and achievements in Kenya

Suzy Coulter, a nurse with the BC Centre for Excellence in HIV who works in the Downtown Eastside, recently returned from Kisumu, Kenya after a four month volunteer placement with a joint US Center for Disease Control and Government of Kenya (GOK) HIV treatment program. She witnessed the challenges and successes of ARV scale-up in Kenya.

Kisumu is in Nyanza province, where the adult HIV prevalence rate is estimated to be the highest in the country at 15 percent (prevalence rates are based on estimates, not confirmed cases). To have a confirmed HIV-positive status is the first challenge that must be overcome in order for people to access necessary treatments. Although Coulter saw several established voluntary counselling and testing centres, where skilled staff provided free rapid HIV tests with mandatory pre- and post-test counselling, the existing services were a drop in the bucket compared to the existing need. According to GOK estimates, four out of five people infected with HIV in Kenya have not been tested.

Coulter attributes this statistic to stigma. "Fear and stigma are completely immobilizing people, preventing them from getting tested," she says. "People with HIV are often seen as immoral and, particularly in rural areas, stigma is perpetuated by the

belief that HIV is witchcraft or a curse." More education and awareness are needed to combat this overwhelming stigma. Reluctance to be tested may also stem from a sense of powerlessness and despair. There is hope that more people will be motivated to be tested now that treatments are becoming available.

## The emergence of peer-run support clubs

Psychosocial support is becoming more widely available to those who test HIV-positive. In Kisumu, post-test clubs run by people with HIV are emerging in both the city and the outlying slums. The groups support both people infected and affected by HIV. Activities include one-on-one peer counselling, public speaking, home-based care visits, and fundraising to assist with funeral costs. This valuable support work is crucial to empowering people with HIV and counteracting the stigma within the community. Post-test clubs are also beginning to play a role in promoting and supporting treatment adherence strategies among members. These clubs have virtually no financial resources and rely on fees from their own members to keep the programs running. Unfortunately, these fees prevent some HIV-positive people from accessing services.

**"Future generations will judge our era in large part by our response to the AIDS epidemic."**

— Dr. Lee Jong-wook, WHO director-general

In Kenya, poverty is a huge barrier to treatment. Although drug prices have dropped significantly, people who receive treatment in government programs must pay for medication out of their own pockets; as a result, treatment programs are cost prohibitive for many. In GOK programs, a month's supply of first-line treatment costs about $10 CAD per month. People must also pay for baseline tests such as CD4 counts, chest x-rays, and liver function tests (viral load tests are not widely available due to lack of technology).

Treating opportunistic infections (OIs) poses another challenge. Many people have active infections, including malaria, tuberculosis, esophageal candidiasis, and cryptococcal meningitis. But the required diagnostic tests and treatments are not easily affordable to the average Kenyan. Transportation to and from clinics adds to these costs. Most Kenyans live below the poverty line on less than $1 per day and can barely put food on the table. Also, many people now have the additional financial burden of caring for children, from their extended families, orphaned by AIDS.

In spite of all the challenges, the largest HIV outpatient clinic in Nyanza province is now treating over 400 people with ARVs. In the few months Coulter spent in the area, six new outpatient clinics opened throughout Nyanza province with well trained, dedicated staff ready to treat more people.

A drug rollout of this magnitude is unprecedented. Commitment and partnership is needed on every level: from community to national to international. The Global Fund to Fight AIDS, Tuberculosis, and Malaria, which supports programs in 180 countries, has a shortfall of billions of dollars and needs long-term multi-year pledges from donors.

## The next challenges

So far, the focus of the global ARV scale-up has been on first-line therapies. Early studies have shown that adherence rates in Africa look favourable and are comparable to Western countries. However, unique and challenging adherence barriers will undoubtedly surface and will need to be addressed.

The next challenge will be to make second-line therapies available for those who either cannot tolerate or experience treatment failure on their first combination. Making these medications available will pose a problem, since second-line therapies are vastly more expensive than first-line generics. Also, children have been a neglected population in the scale-up of ARVs. There are few adapted and affordable pediatric formulations for the approximately two million children living with HIV in the developing world. This situation needs to change.

Effectively distributing ARVs to such a large number of people in resource-poor settings is a daunting task. In a December 2004 interview, Stephen Lewis, the UN Special Envoy for HIV/AIDS, laid out some of the key components to a successful rollout of ARVs: an extensive program of voluntary testing and counselling; a constant and reliable flow of ARVs; facilities and capacity to sustain treatment, including an adequate number of trained healthcare professionals; and community-based health care in rural areas.

Over the next year, it will be important to observe the progress of the 3X5 initiative. We must pay attention to the shortfalls and mobilize our privileged communities and resource-rich governments to support, in whatever ways we can, those people living with HIV in unfathomably challenging circumstances. ⊕

*Kath Webster is a researcher and treatment information counsellor for the treatment information program at the BCPWA Society.*

**What can you do to support ARV programs in Africa?**

***Please donate to Médecins Sans Frontières at <www.msf.ca>***

***or the Stephen Lewis Foundation at <www.stephenlewisfoundation.org>***

# Heroin trial examines impact on HIV infections

*by Jim Boothroyd*

In February, Vancouver researchers launched North America's first study of a promising new treatment for people with chronic dependence on heroin who have not benefitted from conventional therapies. If successful, the therapy could lead to programs that would reduce HIV and other disease infection rates among this highly vulnerable population.

The North American Opiate Medication Initiative (NAOMI) is a two-year clinical trial of heroin-assisted therapy that will enroll 157 chronic heroin users in Vancouver. Researchers in Montreal and Toronto will join the study later this year, bringing total recruitment to 470 participants; half will be randomly allocated to the experimental injection opiate group, while the control group receives the best conventional treatment, oral methadone.

Individuals in the experimental group will come to a clinic up to three times daily to inject individually-tailored doses of diacetylmorphine (heroin) manufactured by a European pharmaceutical company. After 12 months, they will begin a three-month transition to either oral methadone or abstinence programs.

The primary aim of NAOMI is to measure how heroin-assisted therapy compares with methadone maintenance therapy in attracting and retaining people over a 12 month period. The study will also assess whether the experimental treatment improves the health and quality of life of users, and reduces criminal activity.

The hypothesis is that by liberating chronic heroin users from the daily routine of committing crimes, sex work, and other risky behaviours used to obtain drugs, they will be able to stabilize their addictions and get help to improve their lives. Reducing drug-related prostitution and sharing dirty needles also means lowering the risks of infection by HIV and other viruses.

NAOMI participants will have access to social workers, addiction counsellors, nurses, and doctors at the study clinic. European evidence suggests they will take advantage of these services. A study of nearly 2,000 heroin users in Switzerland in the 1990s showed that heroin-assisted therapy helped participants reduce their dependence on the drug, avoid health risks, and improve the quality of their lives; their criminal activity also plummeted.

A five year follow-up study also found that one-third of the Swiss participants remained on heroin, while two-thirds had been "discharged." Of those discharged, about 60 percent were in methadone therapy and 22 percent had quit heroin altogether. In response to these results, the Swiss electorate have twice voted to make heroin-maintenance therapy a permanent program. The Dutch parliament also voted in favour of this novel treatment after their own studies confirmed the Swiss findings.

Further research is needed in Canada, in part because the nature of addictions varies from city to city and treatments must reflect these variances. For example, in Amsterdam most users prefer to smoke heroin while in Vancouver, injecting is preferred.

*Vancouver site of the North American Opiate Medication Initiative (NAOMI)*

For scientific and political reasons, the NAOMI study has very restrictive entry criteria and only a small fraction of those who seek to enroll will be eligible. Vancouver's participants, for example, must meet the following general criteria:

- have lived in the downtown community for an extended period of time
- have depended on heroin for at least five years
- show evidence of daily injections in the last year
- have tried methadone more than once
- are 25 years of age or older.

Still, the study is enrolling steadily and staff expect to meet their enrollment target some time between the end of September and the end of December. The results will not be published for at least two years.

*For a video, documents, and other information about NAOMI, visit the Web site at <www.naomistudy.ca>. To enroll, call the recruitment line at 604.685.6642 or toll-free at 1.800.685.6642 on Tuesdays from 11:00AM – 2:00PM or Thursdays from 5:00PM – 8:00PM.* ⊕

*Jim Boothroyd is communications manager for the NAOMI study and communications manager for the Canadian HIV Trials Network in Vancouver.*

# Hope and caution for STIs

*by Maia Joseph*

For PWAs dreaming of a holiday from the burden of anti-HIV therapy, new study results on structured treatment interruptions (STIs) offer some hope. However, the findings also suggest that breaks may be too risky in cases involving more advanced HIV.

Investigators presented results from six clinical trials at the Conference on Retroviruses and Opportunistic Infections (CROI) in late February. Three trials looked at STIs for people with a history of successful antiretroviral therapy; the other three studies examined STIs before making a switch in therapy.

First, the good news: results indicate that an interruption of effective therapy—that is, therapy in which the CD4 count has improved—is safe, though the optimal length of the interruption may vary from one person to another. The studies suggest that initiating antiretroviral therapy (ART) earlier, when CD4s are higher, could allow for a longer interruption. This strategy forms the basis of some newer clinical studies that examine the effect of stopping therapy when CD4s rise above a certain threshold, and resuming therapy once CD4s decline.

Less positive results emerged from studies of STIs for people experiencing virologic failure and requiring a switch in therapy. Since levels of treatment-resistant virus tend to decrease during a treatment interruption, investigators hypothesized that an STI might have greater benefits than an immediate switch to a new drug regimen for PWAs who are not responding to treatment.

Three studies found, however, that an STI did not benefit such individuals. In a trial sponsored by the Canadian HIV Trials Network, Dr. Sharon Walmsley of Toronto examined a 12-week interruption in people who had experienced virologic failure on first- and second-line ART, but who still had options for constructing a salvage regimen. The study allowed for the use of prophylaxis for opportunistic infections. Study results showed no improved outcomes following a 12-week STI. The proportion of participants able to suppress viral load was the same in both the STI and control groups, but participants in the STI group exhibited lower CD4 counts at 60 weeks.

Another study, which looked at a four-month STI in people with multi-drug resistant HIV and lower CD4 counts, also found what investigators described as a "significantly unfavourable CD4 response," suggesting that a treatment interruption poses a potential risk for this population.

"These studies of people experiencing virologic failure do not support a short-term treatment interruption before salvage therapy," concludes Dr. Walmsley. "However, it does appear that a short-term interruption could be safe for people with high CD4 counts, as long as opportunistic infection prophylaxis is used where appropriate. Still, the goals of [treatment] interruption need to be considered on a case-by-case basis, and individuals should be followed closely by their physicians."

*For more information about study results presented at CROI, visit www.retroconference.org. See poster abstracts #579-585 for the results discussed above.* ⊕

*Maia Joseph is the communications project coordinator and editor 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
Medical Arts Health Research Group, Kelowna

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

**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

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 candidiasis oral

*por José Gutiérrez*

La candidiasis oral, llamada también "afta", es una infección por hongos que se presenta en la lengua y/o la garganta. La candidiasis de la garganta es llamada candidiasis esofágica. Si bien la candidiasis oral puede producirse a veces sin la presencia de síntomas, los más habituales son molestia y ardor en la lengua y la garganta y una alteración en el sentido del gusto (que a menudo se describe como "mal sabor"). También son frecuentes unas placas blancas o amarillentas en la lengua y la garganta, que pueden ser eliminadas con medicamentos. Pueden estar acompañadas de rajaduras, enrojecimiento, dolor e inflamación en las comisuras de la boca. Un caso crónico puede incluir llagas bucales.

La candidiasis oral muy rara vez ocurre si el recuento de células CD4 se encuentra por encima de 500. Los episodios son más comunes a medida que el recuento se acerca a 100 . La candidiasis oral puede ser más difícil de tratar cuando el recuento de células CD4 cae por debajo de 50.

La candidiasis oral es causada por un hongo llamado *Cándida*. Este hongo siempre está presente en pequeñas cantidades en la boca, la vagina, el canal digestivo y la piel. Entre las personas sanas, las bacterias "amistosas" y el sistema inmunológico impiden que el hongo produzca una infección. No obstante, cuando el sistema inmunológico se encuentra debilitado o deteriorado, como puede ser el caso con la infección del VIH, es más factible que la *Cándida* se desarrolle y produzca la enfermedad.

Ciertos medicamentos pueden alterar los organismos naturales que se encuentran en la boca, lo cual puede entonces impulsar el crecimiento de la *Cándida*. Entre ellos está el uso extendido de antibióticos, esteroides y anticonceptivos orales con un alto contenido de estrógeno. Otros factores que pueden provocar la candidiasis incluyen la diabetes, el embarazo, deficiencias de hierro, ácido fólico, vitamina B12 o zinc y el uso de antihistamínicos. Diversos factores que pueden debilitar el sistema inmunológico—desde la quimioterapia para tratar el cáncer hasta el estrés y la depresión—también pueden causar la candidiasis.

Las infecciones orales generalmente son diagnosticadas por la apariencia y los síntomas. El diagnóstico se puede confirmar raspando una lesión y examinándola con microscopio. Generalmente se llevan a cabo otros exámenes de laboratorio si la infección no desaparece después de un tratamiento con medicamentos.

La infección por *Cándida* de la garganta (esófago) es una condición grave. Se encuentra en la lista de las dolencias que caracterizan al SIDA, y afecta a cerca del 20% de las personas con SIDA. La cándida de la garganta frecuentemente se presenta simultáneamente con la candidiasis oral. Los síntomas incluyen dolor en el pecho, náuseas y dolor o dificultad para tragar o comer, por lo cual la persona no siente deseos de comer.

Generalmente, si los síntomas no mejoran con el tratamiento, o se presentan problemas para tragar sin que exista candidiasis oral, se practica una endoscopia. Se trata de un procedimiento en el que se usa un tubo pequeño para examinar el esófago y buscar señales de la infección.

Un tratamiento tópico es el que actúa solamente en el área en la cual se aplica; es por regla general la primera opción para la candidiasis oral y usualmente funciona en los casos benignos y moderados. Los enjuagues bucales generalmente son menos efectivos que las pastillas ya que están en contacto con la boca sólo durante un breve espacio de tiempo. Sin embargo pueden resultar la mejor opción para personas que tengan la boca muy adolorida y muy seca.

En cualquier caso, es muy importante informase con su doctor y seguir el tratamiento apropiado que él o ella le indique. ⊕

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

# Volunteering at BCPWA

## Profile of a volunteer: Deena Paquette

**Whenever Deena is around, the reception area sparkles and shines. She keeps our workspace in perfect order, and answers every question with a smile.**

Mike Verburgt,
*Coordinator of Member Services*

**Volunteer history**
I had never volunteered before coming to BCPWA. Now, I volunteer at the information desk.

**Started at BCPWA?**
September, 2004

**Why pick BCPWA?**
One of my neighbours, a member volunteer at BCPWA, encouraged me to volunteer with him. At the time, I knew nothing about BCPWA and the work they do.

**Why have you stayed?**
For the laughter: it's good for the soul.

**Rating BCPWA**
I would give it a nine out of ten. I love the people I work with, the diversity, and the job I do at the information desk.

**Strongest point**
Commitment. Being on time and doing a good job is crucial to volunteering. Volunteering is a job, we have to be as professional as paid staff.

**Favourite memory**
The day one of our members—a favorite of mine—found housing after living on the streets for the last 12 months.

**Future vision of BCPWA**
More funding—so we can help more people in need.

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## *Interested in writing?*

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

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

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

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

# where to find help

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

### BC Persons With AIDS Society
1107 Seymour St, Vancouver BC V6B 5S8
604.893.2200 or 1.800.994.2437
**e** info@bcpwa.org ***www***.bcpwa.org

### A Loving Spoonful
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.***

## Upcoming BCPWA Society Board Meetings:

| Date | Time | Location | Reports to be presented |
|---|---|---|---|
| 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 |
| June 22, 2005 | 1:00PM | Board Room | Executive Committee — Financial Statements / May |
| July 6, 2005 | 1:00PM | Board Room | Written Executive Director Report — Standing Committees Director of Support Services |
| July 20, 2005 | 1:00PM | Board Room | Quarterly Department Reports |
| August 3, 2005 | 1:00PM | Board Room | Written Executive Director Report — Executive Committee Financial Statements / June — Director of Communictions&Education |

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: Carole Lunny
t 604.646.5376 e carolel@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**
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

## Yes! I want to receive living ⊕ magazine

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Province/State _____ Country_____ Postal/Zip Code_____

Phone _____ E-mail _____

**I have enclosed my cheque of $_____ for *living* ⊕**

❍ $25 within Canada ❍ $50 (Canadian $) International
please send _____ subscriptions

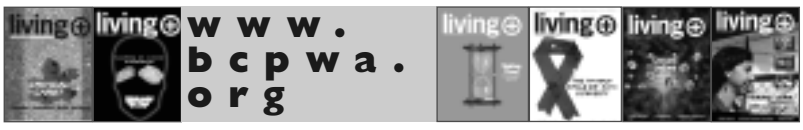
❍ BC ASOs & Healthcare providers by donation:
(Minimum $6 per annual subscription (please send _____ subscription(s))

❍ Please send BCPWA Membership form (membership includes free subscription)

❍ Enclosed is my donation of $_____ for *living* ⊕

** Annual subscription includes 6 issues*

***Cheque payable to BCPWA***




**living ⊕**

**1107 Seymour Street**
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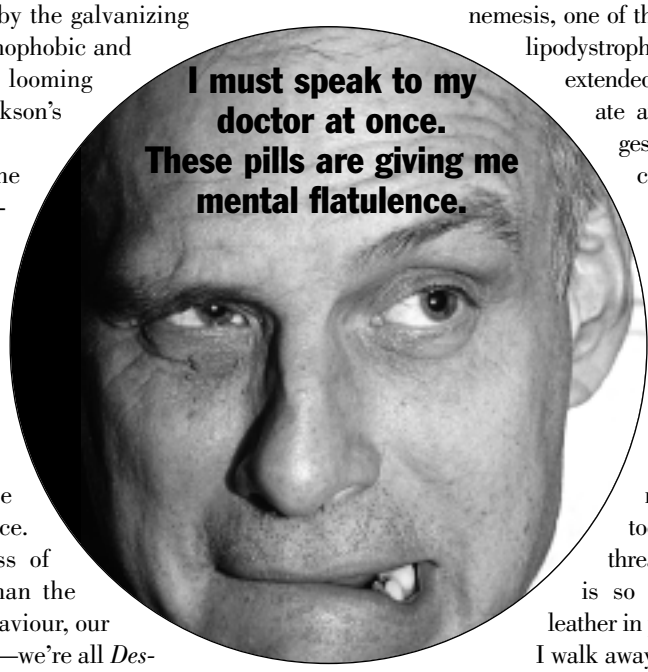
# Queer of queer fundamentalism

*Or, the perils of a bad night's sleep*

*by Francisco Ibáñez-Carrasco*

I wake up. In my twentieth year of living with HIV, I should be able to consume high-tech drugs that don't give me nightmares. They said I would conjure up the most tantric and sexual dreams on this drug—ever. Instead, I have hallucinated flickers of 100 Huntley Street, a gagging Terry Schiavo, a rabid protester screaming "no gay marriage" and wagging a bottle of Coca-Cola, Sue Johansen delivering pithy sexual advice to really dumb Oshawa teenagers blown by the galvanizing finger of a misogynist, and a homophobic and anti-communist church leader looming from a balcony with Michael Jackson's veiled baby swinging over it.

I sense a pattern here. The United States has redefined terrorism for everyone: even Canadians carrying knitting needles on planes or HAART medication across the US border are potential enemies. What an unpleasant, febrile, digital collage of the noticeable rise in fundamentalism everywhere. Wow! I must speak to my doctor at once. These pills are giving me mental flatulence.




It's the unbearable lightness of being. We are less valuable than the aggregate data about us: our behaviour, our shopping and TV viewing habits—we're all *Desperate Housewives*—our biological functions, the number of unprotected sexual encounters, or number of adverse events to medication. Have we become a virtual chimera, a mere accumulation of bodily quirks and electronic impulses? Religious fundamentalists gain ground because they seem to offer solid facts and soulful actions; they drive a hard bargain and do not trade in flimsy representations, harm reductions, or libertine prevention messages.

I am speaking in tongues. I splash my face with chilled water and check myself in the mirror. No blemishes. The curse and condemnation of fundamentalists has not manifested yet. No stigmata in sight. I get dressed. No work today again, courtesy of permanent disability, although those insurance company investigators must have me bugged, they know I get testosterone and I can work out and party like a little Duracell rabbit. They are on to me and my busy volunteer schedule. In time, they'll accuse me of being cured, a lazy Lazarus. I should be working.

By the time I reach the Starbucks at Davie and Thurlow, the metropolitan street kerfuffle has dissipated my anxious hangover. I am looking good, feeling fine. A dose of caffeine will quiet my nerves and I'll review my daily chores but…oh no, the coast is not clear. My nemesis, one of those fellow long-term survivors with lipodystrophy looking like a Shar-Pei, the extended family relative we all hate but tolerate at Christmas, comes up to me and gesticulates. I think to myself, "too much crystal, sister, too old to be doing this, and to be wearing that. And too swishy. We're all bi-curious now."

I stop her dead on her roller coaster tracks. "Listen, my non-fat Chai latté ain't getting any warmer, I'm late for my yoga class, and you need to get a grip on yourself. Do as I did: marry one man, limit your online tricking to a polite minimum, don't practice scat—way too 1980s—go volunteer for a "life threatening illness" organization—AIDS is so passé—and please, stop wearing leather in public. It's simply not done."

I walk away from Typhoid Mary thinking of the horrors of middle age and fundamentalism, and cheering myself on my even keel attitude—progressive but not militant. I check my excellent body care as I strut by the new boutiques in the neighbourhood (bless the 2010 Winter Olympics and Lorne Mayencourt, otherwise Vancouver would be all social housing and panhandlers.) My understated Lululemon ensemble hugs and enhances. Praise the rejuvenating virtues of "E" over crystal amphetamine and post-modern gay liberated life, where positives and negatives, blacks and Jews (and ethnics) are equal under the banner of the almighty pharmaceutical companies. Phew! ⊕

*Francisco Ibáñez-Carrasco's new short story collection, Killing Me Softly, is available in bookstores now.*