inside

features

treatment information

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.

Funding for *living* ⊕ is provided by the BC Gaming Policy and Enforcement Branch and by subscription and donations

living ⊕ Magazine
1107 Seymour St., 2nd Floor
Vancouver BC
V6B 5S8
TEL 604.893.2206
FAX 604.893.2251
EMAIL living@bcpwa.org
BCPWA ONLINE www.bcpwa.org

think+

opinion and editorial

Bring family, friends—and your dog

by Paul Lewand

On Sunday September 25, come celebrate the AIDS WALK for LIFE in Vancouver's Stanley Park. Since 1986, the WALK has raised $4.6 million, making it BCPWA Society's largest annual fundraising event. WALK proceeds go towards such direct services for HIV-positive British Columbians as the Complementary Health Fund, housing subsidies, groceries, social programs, children's camps, and alternative therapies.

This year, we're excited to join forces with the other major walks across Canada to attract national sponsors and revitalize the profile of the WALK. The AIDS WALK for LIFE shifts the focus from simply managing our disease to one of living with dignity and pride. The new national theme, to support and empower, matches the philosophy of the BCPWA Society.

I encourage you join us for the 20th anniversary of the WALK to honour the work accomplished in the last two decades. It's especially important that our members come out and show their support for the event and for one another.

Signing up and participating in the Walk has never been easier: simply visit <www.bcpwa.org> and click on the AIDS WALK for LIFE logo. You can register as an individual, join an existing team, create a new team and challenge others, or sign up to walk with your dog.

On September 25, bring your family and friends to beautiful Stanley Park. Let's make this year's WALK the best ever. Let's make it a celebration of life. ⊕

Paul Lewand is the chair of the BCPWA Society. His dog is Kelso.

REALITY BITES

Health Canada provides Bio-Alcamid for facial wasting

A pilot project is testing injections of the synthetic gel Bio-Alcamid to help treat facial wasting. Health Canada began approving Bio-Alcamid injections on a case-by-case basis in October 2004; since then, more than 125 Canadian patients have undergone the treatment.

Though Bio-Alcamid's long-term effects are unknown, in a 2002 Italian study of 2,000 participants, only 12 people had to have the filler removed after they developed infections. The gel was approved in Europe in 2000. It is used in chins, buttocks, noses, and other soft tissue affected by the disease.

A final decision on full approval is expected from Health Canada this fall.

Source: Toronto Star

T-20 fails to prevent mother-to-child transmission

Doctors from San Francisco have reported a case of mother-to-child transmission of multidrug-resistant HIV via vaginal delivery, despite an undetectable blood plasma viral load. The report's authors, from the University of California, believe that this may have been due to the limited genital tract penetration of the only active drug in the mother's regimen, T-20 (enfuvirtide, Fuzeon). The case report appears as a letter in the journal *AIDS*.

The authors note that this is the first time that they have been unable to prevent mother-to-child transmission in their clinic since the introduction of highly active antiretroviral therapy (HAART) in 1995, even though many mothers have had evidence of drug-resistant HIV.

There is limited data regarding the use of T-20 in pregnancy, although the authors note "its ability to suppress multidrug-resistant HIV-1 should make it an ideal candidate for preventing perinatal transmission." The authors point out, however, that "its activity in other compartments remains undefined."

Source: Aidsmap

Methadone added to WHO list of essential drugs

World Health Organization have added methadone and the opiate substitute buprenorphine to its Essential Medicines list, ending nearly two years of lobbying by treatment advocates.

Inclusion of drugs in the essential medicines list indicates that international experts consider the availability of a drug to be essential to deliver basic health care, and national governments are expected to take note of the recommendation when making policy.

Methadone and buprenorphine are prescribed as substitutes for heroin in order to stop injection drug use and help addicts stabilize their drug intake. Methadone substitution programs attempt to help people stop drug use, but the availability of an opiate on prescription is controversial in countries where tight control of narcotics is the overriding aim of public health policy.

Source: Aidsmap

Research shows acupuncture reduces substance use

A University of British Columbia researcher has shown that acupuncture treatment can help reduce substance use among addicts in Vancouver's Downtown Eastside (DTES).

Patricia Janssen, an assistant professor of health care and epidemiology, led a team that offered acupuncture to residents of the DTES on a voluntary, drop-in basis five days a week. They gave 2,700 treatments over a three-month period at two locations in the DTES. Subjects reported a reduction in overall use of substances in addition to a decrease in intensity of withdrawal symptoms.

The study, the first of its kind in Canada, was published recently in the *Journal of Urban Health: Bulletin of the New York Academy of Medicine.*

Prosecutions for HIV transmission on the rise

A report prepared by The Global Network of People Living with HIV/AIDS Europe (GNP+ Europe) and the Terrence Higgins Trust (THT) has discovered that in at least 36 of 45 European countries surveyed, the actual or potential transmission of HIV can constitute a criminal offence.

At least one person has been prosecuted in 21 of these countries, and there have been at least 130 convictions Europe-wide. Notably, Austria, Sweden and Switzerland are responsible for more than 60 percent of the total convictions and have each prosecuted more than 30 people. At the other end of the scale, HIV exposure and transmission do not appear to be criminalized in Albania, Bulgaria, Luxembourg, Slovenia, and the Republic of Macedonia.

The GNP+ Europe/THT report, *Criminalisation of HIV transmission in Europe*, suggests that prosecutions for HIV transmission have been on the increase throughout Europe.

Source: Aidsmap

Reality Bites

Activists cry foul at drug price increases

A steady onslaught of increases in the price of HIV medications has caused activists in the US to accuse drug manufacturers of artificially inflating the market at the expense of PWAs. As an example, they point to the recent launch of Aptivus, the protease inhibitor tipranavir developed by Boehringer-Ingelheim, which is the highest price ever for this class of medication — more than $13,000 USD per year.

Activists claim the same thing happened with atazanavir (Reyataz), made by Bristol-Myers Squibb. It was the first once-daily PI, and the company priced it at an all-time high, with regular increases since then. It now costs almost $11,000 USD per year.

Activists claim these price increases are "unreasonable, unacceptable, and unjustified." They plan to redouble their efforts against price gouging and profiteering by working with legislators, consumer protection groups, and other advocacy groups.

Hep C treatment should last for 48 weeks in co-infected

HIV-positive patients co-infected with the hepatitis C virus (HCV) should be treated with anti-HCV therapy for 48, and not 28 weeks, according to the results of an Italian trial presented at the Third International AIDS Society Conference on HIV Pathogenesis and Treatment in Rio de Janeiro.

Treatment of HCV in co-infected patients with a combination of peginterferon alfa (Pegasys) and ribavirin (Virazole) is known to be effective in clearing HCV infection in most patients. However, some uncertainty surrounds the optimal duration of therapy.

For patients with the varieties of HCV called genotypes 2 or 3, a course of anti-HCV therapy of 48 weeks is recommended. Some experts, however, have called this regimen into question by advocating the use of HCV drugs for only 24 weeks, as is recommended for HIV-negative patients. In contrast, others have found that this shorter treatment results in an elevated risk of relapse after HCV therapy is stopped.

Source: Aidsmap

Human cells can "silence" HIV genes

Scientists at the National Institute of Allergy and Infectious Diseases (NIAID) have shown that humans use an immune defense process common in plants and invertebrates to battle a virus. The new finding that human cells can silence an essential part of HIV's genetic make-up could have important implications for the treatment of people infected with the virus.

The phenomenon, called RNA silencing, was detected first in plants and later in insects. Although plants and insects lack the sophisticated immune defenses of higher organisms, they nevertheless successfully battle viruses by detecting, and then silencing, viral genetic material. Silencing leads to the destruction of viral RNA. Viruses, however, are not permanently defeated because they have evolved ways to suppress the silencing action.

Until now, scientists have not had clear evidence that RNA silencing plays a role in the defensive repertoire of mammals and other vertebrates.

Tenofovir may linger up to three weeks in body

Sub-optimal levels of tenofovir (Viread) that could lead to drug resistance may linger in the body for at least three weeks after the drug is discontinued, according to a French and Spanish research group. Researchers say the study calls into question previous assumptions about the safety of discontinuing tenofovir treatment.

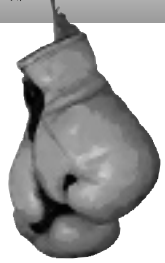
The research group originally set out to determine whether the intracellular half-lives of either tenofovir or didanosine (VidexEC) were prolonged when one drug was dosed with the other. The study found that the intracellular half-life of the drugs remained the same whether dosed alone or together.

The researchers found, however, that intracellular concentrations of both drugs remained high for much longer than expected in three patients who discontinued tenofovir treatment. They suggest that further guidance is needed on the safe discontinuation of tenofovir.

Source: Aidsmap ⊕

Looking for great buns?

Next time you're shopping for freshly-baked bread or buns, head down to COBS Bread at 1160 Davie Street in Vancouver's West End. Simply say "I'm a friend of BCPWA" when you place your order and they'll donate 10 percent of the sale to the BCPWA Society.



Persistence pays off

Representation at CAHR gets results

by Sam Friedman

A basic right of PWAs is the right of representation, with equal credibility and an equal voice in the common response to the AIDS pandemic. In keeping with this right, the BCPWA Society's Community Representation and Engagement Committee (CRE) received a request from the Canadian Association of HIV/AIDS Researchers (CAHR) for a PWA community representative to serve on CAHR's annual scientific conference planning committee.

The CRE committee selected me as a representative, and we generated a list of initiatives required to ensure the inclusion of the AIDS community at the CAHR conference. These initiatives were:

- a PWA lounge
- free registration for all PWAs
- registration and booth fee waivers for community groups and AIDS service organizations (ASOs)
- a PWA on each abstract review committee
- full scholarships for PWAs

The conference planning committee agreed to the lounge and abstract reviewers—not surprising, given that these initiatives had been granted at previous CAHR conferences. However, the proposal for free registration, fee waivers for registration and booths, and scholarships was met with some resistance from some of the planning committee members.

Advocating for the rights of PWAs is often a slow process, and changing the way some doctors and researchers think about inclusion and collaboration with PWAs can be a difficult task. Yet this was exactly what I had to do: convince the planning committee that the inclusion and participation of PWAs at the CAHR conference was a necessary right. The committee needed to be persuaded that it would not be costly for CAHR, and that PWAs could—and would—make constructive contributions to the conference. In order to increase PWA involvement, however, they needed CAHR's financial support, since most PWAs, community groups, and ASOs do not have the financial resources to pay registration costs, booth fees, or travel and accommodations expenses.

Advocating for the rights of PWAs is often a slow process, and changing the way some doctors and researchers think about inclusion and collaboration with PWAs can be a difficult task.

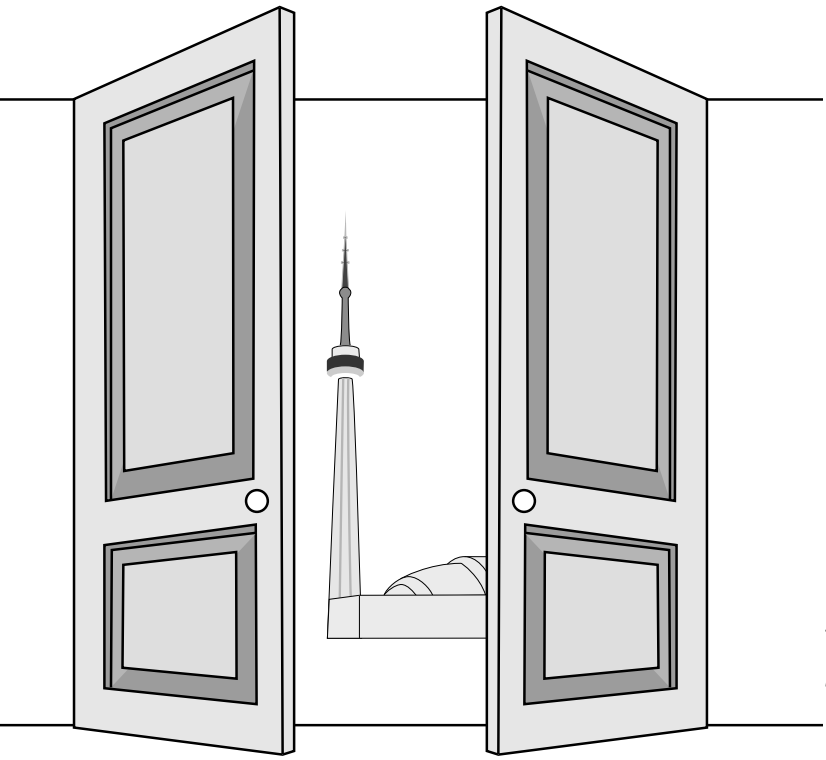
For nine months, I advocated for PWA rights of inclusion and participation as equal participants. I argued that, as a national body of researchers, CAHR had a professional responsibility to assist PWAs, community groups, and ASOs through financial support and a policy of inclusion and respect.

Finally, with the conference quickly approaching and several concessions yet to be won, I made a plea to the committee chair for assistance. This direct route enabled me to bypass the planning committee and make a presentation to the source of CAHR's power: the CAHR Executive Committee. One week later, I learned that the Executive had granted every concession sought!

This decision represents a new beginning of a strong relationship between CAHR and the AIDS community. Though this victory was achieved by bypassing several CAHR policies, CAHR has stated they strongly believe in PWAs' right of inclusion and right to choose our own representatives, and that they are dedicated to supporting and working together with the AIDS community as equal partners. We must continue fighting to ensure that these victories become permanent policy.

Representation on different committees outside of BCPWA Society is just one of the collective purposes of the CRE committee. This work can be difficult but it is also very rewarding, empowering, and can yield positive results for the entire AIDS community. ⊕

Sam Friedman is a dedicated BCPWA Society member, sits on several BCPWA Society standing committees, is the community representative to the CAHR conference planning committee, and also works with the Canadian HIV Trials Network's Community Advisory Committee.



Opening doors

2006 International AIDS Conference shines spotlight on visa application issue

by Ron Rosenes

There is good news to share about a positive change made in the process for people who require visas to enter Canada. Until May 2005, the Application for a Temporary Resident Visa Made Outside Canada required applicants to disclose if they had been treated for any communicable and chronic diseases and, if so, to provide details. People with HIV/AIDS and other health conditions were expected to disclose their health status on the form. The revised application form no longer includes this broad requirement for medical disclosure.

The XVI International AIDS Conference will be held in Toronto in 2006. In October 2004, the Local Host approached Citizenship and Immigration Canada (CIC) to collaborate on a strategy aimed at avoiding problems arising due to large numbers of people wanting to enter Canada to attend AIDS2006.

A priority issue quickly emerged in November 2004 when Shaun Mellors, a long-time HIV-positive activist from South Africa, received an alert while attending a meeting in Toronto. He was very concerned about needing to disclose his HIV status on the Application for a Temporary Resident Visa form and providing test results before obtaining a visa. He promptly alerted the International Council of AIDS Service Organizations (ICASO)—an AIDS conference co-organizer—who housed the Local Host at their international office in Toronto.

Overall, Canada has a good reputation within the international AIDS community since it does not generally seek to exclude visitors with HIV/AIDS. There are three possible grounds for inadmissibility to Canada as a foreign national based on a health condition: danger to public health, danger to public safety, and excessive demand on health and social services. It is CIC policy that people living with HIV/AIDS are not considered a danger to public health or safety and HIV-positive visitors are not normally expected to place a demand on health services.

Changing the visa application

The troubling medical section in the Temporary Resident Visa application affected PWAs since everyone with a health condition was expected to declare their diagnosis on the form. The incriminating question was: "Have you or any member of your family ever been treated for any serious physical or mental disorders or any communicable or chronic diseases?" If your answer was yes, you had to provide your diagnosis under another section requiring "details." Canadian and international activists raised concerns that this medical disclosure requirement presented a barrier to participation in the conference from people whose voices were clearly needed at this important forum.

AIDS2006 co-chairs, Dr. Mark Wainberg and Dr. Helene Gayle, subsequently wrote a letter to the Minister of Immigration, Joe Volpe, at the request of the Conference Organizing Committee (COC). The AIDS2006 COC includes representatives from the International AIDS Society, International Council of AIDS Service Organizations, Global Network of People Living with HIV/AIDS, International Community of Women Living with HIV/AIDS, Canadian AIDS Society, Joint United Nations Program on HIV/AIDS (UNAIDS), and the Toronto Local Host. The COC members were very supportive of the Local Host's efforts to resolve the issue. Other international stakeholders also raised concerns when activist Shaun Mellors shared his story on HIV/AIDS listservs and alerted PWAs to the problems they might also encounter.

The Local Host researched the issue and presented to the Ministerial Council on HIV/AIDS, an advisory group to the federal Minister of Health. With the council's support, teleconference discussions were held between representatives from the Local Host, council, and CIC officials.

Hearing the concerns, CIC agreed to review the medical section and recognized that the medical question was too broad and exceeded the requirements of Canadian immigration law, not only in relation to HIV, but also with respect to other health conditions. CIC worked closely with other government departments to revise the questions to be more specific. The revisions ensure that CIC meets its legislative requirements under the Immigration and Refugee Protection Act (IRPA), without requiring applicants to disclose unnecessary details about their health status.

The medical disclosure requirement presented a barrier to participation in the conference from people whose voices were clearly needed at this important forum.

The visa application questions are now stated as: "Within the past two years, have you or a family member had tuberculosis of the lung or been in close contact with a person with tuberculosis of the lung?" A further question asks: "Do you or an accompanying family member have any physical or mental disorder for which that person will require social and/or health services, other than medication, during the stay?"

The CIC distributed the new form to visa offices worldwide in May 2005 with instructions to immediately remove the old forms from use. CIC also worked during this summer to prepare revised guidelines to assist visa officers in their decision- making process.

Lots of good hands

Researching and advising the federal government involved the work of several people, including members from the Ministerial Council on HIV/AIDS: co-chairs Lindy Samson, an infectious diseases specialist from Ottawa; Louise Binder, a PWA who is also chair of the Canadian Treatment Action Council; and Richard Elliot, with the Canadian HIV/AIDS Legal Network. Several people from the Local Host also helped: Gail Flintoft, a board member who is also chair of the Canadian AIDS Society; Joan Anderson, senior advisor to the Toronto Local Host; and legal advisor Lori Stolz. Immigration lawyer Michael Battista and partners in City of Toronto Public Health, particularly Dr. Rita Shahin, also provided valuable expertise.

When the CIC posted the new visa application form on its Web site, Louise Binder said she was "delighted to participate in the process, at the partnerships that developed, and the results."

A lot more work to do

The Local Host and its partners will identify and work with CIC on other potential barriers to participation in AIDS2006 by people affected by and living with HIV/AIDS. Flintoft is encouraged. "CIC was very open and the Local Host looks forward to more productive work together, contributing to the success of AIDS2006," she says.

The International AIDS Society is researching the issue internationally to assist with decisions on locations for future AIDS conferences. One of the more difficult issues to grapple with is that developed countries generally seek to exclude people from developing countries that they fear will not return home. When the XIV International AIDS Conference was held in Barcelona in 2002, Spanish officials rejected many scholarship recipients from developing countries; this issue became an international embarrassment.

In Canada, we have problematic examples of participants from some developing countries not being granted visas to attend athletic and other events. The AIDS2006 organizers will do all that is possible to provide support to people whose voices we need at AIDS2006. ⊕

Ron Rosenes assisted AIDS2006 co-chair Dr. Mark Wainberg to develop the bid to bring the International AIDS Conference to Toronto. He is a founding member of the AIDS2006 Toronto Local Host board, a member of the Conference Organizing Committee, and vice-chair of the Canadian Treatment Action Council.

Getting a visa to enter Canada for AIDS2006

- The list of countries whose citizens require visas to enter Canada as visitors is available at <www.cic.gc.ca/english/visit/visas.html>.
- The updated visa application form can be found on CIC's Web site at <www.cic.gc.ca/english/applications/visa.html>
- As more information for AIDS Conference registrants is confirmed, it will be posted on the AIDS2006 Web site at <www.aids2006.org>.
- More information on Canada's travel policy is now posted on the Canadian HIV/AIDS Legal Network Web site at <www.aidslaw.ca>.

Survey says...

Results of our readership and Web site survey

by Glyn Townson

You may recall a survey enclosed in the September/October 2004 issue of *Living+* magazine. The purpose of the survey was to gather information to ensure that *Living+* magazine and the BCPWA Society Web site continue to meet the expectations and needs of our membership.

The survey was distributed to 1,450 BCPWA Society members across the province. Of those, 192 surveys were completed and returned to us. Overall, impressions of the magazine were positive:

- Ninety-four percent of respondents found articles in the magazine easy to understand.
- Eighty-two percent indicated that the magazine had significantly increased their understanding of HIV/AIDS.
- The majority of readers who had not received post-secondary education indicated that *Living+* had significantly increased their knowledge of HIV/AIDS.
- Those who had become HIV-positive within the last decade also indicated the magazine had significantly increased their knowledge of the disease.
- The top five categories for article satisfaction were: resource information, patient empowerment, individual advocacy, PWA heroes, and prevention.
- The top five categories for treatment information articles were: side effects, immunology, opportunistic infections, antiretroviral therapies, and nutrition.

In future issues of the magazine, survey respondents indicated that they wanted more articles on: specific health or treatment topics, specific social or economic issues, HIV/AIDS in BC and the global context, information about BCPWA Society, and personal stories.

There was less widespread familiarity with the BCPWA Society's Web site. Seventy percent of survey respondents had never visited it. A significant number indicated that they did not have computer or Internet access. Of the respondents who did use the Web site, most were largely satisfied with it.

The BCPWA Society Communications Committee would like to thank all those who took the time to complete and submit the survey. ⊕

Glyn Townson is vice-chair of the BCPWA Society.

Keep on walking

Canada's first AIDS walk celebrates its twentieth anniversary

by Jeff Anderson

The BCPWA Society's AIDS Walk in Vancouver, the original and longest running AIDS Walk in Canada, celebrates its twentieth anniversary this year. Much has changed—a new name, new sponsors, and new energy—yet the health-related funds and HIV services which were the raison d'être behind the first AIDS Walk are needed today more than ever.

In 1986, the lifespan of people living with HIV was merely a matter of months, and few people are still with us from those early years. Now, PWAs can expect to live many years of longer, healthier lives; we are accepted in our communities and are recognized for our courage and strength.

In addition to the funds raised for HIV programs and health services, the publicity created by the AIDS Walks over the years have educated the public about the realities of HIV, brought families and communities together, and lessened the alienation caused by fear and stigma. The Vancouver AIDS Walk truly changed lives. It also inspired other Walks throughout BC and across Canada. Two decades later, 127 Canadian cities will participate in this fundraising and awareness event, collectively raising millions of dollars for people living with HIV/AIDS in their communities.

The grassroots early years

It all began on a sunny Sunday in September, 1986. Barely one hundred people scrawled homemade signs and met at the English Bay bathhouse to walk the Seawall around the circumference of Stanley Park. That first AIDS Walk raised a meager amount of money.

John Kozechenko, a PWA activist who walked that first year, remembers how fear and AIDS stigma were the predominant public attitudes. Most people stayed away. Trigger Segal, who has volunteered at every Vancouver AIDS Walk event, remembers Joe Ford, organizer of the 1986 Walk, inviting volunteers, participants, and supportive onlookers en route to the volunteer appreciation party at the lounge of his Lotus Hotel.

Quickly, the AIDS Walk grew. After a few early years, the BCPWA Society added a presentation and concert stage at Sunset Beach near English Bay. Organizers recruited Seawall strollers as on-site volunteers to help erect tents and strike the stage. Gary Gilbert was the first stage producer, juggling speakers and musicians before and after the Walk. Gilbert's early work established the legacy of inspiration and great entertainment we have come to expect at the Walk.

Joe Average, volunteer extraordinaire

Over the years, the AIDS Walk stages became an expression of the compassion our friends, family, and neighbours have extended toward the PWA community. The best among our leaders and entertainers—from Aboriginal chiefs to premiers, from health ministers to a prime minister; from comedians to singers, drag queens to drag kings—have appeared on the stage in a common cause: to support people with HIV/AIDS. We've enjoyed more heartfelt support than we ever dreamed possible, as the community shared our vision of social justice and healthy lives.

Through the years, of all the contributors—from corporate sponsors and supportive businesses to fundraising teams and individual walkers—no one has symbolized the volunteer spirit of the Walk more than Vancouver artist Joe Average. An Order of Canada recipient and an inspiration to both HIV-positive and HIV-negative people, Average has been a tireless supporter for most of the Walks since 1986.

This year, after much deliberation, BCPWA Society decided to join the coast-to-coast WALK for LIFE campaign, coordinated by the Canadian AIDS Society's national com-

continued on next page

mittee. As such, this year Joe Average did not supply the image for AIDS Walk posters, advertisements, t-shirts, and other promotional materials. Using a shared logo and materials created by Allard Johnson Communications in Montreal, this new campaign lends increased national sponsorship and brand recognition to the Vancouver Walk, adding to more than just the bottom line.

Helping PWAs in need of health supports

The Vancouver Walks have been the sole source of income for the BCPWA Society's Complementary Health Fund (CHF), the largest self-directed health-related reimbursement fund for persons with HIV in all of Canada. The CHF is available to any PWA in the province who needs it. Since that first Walk in 1986, we have raised over $4.6 million for vitamins, purified drinking water, and other health-related goods and services not covered by private or provincial health plans.

Over the years, the BCPWA Society's AIDS Walk has also funded dozens of HIV/AIDS agencies in the Lower Mainland who, in turn, direct revenue raised to programs and services for PWAs. Because most smaller organizations weren't able to coordinate their own Walks in the early years, the Walk shared the funds raised with other HIV/AIDS groups in the Lower Mainland.

Income is a key determinant of health, especially for PWAs. People with high incomes, even in the Lower Mainland, have better health than those with low incomes. That's why the WALK for LIFE, and the associated CHF, is so crucial to people with HIV. Many health oriented fundraisers focus on research, which is certainly important; however, because people with HIV/AIDS are more susceptible to poverty, the revenue raised from the WALK for LIFE can fund individually accessed health goods and services, which is essential to the well-being of PWAs. The CHF can direct up to $55 a month, per person, to our own health improvements—at a time when most corporate and governmental income falls short of the poverty line.

The Walk enters the electronic age

Back in 1986, AIDS Walk organizers kept few donor records and the BCPWA Society created its first newsletter on a typewriter. Today, the WALK for LIFE employs the newest Internet technology to allow flexible participation, on-line registration, and even personalized individual walker and team Web sites to make tracking contributions and issuing income tax receipts quicker and easier.

This year, BCPWA Society has created a highly informative and interactive Web site. Visit <www.bcpwa.org> and click on the red-ribbon WALK for LIFE logo. If you're a walker, you can create your own Web site from an easy-to-use interface. You can also send e-mails to prospective donors with a direct link to your personal Web page; sample letters are provided. Donors receive an e-mail confirmation of their gift and an instant electronic tax receipt. You can easily generate reports to track the success of your fundraising efforts, including the people you've contacted and those who have donated. All donations to the WALK for LIFE can be made on-line, quickly and simply. All information is strictly confidential and no personal information from donors is ever shared with other individuals or organizations.

It all began on a sunny Sunday in September, 1986. Barely one hundred people scrawled homemade signs and met at the English Bay bathhouse to walk the Seawall around the circumference of Stanley Park.

The Vancouver AIDS Walk began as a fundraiser but has evolved into a full day of sharing, caring, and learning for all Vancouverites, through an on-site concourse of information booths. The Walk now includes friends, families, and the corporate community, funding health goods and services for more than 15,000 people with HIV in BC.

Still, after more than 20 years, people affected by and infected with HIV sometimes tire from the continuing struggle with a terminal illness. In an era when increasing numbers of uninformed people think HIV is curable, and the public perception is that the disease has become a "*manageable* illness," families who have lost loved ones to AIDS understand that there's still nothing manageable about HIV. We must rise to this annual opportunity.

As a caring community, we are challenged to remember that PWAs still need these crucial goods to improve health and better our futures. We can exceed this year's WALK for LIFE goal of $400,000 by asking our friends, families, and colleagues to help.

We must seize this opportunity, too, to share our plight and our challenges. And we must remember to thank those who help us—this year and each year—to improved health and better lives. As long as those who care about us are reminded we care for them, too, and they appreciate our place in their lives, our place in our community will always be there. Pledge, volunteer, and WALK for LIFE. ⊕

Jeff Anderson is a long-time activist and volunteer, including past treasurer of the BCPWA Society from 1997-2002. He currently chairs the Vancouver HIV Peer Advocacy Action Group.

Where the money goes

In addition to BCPWA Society's, funds raised from this year's WALK for LIFE will benefit 10 other AIDS service organizations to help them provide direct services for PWAs.

AIDS Vancouver provides prevention and education initiatives directed towards uninfected individuals who are vulnerable to HIV/AIDS. The organization also provides services to HIV-positive individuals who require assistance managing their affairs and developing long-term health care plans. WALK proceeds, allocated to the Case Management Financial Assistance Fund, will provide support to meet critical short-term needs of people living with HIV.

Asian Society for the Intervention of AIDS provides culturally appropriate and language specific support, outreach, advocacy, and education on HIV/AIDS and related issues. WALK proceeds support the volunteer-driven Positive Asians Dinner, supplement the PWA volunteer honorarium program, and contribute to emergency financial support established to enhance the quality of life for Asian PWAs and their families.

Camp Moomba/Western Canadian Pediatric AIDS Society is committed to helping children living with or affected by HIV/AIDS by providing recreational, social, educational, and support programs. WALK funds will go towards Camp Moomba program, which builds a fun, enriching, and supportive community through a summer camp.

Friends For Life provides complementary health services, free of charge, to people with life-threatening illnesses like hepatitis C, AIDS, and cancer. Money raised at the WALK will be used to provide massage/bodywork, workshops, individual counselling, support groups, meals served in a warm social environment, and care for individuals confined to their homes.

Healing Our Spirit's mission is to prevent and reduce the spread of HIV/AIDS and to provide care, treatment, and support services to Aboriginal peoples infected and affected by HIV/AIDS. WALK proceeds will assist Aboriginal PWAs with emergency funds, moving expenses, food vouchers, participation in the APHA retreat, and the annual Christmas Dinner.

McLaren Housing Society of BC provides safe, affordable housing to people living with HIV/AIDS on very low incomes. Currently, McLaren administers 62 apartment homes at Helmcken House, Mole Hill, and Seymour Place and 32 portable housing subsidies downtown Vancouver. WALK funds go directly towards rent subsidies, to help reduce the long wait list, which has over 200 names.

Positive Women's Network supports women living with HIV/AIDS to make informed choices. PWN provides safe access to support, advocacy and education/prevention to women and their communities throughout BC. Because safe, affordable, decent housing is a concern for women living with HIV/AIDS, WALK proceeds will fund portable housing subsidies for these women and their children.

Surrey HIV/AIDS Centre Society has a number of programs that will benefit from the WALK, including the Djaeff Mahler Grocery (a high-protein supplementary food bank) and subsidized housing.

Wings Housing Society works towards ensuring that every person living with HIV/AIDS has adequate, affordable housing. Wings provides 110 portable rent subsidies and operates a 31-unit apartment building for PWAs. WALK proceeds will be used for direct client emergency needs.

YouthCO AIDS Society is a youth-driven agency that works with youth ages 15-29 to address HIV, hepatitis C and related issues. It provides prevention education services, sexual health and harm reduction information, volunteer opportunities, referrals, as well as advocacy, group, and individual support. WALK proceeds will go towards its Support Program, which provides monthly social dinners, support and discussion groups, recreational activities, weekend retreats, and health information. ⊕

20 years AIDS WALK

20 years AIDS WALK

Photographs by Tom Burley, John Kozachenko & Britt Permien

CPP amendments ensure automatic reinstatement of disability benefits

by Glyn Townson

During the past few years, the Canadian Working Group on HIV and Rehabilitation (CWGHR) has been working with other episodic disability groups to remove barriers for people seeking to re-enter the workforce.

According to CWGHR's recently published report, *HIV and Disability Insurance in Canada: An Environmental Scan*, concerns about reassessments of Canada Pension Plan disability benefits is a barrier for many people returning to the workforce.

Staff from Social Development Canada (SDC) claim there are many commonly held misconceptions about reassessment and the potential loss of CPP disability benefits. Guidelines state that employment income over $4,100 per year must be reported to CPP disability. The intention, through this practice, is not to cut benefits; rather, it is a mechanism for SDC to evaluate whether or not the person qualifies for other available CPP supports in returning to work. CPP disability recipients may volunteer or attend school without it affecting their benefits. Other support programs include vocational services and paid work trials, where clients can work and still collect CPP disability benefits for up to three months.

Since January 31, 2005, SDC has responded to concerns about loss of benefits with automatic reinstatement. When you return to work and your CPP disability benefits terminate, you will receive forms from SDC in case you need to apply for automatic reinstatement.

If within two years of terminating your CPP disability benefits, you cannot continue working because your disability has recurred, you can request a reinstatement of your benefits. All you have to do is complete a form confirming you cannot continue to work due to a recurrence of your disability; your doctor will also need to fill out a form confirming your disability has recurred. You can expect your CPP disability benefits to begin very soon once the request is accepted.

There may be times when you can work on a regular basis, followed by periods when you cannot work due to your disability. With automatic reinstatement, there is no limit on the number of times you can request benefits, provided you meet the requirements.

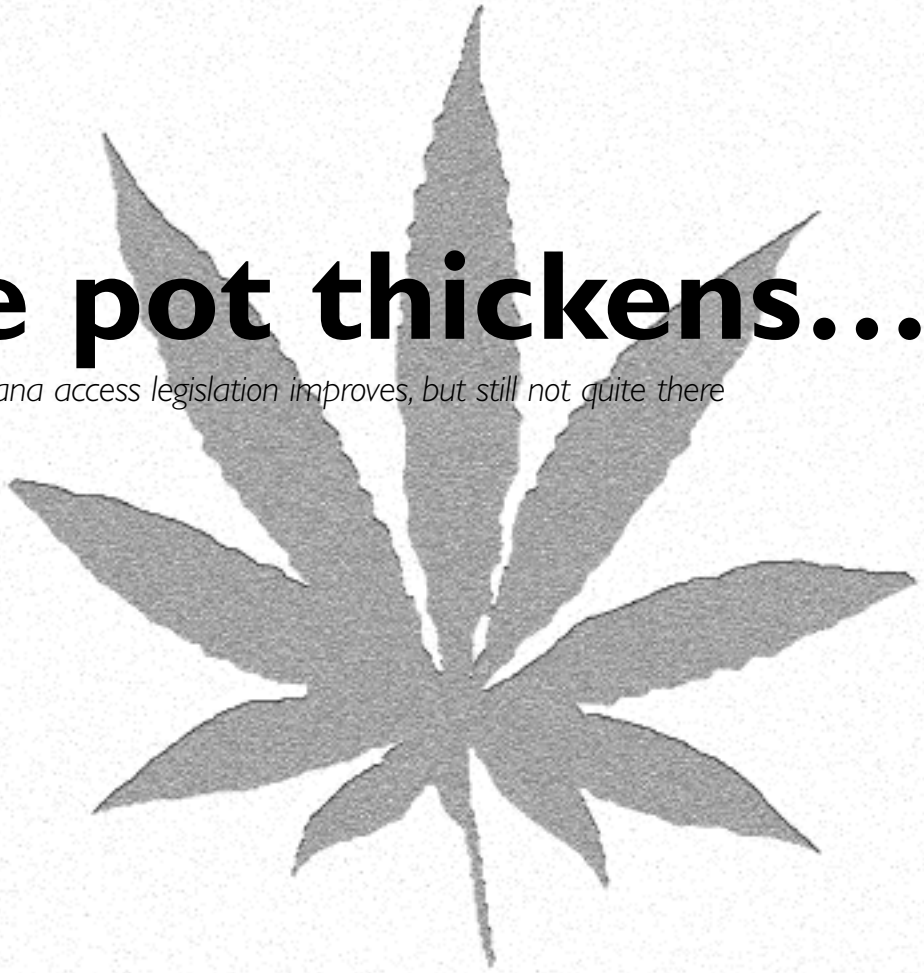
CPP disability benefits will begin the month after you become unable to work. If your children are still eligible, their benefits will also be reinstated.

When your benefits are reinstated, the amount of your CPP disability income will generally not be less than what you were receiving before you stopped benefits previously. The amount should also reflect annual increases and any other increases due to additional CPP contributions. If your family situation has changed, your benefit may increase or decrease accordingly.

If your disability recurs after the two year period and you've been working and contributing to CPP for more than two years, you will not be eligible for automatic reinstatement. You may, however, be eligible for a fast track reapplication, which is available for up to five years after your CPP disability benefits have terminated.

For more information, visit the SDC Web site at <www.sdc.gc.ca> or call 1.800.277.9914, TTY 1.800.255.4786. ⊕

Glyn Townson is the vice-chair of the BCPWA Society.



The pot thickens...

Medical marijuana access legislation improves, but still not quite there

by Jason Wilcox

Since the early days of the HIV epidemic, PWAs have used marijuana for medicinal purposes to counteract treatment side effects and the effects of AIDS. Despite the federal government's legitimization of medical marijuana (MM) in 1999 and the relentless efforts by AIDS activists to remove the stigma and criminality associated with this alternative medicine, the federal government continues to frustrate attempts to access MM to ease the suffering for thousands of PWAs across Canada.

However, on June 29, 2005, recent amendments to the Medical Marijuana Access Regulations (MMAR) came into effect. These changes to the MMAR provide an easier application process for PWAs and make it easier to obtain permission to possess and medicate with marijuana. Despite these hopeful actions, the amendments have not legalized pot use, but do provide a clearer framework for exempting persons with terminal illnesses from criminal prosecution.

More reasonable eligibility requirements

The biggest change to the MMAR is the category under which a PWA can obtain a licence to cultivate and possess MM. Under the former regulations, a general practitioner was required to issue a prognosis of imminent death (within a year), in order for a patient to be considered eligible as a category 1 candidate for MM. With the array of treatments currently available to PWAs, a doctor would likely find it difficult to make such a prognosis. The new regulations state that a "category 1 symptom is associated with a terminal illness or its medical treatment." This change in wording provides a more reasonable approval process for PWAs in Canada.

New wording on the MM application is also easier for the medical community to understand. General practitioners must confirm that the applicant is being treated within the context of end-of-life care and they need to verify the applicant's illness. The mandatory annual licence renewal process seems easier, too. If nothing has changed since the last permit was issued, only a one page document requires a doctor's signature prior to renewal.

At this point, the government continues to supply MM for people with HIV, with mixed reviews about the efficacy of the government-supplied marijuana. A number of people prefer to obtain privately grown pot for many reasons, including its better medicinal effect.

In a media release issued on the day these amendments came into effect, the Canadian AIDS Society (CAS) raised concerns about the designated production licence and lack of personal choice. The CAS stated: "The Society has repeatedly asked for Health Canada to expand the distribution of medical marijuana to allow designated growers to grow for many authorized medical users. The new regulations do not allow for that.

In fact, Health Canada's vision is to phase out issuing licenses to grow starting in 2007." The government's intention has raised serious concerns about the right to fair and free access to MM without undo state interference in relation to Section 7 of the Canadian Charter of Rights and Freedoms.

At your local pharmacy?

A close review of the amendments to the MMAR and a recent government pilot project show federal intent to move toward distributing government-supplied cannabis through pharmacies. In December 2003, a media release issued by Health Canada stated: "Health Canada will continue discussions with pharmacists and provincial/territorial regulators of pharmacy practice regarding the possibility of establishing a mechanism whereby marijuana for medical purposes would be provided through pharmacies in due course."

The biggest change to the MMAR is the category under which a PWA can obtain a licence to cultivate and possess medical marijuana.

Amendments to the MMAR have not addressed the issue of who pays for MM. Licensed patients remain personally responsible for the cost of their cannabis, without consideration of their ability to pay. The lack of payment for PWAs, either by provincial PharmaCare or by the federal government, is highly problematic. PWAs unable to pay out-of-pocket for cannabis must instead take prescription synthetic substitutes such as nabilone (Cesamet) and dronabinal (Marinol) which are covered by provincial formularies. For many PWAs, the synthetic substitutes have not helped their medical symptoms; moreover, in some cases, the substitutes have caused unwanted side effects such as headaches and stomach irritation.

The question remains: if provincial formularies already pay for prescription drugs containing synthetic THC, why should the patient be responsible for purchasing whole cannabis medicine provided by Health Canada? This practice only serves to disenfranchise PWAs due to their inability to pay. In addition, under federal requirements, the whole plant product and these pharmaceutical medicines both require prescriptions from a doctor. Given this fact, it is difficult to understand why one medicine is covered and the whole medicine cannabis product is not.

According to Health Canada, as of June 20th 2005, 821 persons have been licensed to possess marijuana for medical purposes since the inception of the MMAR in 1999; of those, 594 persons are also licensed to cultivate marijuana. However, PWAs still face barriers gaining federal exemption: currently there are an estimated 60,000 PWAs in Canada, and an estimated 23 percent to 50 percent of them use cannabis as part of their therapy. That means that between 13,800 and 30,000 PWAs are not currently benefitting from legal access to pot.

A bureaucratic application process

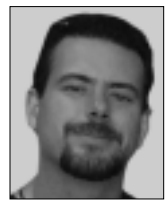
Even with the new amendments to the MMAR, there are still many barriers to obtaining a licence to possess or grow cannabis. Some PWAs have limited literacy and therefore cannot manoeuvre through the bureaucratic hurdles of the new 33-page application and lengthy completion process. Thus, participation in this program ranges from troublesome to impossible for many applicants. Health Canada estimates that up to seven percent of British Columbians—or about 290,000 people—use marijuana for medical purposes, yet from January 1999 to September of 2004 it received only 2,838 applications for MM.

The refusal rate seems to be a significant factor explaining why PWAs did not access MM in the past. The Ontario Supreme Court (OSC) noted this when it ruled the regulations unconstitutional. Before the new amendments, the MMAR made sick people rely on drug dealers to supply their medicine. In his July 31, 2001 OSC ruling, Mr. Justice Sidney Lederman stated, "A scheme that authorizes possession of marijuana by seriously ill individuals but which drives some of them to the black market...undermines the rule of law and fails to create a constitutionally valid medical exemption to the criminal prohibition against marijuana."

What could improve this application process for PWAs in medical need? A fast track system at the federal level, medical association support, and MM support groups, might help PWAs obtain their federal exemption.

Health and human rights concerns are at the forefront of MMAR discussions. An individual's right to liberty and security under Section 7 of the Canadian Charter of Rights and Freedoms is violated when the individual's choice of medical treatment is prohibited upon threat of criminal prosecution. Privacy with regard to personal information and storage of marijuana remain key issues, too.

The recent changes to the Medical Marijuana Access Regulations are a good step forward to correcting a long-standing injustice to PWAs suffering needlessly, but many improvements to quality and access await further government action. ⊕



Jason Wilcox is a member of the Canadian AIDS Society's national steering committee on cannabis as therapy, access and regulation issues for people living with HIV/AIDS, and a PWA peer advocate living in Victoria.

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.

Help or hype?

Early tipranavir research results show promise, others reveal the same old issues

by Rob Gair

The introduction of protease inhibitors (PIs) in 1995 heralded an unprecedented advance in the treatment of HIV infection. Their use with other HIV drugs became known as highly active antiretroviral therapy (HAART) and for the first time since the epidemic began, there was significant improvement in quality of life and fewer deaths for people with HIV/AIDS.

Despite these advances, there have been many challenges with HAART, including side effects and poor adherence to complicated medication schedules. One of the problems associated with poor adherence is the development of drug-resistant viruses.

Tipranavir (Aptivus), from Boehringer Ingelheim, is the first in a new group of PIs developed for the treatment of HIV infection. Certain changes in its chemical structure make tipranavir significantly different from currently available PIs, hence the moniker "second generation." These changes apparently give the drug more flexibility, allowing for a better fit into the active site of the HIV protease enzyme. In theory, the changes offer better activity against resistant HIV.

Early results from two ongoing studies examining the efficacy and safety of ritonavir-boosted tipranavir showed superior activity compared to other ritonavir-boosted PIs, including lopinavir, saquinavir, amprenavir, and indinavir. Treatment experienced study participants

also received optimized nucleoside reverse transcriptase inhibitors (NRTI) and non-nucleoside reverse transcriptase inhibitors (NNRTI) background drugs. Response was defined as a 1 $\log_{10}$ decrease in viral load compared to baseline after 24 weeks of therapy.

In the North America/Australian RESIST-1 study, 41.5 percent of people receiving tipranavir achieved treatment response compared to 22.3 percent in the group receiving other PIs. As well, more people in the tipranavir group achieved undetectable viral loads and had significant increases in CD4 counts. The European RESIST-2 study revealed similar results.

These findings are promising at face value, but it's important to note that the RESIST trials only studied individuals with a relatively low level of PI resistance. As well, the results only reflect six months of treatment, which is not long enough to assess whether the drug will develop a pattern of resistance. This observation is important, since other findings suggest tipranavir has resistance patterns similar to other PIs. Considering all the factors, it could be that the positive results observed in RESIST may not translate to people in the general population or to those who have higher levels of PI resistance.

Certain changes in its chemical structure give tipranavir more flexibility, allowing for a better fit into the active site of the HIV protease enzyme.

In the RESIST trials, ten percent of individuals taking tipranavir had liver complications compared to three percent of those taking other PIs. Very few study participants showed clinically significant liver problems, but the importance of this finding is still uncertain. The RESIST trials also showed increased cholesterol levels in people taking tipranavir. As well, since tipranavir is a sulfa-based drug, people with sulfa allergies should use it with caution.

Theoretically, tipranavir's unique chemical structure imparts greater activity against HIV that is resistant to other protease inhibitors. Early results from ongoing clinical trials reinforce this finding, but these studies tested the drug in people with a relatively low level of PI resistance. The activity of tipranavir in people with higher levels of PI resistance has not been determined. There are also concerns about possible adverse effects, especially liver problems and elevated cholesterol.

Tipranavir has recently been given a "cautious approval" from US drug regulators who pledge to closely monitor for side effects. The drug is not yet available in Canada, but an application for approval is currently under review. ⊕

Rob Gair is a pharmacist at the BC Drug and Poison Information Centre in Vancouver.

BREAKING THE CYCLE

Corrections Canada is slow to address the issue of HIV and injection drug use in prisons

by Terry Howard

Federal and provincial prisons seem to have a revolving door for inmates living with HIV/AIDS who also use injection drugs. Very little is being done to help break the cycle of men and women released from prison who re-offend and then soon after return to prison.

According to reports by the Canadian HIV/AIDS Legal Network, HIV prevalence among prisoners is ten times greater than in the general population. This statistic reflects the reported rate; the actual rate is likely much higher, since many inmates prefer not to disclose their HIV status. The rate of HIV infection for female inmates is roughly three times higher than for male inmates.

The average period of incarceration for a federal prisoner is three years. Provincial inmates remain in prison, on average, for seventeen days, after which time they return to *your* community. Clearly, this is a public health and safety issue—not just a problem in prisons.

The Office of the Correctional Investigator concluded that there has been no movement by the CSC on the issue of needle exchanges in prisons over the past decade.

The Correctional Service of Canada (CSC) is certainly aware of the problem. Since 1994, various organizations have submitted strongly worded recommendations aimed at addressing the issue of HIV and injection drug use in prisons. The CSC's own Expert Committee on AIDS and Prisons, which included representation by the BCPWA Society, concluded that the CSC must address access to sterile injection equipment by inmates to reduce the rising rates of HIV infection. In September 1996, the Canadian AIDS Society and Canadian HIV/AIDS Legal Network concluded that the prison system and governments should immediately implement measures for clean needle distribution. That same year, the United Nations Commission on Human Rights stated that governments have a moral and legal responsibility to prevent the spread of HIV among prisoners and prison staff as well as to care for those infected.

Governments also have a responsibility to prevent the spread of HIV within communities. Prisoners are part of the broader community; they come from the community, and they return to it.

The list of recommendations continues:

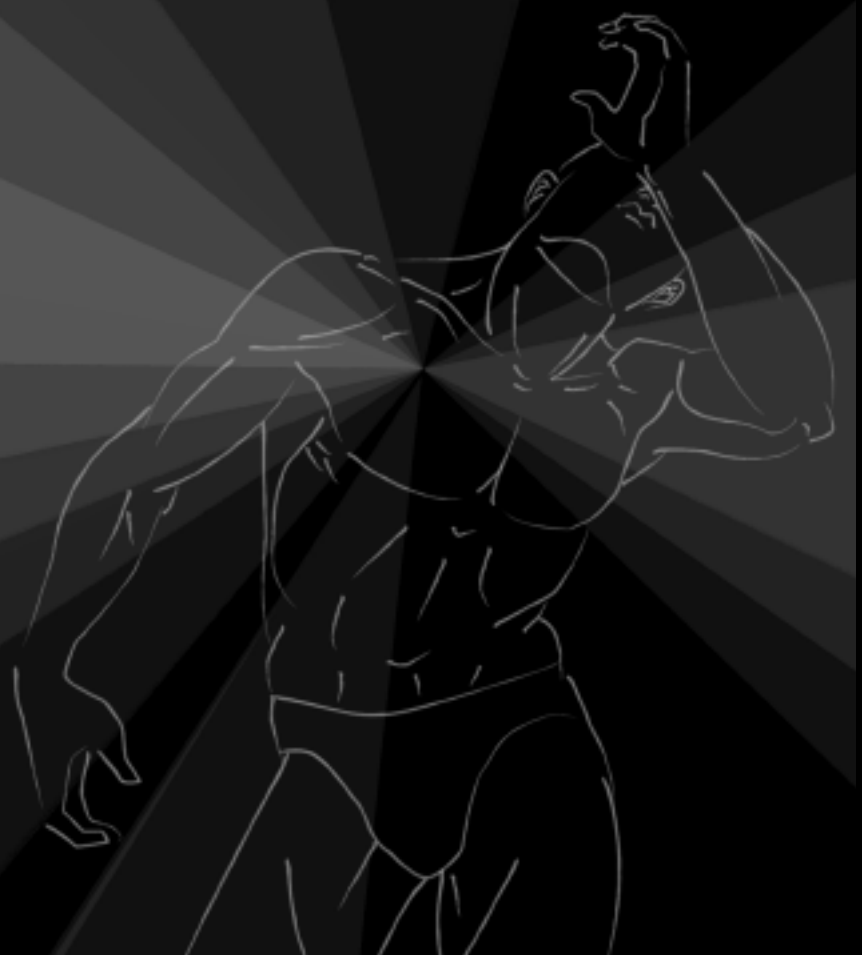
- In September 1999, the CSC's Study Group on Needle Exchange Programs recommended a pilot program for needle exchange in prisons.
- In June 2003, the House of Commons Standing Committee on Health recommended that the CSC provide harm reduction strategies similar to those within the community.
- In December 2003, the Canadian Human Rights Commission recommended that "CSC implement a pilot needle exchange program in three or more correctional facilities, at least one of which should be a women's facility, by June 2004."
- In October 2004, the Canadian HIV/AIDS Legal Network conducted an extensive study of prison needle exchange programs in pilot sites around the world and made one recommendation: "Both federal and provincial/territorial correctional services in Canada should immediately take steps to implement multi-site pilot needle exchange programs."

Finally, the Office of the Correctional Investigator—a body that investigates and responds to complaints directed towards the CSC—concluded that there has been no movement by the CSC on the issue of needle exchanges in prisons over the past decade, despite the number of reports from government and non-government agencies that have advocated for the provision of sterile needles to Canadian prisoners. They recommended that the CSC "introduce before March 31, 2005 a safe needle exchange program, and failing a positive response from CSC, for the Minister responsible to direct the introduction of such a program." The CSC has "agreed to explore" the issue.

After ten years, it's time for decisive action, not more discussion. ⊕

A special thank you to Howard Sapers, Office of the Correctional Investigator Canada, for providing the information for this article.

Terry Howard is the coordinator of the prison outreach program at the BCPWA Society.



A DANGEROUS DANCE

Watch out for interactions between antiretrovirals and street drugs—they can be deadly

by Anne Drummond

On an October morning in 1995, a 30-year-old man died from a severe reaction to Ecstasy (MDMA). Earlier in the evening, he took 180mg of MDMA with a few beers. Four hours later, he was seriously ill with an excessively high heart rate and respiratory rate. He had a seizure with convulsions, vomited, and then went into cardiorespiratory arrest. Doctors were unable to resuscitate him. His blood concentration of MDMA post-mortem was ten times higher than expected, given that he had only taken 180mg of MDMA.

The patient's history showed that he had tested HIV-positive in 1991 and developed AIDS in 1995. Because he had a low CD4 cell count, his physicians added ritonavir (Norvir) 600mg twice daily to his existing antiretroviral regimen of zidovudine (Retrovir/AZT) 200mg three times daily and lamivudine (3TC) 150mg twice daily.

Since he had taken two to three tablets of MDMA on several previous occasions with no ill effects, doctors concluded that a ritonavir interaction had increased the level of MDMA in his blood. Despite taking a relatively small amount of Ecstasy, he died from an overdose.

Deaths spark some research

Due to moral, ethical, and legal issues, there is little research on interactions between street drugs and antiretroviral therapy. However, a few deaths of PWAs on highly active antiretroviral therapy (HAART) after using street drugs have prompted some investigation into the issue of drug interactions. The growing population of HIV-positive people on HAART who are injection drug users (IDUs) also necessitates increased awareness of the potential for harmful drug interactions.

The HIV-positive IDU population has many faces: men who have sex with men (MSM); middle-class recreational users; homeless men, women, and youth; Aboriginal people; and male and female sex workers. While these groups are vulnerable to harmful drug interactions, young MSM and other users of club

drugs tend to be at greater risk, partly due to factors such as alcohol consumption, crowded conditions, and excessive and prolonged activity in the club scene. Club drug users, more than PWAs from other groups, are also most likely to be on antiretroviral treatment and perhaps other metabolic or psychiatric drugs.

While research has clearly established the relationship between the sex trade and substance abuse, and while sex workers have a higher prevalence of HIV infection than the rest of the IDU population, they may experience fewer drug interactions since they are less likely to be on HAART. Male sex workers in particular are extremely marginalized: they are young, homeless, often aboriginal, many have not completed high school, seldom interact with the health care system, and are rarely reached by traditional education and prevention programs. Similar conditions apply to other highly marginalized groups such as Aboriginal and homeless adults and youth.

TheP450 system

Most drugs are foreign to our bodies and need to be metabolized (broken down) by chemical reactions into molecules that can be easily excreted in the bile or urine. Also, some drugs need to be metabolized to release their active ingredients. The liver plays a central role in metabolizing most drugs, but the lungs, intestine, and even parts of the brain contain the enzymes necessary for the metabolism of drugs. Cytochrome P450 is a family of iron containing enzymes in the liver that break down and detoxify drugs in humans.

The P450 system is highly sensitive to environmental factors such as insecticides, herbicides, smoking, drugs, and caffeine. As a result, drug metabolism in the liver varies greatly among individuals, which accounts, in part, for variation in treatment response among people on HAART and other drugs. Many enzymes in the P450 system are involved in the metabolism of more than one drug; therefore, the more drugs you are taking, the more likely you are to experience an interaction.

Avoid combining MDMA and ritonavir; at least one death and a number of near-fatal reactions have been reported.

Drug interactions involving the P450 system are common and result from either inhibition or stimulation of the enzyme system. Enzyme inhibition usually involves competition with another drug for the enzyme binding sites. If two drugs are present that are both metabolized by the same enzyme, the drug that binds more strongly to the enzyme will be metabolized, while the other drug remains in the plasma and may accumulate to dangerously high levels.

Enzyme stimulation occurs when a drug increases the enzyme's capacity for breaking down another drug. This results in more rapid metabolism of that drug or another drug and consequently lowers the level of that drug in your system.

Viral rebounds and drug resistance

Aside from the dangers of an overdose reaction to MDMA or crystal meth, drug interactions with HAART are of particular concern because plasma concentrations of antiretrovirals may be reduced below therapeutic levels and cause viral rebound and/or the development of drug resistance. Not all drug interactions with antiretroviral drugs are harmful; some are beneficial and clinicians use them to improve the efficacy of a regimen. For example, the protease inhibitor (PI) ritonavir raises plasma levels of the PIs saquinavir (Fortovase), indinavir (Crixivan), and amprenavir (Agenerase), by inhibiting the metabolism of these drugs in the liver.

Although there has been little research on the interactions between street drugs and HAART, many drug interactions can be predicted based on knowledge of the enzyme systems involved in metabolism of the drugs in question.

Watch out for these interactions

Alcohol. Abacavir (Ziagen) can potentially interact with alcohol since both are metabolized by the enzyme alcohol dehydrogenase. Researchers observed a 41 percent increase in plasma levels of abacavir in a crossover study with HIV-positive individuals who took 600mg abacavir with 0.7mg/kg of ethanol. This increase was of little clinical significance, however, because it did not reduce the therapeutic effect of abacavir.

Bouts of heavy drinking can inhibit P450 enzymes and thus raise plasma levels of medications such as beta-blockers and some anti-depressants. With chronic use, alcohol can stimulate the enzyme system, causing sub-therapeutic levels of medications such as oral contraceptives, PIs, non-nucleoside reverse transcriptase inhibitors (NNRTIs), and statins.

In addition, chronic heavy use of alcohol damages the liver, making it more difficult to process antiretroviral drugs.

Marijuana. Tetrahydrocannabinol (THC), the active component of *Cannabis sativa* will interact with any other drugs using the same P450 enzyme for metabolism. In two studies, patients receiving PIs indinavir and nelfinavir (Viracept) smoked THC and then received synthetic cannabinoid dronabinol (Marinol). In both cases, there were 17 to 22 percent decreases in plasma levels of the antiretrovirals, but with no detrimental effect on their activity. The PIs, however, appear to increase THC levels in the blood, so even small doses are very potent; the same appears to apply to dronabinol. This interaction is not dangerous.

Rave drugs. MDMA (Ecstasy) and other amphetamines are likely to interact with ritonavir and other PIs. Ritonavir, and

continued on next page

possibly other PIs and some NNRTIs, can increase blood levels of all amphetamines with serious and potentially fatal consequences. Avoid combining MDMA and ritonavir; at least one death and a number of near-fatal reactions have been reported.

Although little is known about the metabolism of LSD, there have been anecdotal reports of more intense and much extended trips with LSD while on HAART containing PIs.

Frequent use of ketamine (Special K) in conjunction with PIs can increase the side effects of HAART: nausea, fatigue, kidney, and liver toxicity. In particular, ketamine and HAART can cause a severe chemical hepatitis (inflammation of the liver), which requires hospitalization and results in liver damage that will compromise future HAART efficacy.

Due to moral, ethical, and legal issues, there is little research on interactions between street drugs and antiretroviral therapy.

Benzodiazepines. Benzodiazepines such as triazolam, midazolam, and alprazolam are all metabolized by the same P450 enzyme as protease inhibitors. Interactions with PIs, and non-nuclecide reverse transcriptase inhibitors (NNRTIs) delavirdine (Rescriptor) and efavirenz (Sustiva) are likely to increase concentrations of the benzodiazepines to toxic levels, with additional effects such as extreme sedation and slowed respiration.

Ritonavir has also been implicated in harmful interactions with alprazolam. In one study, ritonavir initially inhibited the enzyme and increased plasma levels of alprazolam. After prolonged use, ritonavir induced the enzyme and caused a reduction in alprazolam levels. Patients experienced benzodiazepine withdrawal sym toms.

Other benzodiazepines such as lorazepam, temazepam, and diazepam are metabolized by a variety of enzymes, so drug interactions with antiretrovirals are less likely.

Cocaine. While there are no reports of interactions between cocaine and HAART, ritonavir, indinavir, and efavirenz are potent inhibitors that may lead to increased levels of the norcocaine metabolite in the blood when combined with cocaine; the effect may be life-threatening cocaine toxicity. Cocaine may also depress the immune system. Moreover, in trials using mice, cocaine enhanced replication of HIV.

Heroin. Heroin is rapidly metabolized to morphine by enzymes in the blood and liver. Nelfinavir and ritonavir both accelerate morphine metabolism causing levels of morphine to decrease; in these cases, increased heroin doses are required to avoid withdrawal symptoms.

Methadone. Methadone assists in stabilizing the lives of heroin (opioid) dependent individuals. Interactions between methadone and PIs and NNRTIs are common. Patients on methadone who also take efavirenz (Sustiva) or nevirapine (Viramune) are likely to experience opiate withdrawal symptoms, since these NNRTIs cause a significant lowering of methadone levels.

Studies have shown that the PIs amprenavir, lopinavir/ritonavir (Kaletra), and to a lesser extent nelfinavir, reduce methadone concentrations sufficiently to warrant increasing the methadone dose.

Methadone causes a decrease in plasma levels of didanosine (Videx/ddI) when it is taken in the buffered tablet form, but the enteric-coated Videx EC formulation is not affected by methadone.

Methadone can increase plasma levels of zidovudine by up to 40 percent. The increases in side effects—nausea, vomiting and headaches—from overmedication of AZT are sometimes confused with opiate withdrawal symptoms.

The bottom line

Despite our knowledge about street drug interactions with antiretrovirals, there are some significant confounding variables. Even if we know that drugs use the same enzyme for metabolism, it is not always clear whether the drugs will interact through induction or by inhibition. In addition, some people will be more susceptible to drug interactions than others will. Finally, street drugs are often laced with other drugs that are often unknown, which further increases the potential for harmful drug interactions.

Therefore, if you are using any other drugs, either prescribed medications or recreational drugs, inform your physician to avoid the possibility of drug interactions that may compromise your antiretroviral therapy—or even endanger your life. ⊕

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

What you need to know about **drug resistance** and **adherence**

presented by:

British Columbia Persons With AIDS Society
www.bcpwa.org

supported by:

AbbottVirology™
From Research to Reality

This is a **free event** for persons living with HIV/AIDS and any interested participants. Dinner provided. Please RSVP to 604.893.2274 or treatment@bcpwa.org before September 30th.

Just what you knead

Here's a primer on different massage therapy styles

by Kenn Blais

We all know that massage feels good and alleviates pain and muscle tension. Psychologically, it can leave you feeling more peaceful and relaxed. However, it also has other physical therapeutic benefits, including for people with HIV/AIDS.

Massage enhances the movement of fluids—including blood, digestive fluids, lymph, and glandular secretions as well as intercellular fluids, thereby allowing communication between cells. Although it's important to kill bacteria and fungi in your body, if these dead organisms are not removed, they decay and release more toxic waste into your system. This is added to the waste produced by your body's own functions, such as lactic acid (which causes acute pain and anxiety) and free radicals which can "rust" many necessary chemicals in the body.

Add to this your daily dose of antiretroviral medication, plus more pills to counteract their side effects, and you begin to understand the importance of efficient expulsion of wastes. Massage can also soften muscle fibres and connective tissue to decrease chronic muscular tension.

There is some research to support the benefits of massage for PWAs. The Touch Research Institute (TRI) at the University of Miami School of Medicine has conducted a number of controlled clinical trials. In 1996, a one month study involving 29 HIV-positive men who received daily massages showed significant increases in their natural killer cell numbers, significant decreases in the hormone cortisol (released during periods of stress or agitation) and anxiety, and greater states of relaxation.

In 2000, the TRI conducted a 12-week study of 24 HIV-positive adolescents who were randomly assigned to either a massage group or a relaxation group. The massage group received a 20 minute seated massage twice a week while the relaxation group was led through a progressive relaxation exercise for two 20 minute sessions a week. Results showed that natural killer cells increased among participants from the massage group only. Moreover, the massage group showed improved immune function and, according to a depression assessment scale, individuals from the massage group reported feeling less depressed than people from the relaxation group.

There are over 100 officially recognized styles of massage, many of which overlap in terms of technique and therapeutic benefits. The following outlines four major genres, and some of the more popular styles in each group.

The soft tissue styles

Swedish massage is the basis of traditional therapeutic or Western massage. This technique involves rubbing and kneading the soft tissues (skin, muscles, ligaments, tendons, connective tissue, and membrane) of the body. The massage is done in a continuous, flowing motion with emphasis on increasing circulation by working from the extremities towards the heart.

Another soft tissue style is the medical massage, which treats a particular injury or problem area. Medical massage requires a doctor's referral.

The deep tissue styles

Contrary to popular belief, deep tissue work does not involve pain. However, to access the deeper layers of the body, the muscles must be thoroughly warmed and relaxed. The practitioner works with the resistance of the muscles, "persuading" flexibility and allowing access to underlying tissues. Much of deep tissue massage focuses on the connective tissue, which forms a continuous web throughout the body. Styles of deep tissue massage include Rolfing, myofascial release, and traeger.

Effective manipulation of the connective tissue is like pulling on the corner of a tablecloth and moving every dish on the table. The connective tissue is an important part of our immune system. By warming, pulling, and stretching in specific areas and patterns, the practitioner is able to access very deep areas.

Deep tissue massage is considered the psychotherapy of the touch therapies—it is effective for emotional ailments and increases mental clarity.

Type of massage	Benefits	The session
Swedish massage	Improved blood and lymph flow and increased nutrient intake. Loosens joints and chronically tensed muscles. Releases endorphins.	Lasts 30 to 90 minutes. Client is fully undressed and covered. Oil, lotion, or powder is used for smooth stroking without irritating skin.
Medical massage	Specific to a particular injury or treatment.	Usually lasts 20 minutes. Same technique as Swedish massage, but practitioner works only on area indicated.
Deep tissue massage	Structural releases and improved structural integrity.	Lasts 60 to 90 minutes, for up to ten sessions. Client is fully undressed and covered on massage table. Sitting or standing positions may be involved. Oils may or may not be used.
Shiatsu	Disease prevention by maintaining proper balance in the body. Often used for acute and chronic pain.	Lasts 30 to 90 minutes. Client lies on a futon mat on the floor wearing loose comfortable clothing. No oil is used.
Reflexology	Improves circulation and stimulates lymph glands to remove toxins. For acute and chronic pain; helps headaches, back pain, blood pressure, and emotional disorders. Increases energy and alertness.	Lasts 30 to 60 minutes. Client is fully clothed in a chair or lying on a table with shoes and socks removed. Oils, lotions, or powders may be used.
Therapeutic touch	For acute pain and acute anxiety. Raises hemoglobin as well as increases the temperature of the extremities for increased circulation.	Lasts 15 to 30 minutes. Client sits in a chair or lies on a table, fully dressed.
Reiki	Focuses on the glands and endocrine system, which regulates hormones.	Lasts 60 to 90 minutes. Client lies on a table, fully clothed. No oils are used.

The reflex styles

The body contains a concise and intricate series of reflex systems. Stimulation of certain areas release neurotransmitters that trigger muscle and nerve impulses to specific areas deep within the body.

Shiatsu literally means "finger pressure." This style of massage is based on the circulation of the vital life force through the meridian system of twelve energy pathways in the body. Each meridian relates to specific organs and their functions, which are stimulated through various points along its pathway on the skin. The pathways act like a series of locks in a canal, to either enhance or decrease the flow of energy, which may be blocked or unbalanced. The goal is to prevent disease by maintaining proper balance within the body.

Reflexology has ancient origins. It is based on patterned reflex zones, primarily located in the feet (but also in the hands and ears), which are used as a map of the entire body. The work involves varied types of pressure applied to specific areas called referral zones, since these zones correspond to another area of the body. Specific points coordinate with different organs, glands, or body parts.

The energy work styles

The non-touch energy work styles are probably the oldest of the healing traditions. They utilize the subtle electromagnetic field that surrounds the body as well as the wavelengths from the universal field.

Therapeutic touch has been thoroughly researched and is used extensively in clinical settings. Practitioners hold their hands over, around, or opposite deficient areas in order to direct in a flow of energy from the greater universal source.

Reiki is Japanese for "universal life energy." Practitioners undergo three degrees of training to become conduits for the flow of universal energy. They place their hands lightly in ten to 20 specific areas for three to five minutes each. These areas correspond to the chakras or energy wheels, which relate to specific organs and glands. The principle of the work is that the client draws in the energy where needed. ⊕

Kenn Blais is a massage therapist and treatment information counsellor for the Treatment Information Program at the BCPWA Society.

Fat free

New compound shows early promise in reducing lipodystrophy

by Zoran Stjepanovic

One of the most common issues that the BCPWA Society's Treatment Information office hears about is lipodystrophy and unwanted body shape changes that can result from HIV disease and related medications. Many PWAs experience fat accumulation—fat gain in the belly and "buffalo humps" on the back of the neck. Others experience facial lipoatrophy, which results in sunken cheeks. For many PWAs, these body shape changes are stigmatizing and contribute to low self-esteem and confidence. Living in a culture consumed with body image, HIV-positive individuals can become quite discouraged and, not surprisingly, may have fears about initiating HIV therapy known to cause these side effects.

Unfortunately, there are no treatments other than surgical removal (liposuction) for lipodystrophy or cosmetic surgery (implants) for sunken cheeks. Furthermore, these procedures have risks, and results may only be temporary.

Some PWAs take growth hormones to reverse belly fat and add muscle. There have been some experimental studies showing that injections of high doses of growth hormone may help reverse fat accumulation in the belly; however more research is needed. Since growth hormones can also burn fat in other areas of the body—such as under the skin—there is a risk of making the appearance of wasting even worse.

There may be an alternative. A new compound, TH9057, currently under investigation, is showing promising early results in its ability to reduce some fat in the belly. TH9057 is a peptide that stimulates the brain to produce growth hormone in small amounts. Although the brain's pituitary gland usually releases growth hormone each day, research shows that PWAs have less than normal amounts of growth hormone in their bodies. Introducing this compound causes the body to produce small amounts of naturally occurring growth hormone, which results in loss of fat without the appearance of fat wasting.

Results from phase II studies of TH9057 were presented last year at the 6th International Workshop on Adverse Drug Reactions and Lipodystrophy in HIV in Washington, DC. Sixty-one PWAs from Canada and the US participated in the trials. All participants had excess abdominal fat, were taking antiretrovirals, and had raised blood sugar levels. The average age was 45. Participants received either TH9057 1mg/day, 2mg/day, or a fake injection (placebo).

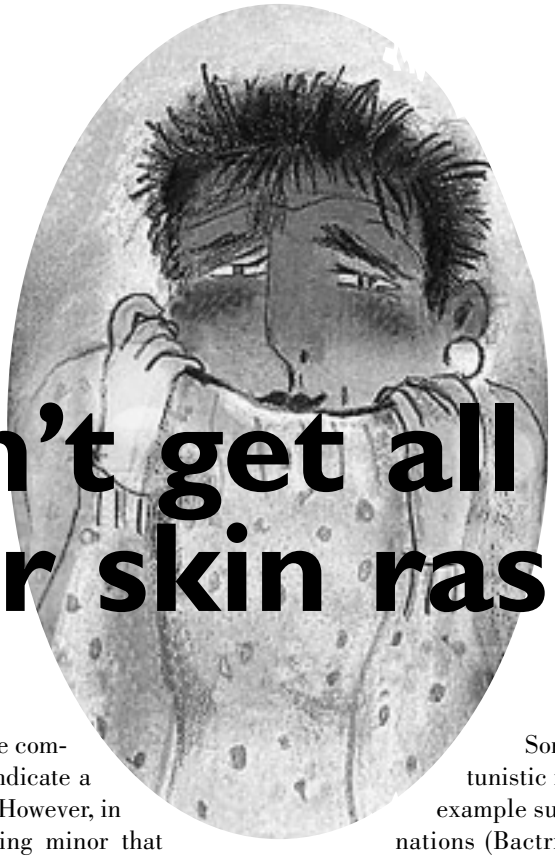
PWAs who received 2mg/day experienced a 16 percent decrease in abdominal fat, and lost about 1kg of fat in their bellies. Some participants experienced side effects from the injections, including headache, rash, and some bone and joint pain. There were no reports of diabetes resulting from these injections.

Theratechnologies, a Canadian-based biopharmaceutical company investigating TH9057, issued a press release in July indicating that phase III clinical trials of this compound will soon be underway. The phase III trial will investigate the safety and efficacy of the TH9057 by administering 2mg of this compound daily to study participants, over a 26-week period.

It's still early to tell whether this compound will be fully effective in reducing unwanted abdominal fat. It may be a while before findings from the phase III studies are released and even longer until the compound is made available. Nevertheless, it is encouraging to see that research in this area is underway, since lipodystrophy is such a significant concern for many PWAs taking antiretroviral therapy.

Theratechnologies hopes to conduct this study in 35 sites across Canada and the US and intends to recruit 400 patients. As of this writing, it is still unknown whether or not the study will take place in Vancouver. Call the BCPWA Society Treatment Information office at 604.893.2243 for updates. ⊕

Zoran Stjepanovic is the treatment information coordinator with the BCPWA Society.



Don't get all red over skin rashes

by R. Paul Kerston

With HIV, skin problems are common. Some skin rashes indicate a serious medical problem. However, in other cases, a rash can be something minor that resolves itself with no major consequences. Skin rashes can be caused by HIV itself or as a result of a drug reaction or side effect. Other causes may be entirely unrelated to HIV disease.

In terms of HIV drug reactions, non-nucleoside reverse transcriptase inhibitors (NNRTIs) such as nevirapine, delavirdine, and efavirenz can all cause rashes. If you suspect one of these drugs has caused a rash, call your doctor. Most often, the rashes are not severe and disappear quickly, sometimes without treatment. You can usually prevent rashes when beginning NNRTIs by starting with lower dosages.

Among the nucleoside reverse transcriptase inhibitors (NRTI), abacavir can cause a serious hypersensitivity reaction. Symptoms may include a rash, but sometimes also involve respiratory problems and/or flu-like symptoms. Although relatively few people experience this hypersensitivity reaction (roughly five to eight percent of participants involved in abacavir drug trials), it usually manifests within the first weeks of treatment.

If your doctor prescribes abacavir, your pharmacist should provide a list of important signs to watch for. If any of the potential signs or symptoms appear, stop treatment immediately and call your doctor. If your healthcare professional suspects an abacavir hypersensitivity reaction, you should never take the drug, since it can be very dangerous, even fatal.

Protease inhibitors (PIs) such as nelfinavir mesylate can also cause rashes. One study revealed that roughly five percent of HIV-positive patients with very low CD4 counts who started treatment with PIs developed a rash, generally in the first few weeks after initiating treatment. The risk was significantly higher in women and in patients who didn't receive a highly active antiretroviral therapy regimen.

Some medications used to treat opportunistic infections can also cause rashes. For example sulfonamide and trimethoprim combinations (Bactrim), used to prevent or treat Pneumocystis carinii pneumonia (PCP), can also cause a rash.

Treatment for rashes often involves topical skin creams, including corticosteroids, which may require a referral to a dermatologist for a prescription. Alternative treatments include flaxseed oil or other essential fatty acid supplements, since HIV can cause a gradual depletion of fatty acids. Essential vitamins, such as A, B, and E, plus minerals such as zinc, can also help with basic skin care.

In addition to rashes, seborrheic dermatitis (flaky skin and scalp), is believed to be caused by fungi, and is also common among people living with HIV. Depending upon the area affected, the condition can be treated with shampoos, creams, or one of the "conazole" drugs. Another type of fungal skin problem, folliculitis (an inflammation of hair follicles), can cause an itchy rash. Bacterial varieties of rashes generally require antibiotics.

With proper care, rashes are often manageable. Still, it is important to determine their cause and treat them if necessary. If you have questions, see your doctor. You can also contact the BCPWA Society Treatment Information Program office at 604.893.2243 or treatment@bcpwa.org for information. ⊕

R. Paul Kerston is a researcher with the Treatment Information Program at the BCPWA Society.

Spoiled rotten

Learn how to prevent food borne illness

by Diana Johansen

Food, full of life-giving nutrients, provides the nourishment we need for health and sustenance. However, food can also be a source of illness if it's contaminated. HIV infection places individuals at greater risk of food poisoning because a weakened immune system can't defend against contaminants in unsafe food. HIV-positive people who contract food borne illnesses often develop more severe symptoms, which can be recurrent and difficult to treat. These symptoms include nausea, vomiting, chills, cramps, and diarrhea—all very common ailments among persons living with HIV/AIDS.

To prevent food borne illness, first we need to ensure that the food itself is safe and won't cause harm when it is eaten or prepared properly. Food hygiene involves all the strategies necessary to keep the food safe at each stage of the food chain. There are many stages in the supply of food—from its source to our table—where food can become contaminated by environmental factors, microorganisms (such as bacteria), or toxins. As consumers, we have little control over the early stages of food production, transportation, processing, and storage, but we can take appropriate measures in our selection and personal handling of food.

Common types of food borne infections

Salmonellosis is an illness caused by eating foods contaminated with the *Salmonella* bacteria. The symptoms, which usually develop six to 48 hours after exposure, include nausea, vomiting, cramps, and diarrhea. Symptoms typically last up to one week. The most high-risk foods are raw or undercooked eggs, poultry, meats, and fish. However, vegetables, herbs, spices, and shellfish have also been implicated.

Campylobacter is bacteria found in raw or undercooked poultry and unpasteurized milk. Symptoms of campylobacteriosis (infection) include abdominal pain, watery diarrhea, nausea, headache, fever, and muscle pain which begin two to five days after eating contaminated food and last for seven to 10 days.

Listeriosis illness presents flu-like symptoms such as fever, chills, headache, and possibly nausea and vomiting two to 30 days after exposure. Infection is not as common with this bacteria but the disease can develop into meningitis with an increased mortality risk. *Listeria* is found in unpasteurized milk and cheese, raw or undercooked meat, poultry, fish, hot dogs, and possibly deli meats.

E. coli are bacteria found in raw or undercooked meats, especially ground meat. You may also find it in unpasteurized milk, juice, or apple cider, raw fruits and vegetables, and raw bean or alfalfa sprouts. Symptoms, including bloody diarrhea and stomach cramps, occur seven days after infection at last two to five days. Severe infection can result in hemolytic anemia, kidney failure, and long-term kidney problems.

Other contaminants

Mould is a fungus that thrives on moist foods like fruits and vegetables. Some moulds produce dangerous mycotoxins, which may be invisibly distributed around the mould; they may not be destroyed by heat and can live for a long time.

Some foods contain natural toxins that must be neutralized by cooking or avoided altogether. Solanine is found in green potato skins; lectins are found in raw legumes (dried beans and lentils); toxins are found in raw cassava.

Industrialization and large-scale food production have also contaminated our food supply. For example, farmed salmon contains more PCBs, dioxins, and pesticides than wild salmon, and tuna has high levels of mercury.

Safe food becomes high risk when it comes into contact with contaminated foods, unclean equipment, infected food handlers, insects, rodents, or chemicals. Bacterial contamination

causes illness when bacteria grow to high numbers in foods or they produce toxins in the food. Bacterial growth requires food, especially non-acidic foods, moisture, and warm temperatures. Heat will kill most bacteria but not toxins that may have formed.

Taking precautions

Food borne illness is largely preventable by taking the following precautions:

Purchasing. This is the first place we have control over our food supply.

- Buy only pasteurized milk, dairy products, apple cider, and fruit juices.
- Avoid damaged packages and dented cans.
- Avoid cracked eggs, alfalfa sprouts, and bruised or moldy fruits and vegetables.
- Buy only bulk foods that you are going to cook.
- Check the "best before" date and buy foods with a longer date.
- Buy cold and frozen foods last when at the supermarket.
- Take foods home immediately for refrigeration.

Storage. This is where we protect our personal food supply.

- Protect foods from insects and rodents by keeping them in plastic containers or the refrigerator.
- Keep foods that need to be cold or frozen in the refrigerator or freezer.
- Keep meats on the bottom shelf of the refrigerator so they won't drip on other foods.
- Don't reuse plastic bags for food storage.

Preparation. Most contamination happens in the home during this stage.

- Wash your hands before preparing food and frequently during preparation using soap and hot water.
- Use clean equipment and work surfaces. To be extra clean, make a solution of 1 teaspoon of bleach to 1 litre of water and rinse counters from time to time. Use clean washcloths and towels.
- Wash fruits and vegetables well under running water.
- Thaw foods in the refrigerator, not at room temperature.
- Avoid cross-contamination of foods. Do not let raw meats, poultry, or fish come in contact with other foods. Use a different cutting board and wash hands and utensils with soap and water immediately after handling raw meats. Dispose of packaging and wash up any splatter of meat juices.
- Don't eat raw cookie or cake batter.
- If you discover mould on any part of your food, throw away the food; don't scrape off the mould and eat the rest.

Cooking. The rule of thumb is that all animal foods should be cooked well done.

- Cook all meats, poultry, eggs, and fish to the well-done stage, especially ground beef. The juices of chicken are clear, egg yolks are firm, and meat is not pink. A thermometer should reach 180°F for chicken and 160°F for hamburgers. Eating raw eggs or fish (sushi) is not advisable.
- Cook hot dogs and deli meats until steaming hot.
- If you cook in a microwave, let food stand to finish cooking.
- Keep hot foods hot (over 140° F) and cold foods cold (under 40°F). Bacteria grow best at warm temperatures so don't leave foods sitting at room temperature for more than two hours.
- Cut green parts off potatoes; the potato is fine to eat otherwise.

Leftovers. Leftover food is safe and practical if handled properly.

- Store leftovers in the refrigerator or freezer right away. It is okay—and much safer—to put hot foods in the refrigerator right away.
- Eat refrigerated leftovers within two days and only reheat once.
- Reheat leftover gravies and sauces to boiling and other leftovers to 160°F (steaming hot). If you use a microwave, stir food at midpoint during cooking to heat it all the way through.
- When in doubt, throw out food, because contaminated food doesn't always look or smell bad.

Restaurants. You can safely enjoy eating out with the same precautions taken at home.

- Eat cooked foods like well-done poultry, meals, fish, shellfish, and eggs.
- Avoid salad bars, sandwich bars, and juice bars.
- Caesar salad and some desserts like mousse and tiramisu may contain raw egg; these foods should be avoided.
- Sushi made with vegetables or cooked seafood is safer than that made with raw fish and seafood.
- Choose restaurants that are clean and seem to have high standards of food sanitation.
- Hot food should be served hot.

Avoid other contaminants

Eating a wide variety of foods minimizes contact with any specific contaminant, such as mercury. Foods that have healthy properties sometimes have risks, so don't eat them in great quantity. For example, only eat tuna and farmed salmon, valued for their omega 3 fatty acids and healthy heart profile, once or twice a week.

Safe food is largely in your hands. Get all the nourishing value out of your food without risking your health by taking good care of your food supply at all levels. ⊕

Did you know?

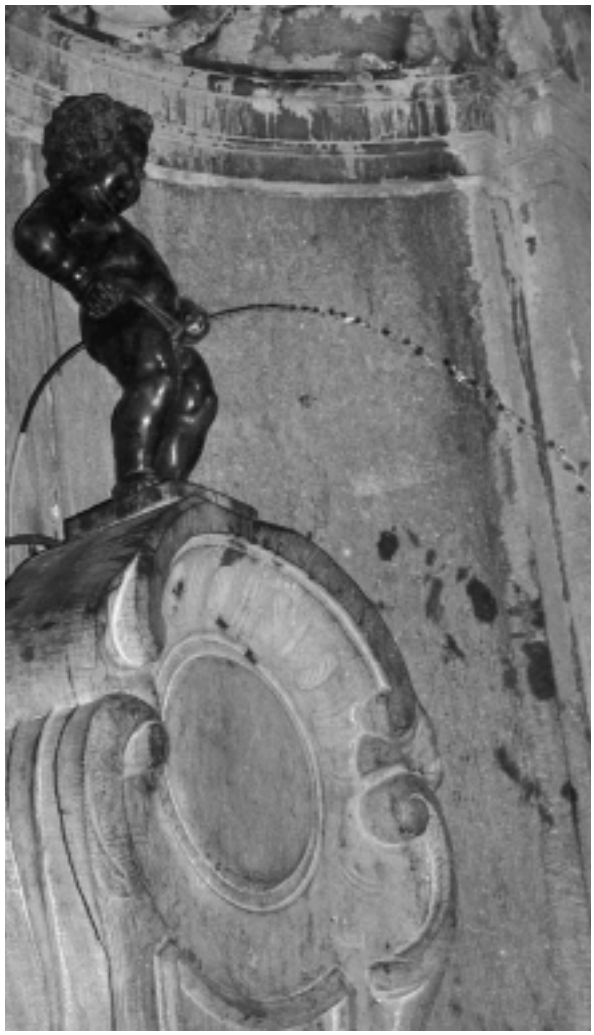
People with HIV/AIDS are approximately 20 times more likely to get *Salmonella* poisoning than individuals with intact immune systems.

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

Sweet pee

Reducing the chance of urinary tract infections

by Ágnes P. Kalmár



Urinary tract infections (UTIs) are very common among the general population. Most of these infections are caused by bacteria such as *E. coli*. Some of the symptoms include burning pain upon urination, frequent need to urinate, dark bloody colour of urine, fever, and chills. Women are more likely to get UTIs than men, but UTIs in men are harder to treat and are more likely to recur. People with diabetes and immunodeficiencies, such as a low CD4 count or high viral load, are also at higher risk of getting repeat UTIs.

There are some simple steps you can take to help reduce the chance of infection and recurrence:

- Drink plenty of fluids to help irrigate the bladder; eight to 10 cups a day is recommended, including coffee, tea, juice, milk, and water. Water is essential.
- Eat an overall healthy diet to keep your immune system strong.
- Drink cranberry juice.

In order for a UTI to develop, the bacteria must stick to the wall of the bladder to multiply and cause an infection. Studies repeatedly show that cranberries have an active ingredient called proanthocyanidins that prevent the bacteria from sticking to the wall of the bladder and are, instead, flushed out with urine. This unique mechanism also prevents the bacteria from becoming resistant to cranberries, which commonly occurs with antibiotics. Among those who are prone to UTIs, cranberry juice reduces recurrence by about 50 percent. However, once you have an active infection, cranberries will not cure it; you need to get antibiotics from your doctor.

Bear in mind a few things when you head to the grocery store. Most of the cranberry juice on the shelf is not really juice, but cranberry cocktail. One hundred percent cranberry juice is very bitter tasting and hard to find. Your best bet is to find a cranberry cocktail that is about 25 percent juice and 75 percent sugar water, or a blend of other juices.

Another option is light cranberry juice, which replaces the sugar with artificial sweeteners, cutting the calories by two-thirds. If you have diabetes, you need to stick to the light cocktails since the regular juice will increase your blood sugars.

Studies show that to reduce the chance of recurring UTIs, you must drink two cups of 25 percent cranberry cocktail each day. It's best to drink one glass in the morning and one at night, for a continuous effect.

Cranberry pills are hit-or-miss. There's no guarantee that the active ingredient is even present, and the actual quantity of the active ingredient remains uncertain, so you're better off sticking to cranberry juice or whole cranberries.

Remember, all of these suggestions help in preventing UTIs, but they will not cure an infection if it's already present. See your doctor if you have any of the symptoms of a urinary tract infection. ⊕

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

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.

Healthy eating on the run

by Jennifer Hrushkin

I'm going back to school in September and know that between working full time and taking classes, my life will be busy. I would like to have a healthy diet, but am not sure how I can manage this.

Whether it's back to school, back to work after summer vacation, or just a non-stop schedule, it's difficult to juggle a hectic lifestyle with healthy eating. With a bit of planning, however, you can make easy, healthy meals.

Healthy eating involves several things: eating a wide variety of foods; eating regularly throughout the day; choosing foods packed with vitamins, minerals, and other nutrients; and choosing low fat foods more often. *Canada's Food Guide to Healthy Eating* divides foods into four distinctive groups: grains, fruits/vegetables, milk products, and meat and alternatives. A balanced meal includes foods from three or four of these groups.

Here are a few suggestions:

Be prepared

- Buy the basics: eggs, bread, lean meats, canned fish or vegetarian sources of protein, milk or soy beverages, and fruits and vegetables. Write a grocery list that includes several foods from each food group. Focus on foods found on the perimeter of the grocery store—usually the less processed foods.
- Purchase larger quantities and divide into individual portions. Fresh meats can be frozen.
- Choose fresh, frozen, or canned foods. Have frozen vegetables on hand or try the pre-packed salads.
- Spend a day making several entrees and freeze in individual portions. After school or work, it's convenient to reheat small portions of casseroles, chili, soups, and meat or vegetarian entrees.

Be creative

- You don't need to limit breakfast foods to breakfast and lunch foods only for lunch. Why *not* have cereal for dinner? Add an egg and a piece of fruit for a balanced meal.
- Make it social
- Take turns with a friend preparing dinner. You'll save time, learn new recipes, and dine in good company.
- Keep it simple
- Healthy eating does not need to be gourmet or take an hour to prepare. Try a roast beef sandwich, salad, and a glass of milk.

Need some meal ideas? Try a poached egg on toast with a piece of fruit. Bean and lentil dishes are also simple and healthy. Or try this chicken recipe with homemade "shake and bake" coating:

> 4 1/2 cups fine bread crumbs
> 1/2 cup flour
> 3/4 cup dried parsley
> 1/2 cup dried basil
> 2 tablespoons each paprika, oregano, onion powder, thyme, and rosemary
> 2 teaspoons each of salt, garlic powder, pepper

Combine all ingredients and stir well. Mix ingredients ahead of time and store. Refrigeration is not necessary because they are all dry ingredients. After work or school, coat chicken breasts with the mixture. While it's baking, cook rice, steam vegetables, and/or have mini carrots with a low fat dip.

For those nights when you know you won't be able to spend time cooking, you can still make healthy choices with "fast" food. Many TV dinner brands have healthier choices (aim for about 50-60 grams carbohydrate, 21 grams protein, and less than 10 grams fat). Add vegetables and a healthy dessert. Or buy a whole grain, low fat submarine sandwich. If you order pizza, choose a vegetable loaded, lean meat variety with a whole wheat crust.

Remember, it is worthwhile to plan your meals, and it will pay off in the long run. For more ideas to fit your lifestyle, health condition, and food preferences, ask a dietitian. ⊕

Jennifer Hrushkin is a registered dietitian at St. Paul's Hospital in Vancouver.

Cookbooks for fast recipes

The HeartSmart Shopper: Nutrition on the Run, Ramona Josephson, Douglas & McIntyre, 1998

Full of Beans, Violet Currie and Kay Spicer, Gordon Soules Book Publishers, 1993

Dietitians of Canada: Great Food Fast, Bev Callaghan, Robert Rose Publishing, 2000

Choice Menus Presents: Meal Planning with Recipes for One or Two People, Marjorie Hollands and Margaret Howard, Canadian Diabetes Association, 2000

The young and the restless

HIV-positive youth must grapple with sexual health—which isn't always easy

by Sarah Fielden and Melanie Rusch

No matter how youth become HIV-positive—whether through injection drug use, sexual activity, or perinatal exposure—their sexual health is of paramount importance so they can keep themselves and their partners informed and healthy.

Sexual health does not end with an HIV infection, but it does change. Research shows that many HIV-positive youth remain at risk for other sexually transmitted infections (STIs), unplanned pregnancies, and re-infection with more dangerous or resistant strains of HIV. They are, in this respect, more at risk—both biologically and socially—than other youth.

The broad classification of youth spans from ages 13 to 29. Thus, when talking about sexual health for youth, a 13-year-old's sexual needs differs widely from those of a 29-year-old. That said, many Canadian youth begin to have sexual intercourse at a relatively early age. According to the BC Adolescent Health Survey in 2003 by McCreary Centre Society, about one-quarter of BC high school students are sexually active, and 20 percent of them are sexually active by age 15.

HIV-positive youth need information on sex

A lot of people prefer not to think about young people having sex. And, often, young people are made to feel ashamed of their sexuality. As a result, many adolescents' first sexual experiences are confused by incomplete and inaccurate information; and, more often than not, the encounter is unsafe. Teens are at the highest risk among sexually active population groups for becoming pregnant and contracting STIs, especially since they are often having unprotected, unsafe sex. Sexual education of young people with HIV is crucial to their health, wellness, and to reduce the risk of transmission.

Sexual risk behaviour is defined as any sexual activity that exposes someone to infection, disease, or pregnancy. A number of factors put HIV-positive youth at risk. Some are personal, others are social, and still others are cultural. For example, young people living with HIV might not have access to accurate or relevant information. There is a lot of prevention information available, but not much information on the subject of healthy sexuality for HIV-positive youth. Young people with HIV have to

sort through stigmatizing educational materials and messages in public circulation to even begin to understand the possibilities.

Aside from a lack of information, many other internal and external forces influence sexual risk behaviours among youth, such as experiences of physical and/or sexual violence, low self-esteem, depression, alcohol and drug abuse, and mental health issues. Poverty, lack of education, and the absence of social supports also influence people's health behaviours and limit their choices. Some young people are also part of vulnerable groups of people, such as Aboriginal populations, whose history of marginalization and cultural oppression, has exposed them to more high-risk behaviours, such as injection drug use and survival sex work.

Highest rates of STIs among female youth

STIs are common among young people. This claim is reflected, for example, in rates of chlamydia and gonorrhea in Canada, with over half of reported cases appearing among youth aged 15 to 29. The highest rates and increases in STIs in Canada are in young people 15 to 19 years old, especially females. In addition to learning about HIV, HIV-infected youth should know about other STIs including chlamydia, genital human papillomavirus (HPV), gonorrhea, hepatitis, herpes, syphilis, and trichomoniasis. Symptoms can include lumps, sores, and rashes, but other symptoms are invisible and therefore difficult to detect. Health Canada recommends that people be aware of any changes in health, or symptoms such as:

- Different or heavier discharge from the vagina
- Discharge from the penis
- Burning feeling during urination
- Sores, particularly in the genital or anal areas
- Itchy feeling around the sex organs or anus
- Appearance of rash
- Swollen glands in the groin

Like HIV, other STIs—also known as sexually transmitted diseases or venereal diseases—are infectious and contagious bacteria or viruses that spread from one person to another primarily through anal, oral, or vaginal sexual contact. Infected blood in needles and syringes can also spread certain STIs through sharing or needlestick injuries. In addition, infected mothers can inadvertently pass on some STIs through pregnancy, childbirth, or breastfeeding. A person can have many different STIs at once and the same STI multiple times. Luckily, many STIs are treatable, if not curable, but they can all become dangerous if ignored. [*Note: For more information about STIs, see living+ issue #37, pp. 20 – 22.*]

HIV and STIs and immune cells

HIV and STIs can advance one other through several mechanisms. The presence of genital sores may increase the possibility of infection with HIV, not only because of breaks in the skin, but also because of the presence of increased immune cells—the same cells that HIV infects. An STI that causes discharge may also increase the number of immune cells in the genital area, thereby increasing the risk of HIV infection.

If someone has both an STI and HIV, the presence of sores and discharge may be more severe and the number of immune cells infected with HIV may increase the risk of HIV transmission to a partner. Also, since HIV weakens the immune system, people who are HIV-positive are more susceptible to infections in general, including STIs. So, it is important for both HIV-positive and HIV-negative individuals who are sexually active to be regularly checked for STIs.

Teens are at the highest risk among sexually active population groups for becoming pregnant and contracting STIs, especially since they are often having unprotected, unsafe sex.

During vaginal, anal, or oral sex, using latex condoms or a dental dam (for oral sex on females) consistently and correctly will reduce the risk of STIs and HIV transmission. For those young people who choose not to have intercourse, there are many other lower risk ways to be sexual, including masturbation, mutual masturbation, and oral sex (especially with a latex barrier).

Sexual intimacy is a natural and healthy part of life. HIV-positive youth need to be empowered and they need skills to nurture and manage their healthy sexuality, such as disclosing to partners, using protection and contraception, and making choices around having children. ⊕

Sarah Fielden (l) is an Interdisciplinary PhD student and Melanie Rusch is a PhD candidate in the Department of Healthcare and Epidemiology, both at the University of British Columbia. They both work at the BC Centre for Excellence in HIV/AIDS and are trainees of the Michael Smith Foundation for Health Research.

Resources

Positive Youth Outreach in Toronto recently released a sexual education guide for HIV-positive youth. Visit their Web site at <www.positiveyouth.com> for contact information. Other on-line resources include Health Canada at <www.phac-aspc.gc. ca /publicat/std-mts/ index.html> and the BC STD hotline at 1.800.661.4337

Snapshots of CAHR

Highlights of the 14th annual Canadian Association for HIV Research conference

by Carole Lunny

Remember the television commercial that showed an egg and included a voice-over saying: "This is your brain"? Then the egg was cracked into a hot frying pan and the voice-over completed the thought:, "This is your brain on drugs." Well, at this year's Canadian Association for HIV Research (CAHR) conference in Vancouver, Dr. Tim Condon talked about how drug use changes the brain in fundamental and long-lasting ways, like the egg changing as it's fried.

This presentation was just one of the many highlights of this year's CAHR conference. Other highlights included a presentation on liver transplantation and HIV, and two presentations by BCPWA Society representatives.

Addiction as a brain disease

To elaborate on the egg in the frying pan analogy, Dr. Condon explained during in his presentation entitled "Addictions and Brain Disease," that brains of addicts are different from the brains of non-addicts. For example, dopamine receptors are lower in addicts. Addiction disease expresses itself as compulsive behaviour but one that is contextual, meaning that environment is an integral part of the disease.

According to Dr. Condon's abstract, "powerful research tools and extraordinary science advances have shown us that addiction is a complex brain disease expressed as a form of compulsive behaviour whose development and recovery are shaped by behavioural experience and environmental and social context."

Dr. Condon also claims that memories are an important part of addiction, as cravings play a key role in relapse. As a result, he sees addiction as a chronic relapsing disease. Successful treatment can be cost effective but only by having a long-term treatment strategy in place. Dr. Condon did say that the changes in dopamine levels could be reversed, but only slowly and over time.

Dr. Condon explained in his presentation entitled "Addictions and Brain Disease," that brains of addicts are different from the brains of non-addicts.

Organ transplantation

Dr. Tim Christie and colleagues from the BC Centre for Excellence in HIV/AIDS presented a paper critically evaluating the requirement that HIV-positive patients must be on highly active antiretroviral therapy (HAART) prior to receiving a liver transplant in Canada. The review concluded that a transplant could be performed safely in an HIV-positive person who was not currently on HAART, but that if administered after transplantation, HAART helped improve outcomes. Further, the researchers stated that it was unethical not to conduct research on HIV-positive people who required a liver transplant, but who were not on HAART.

BCPWA at CAHR

The BCPWA Society was represented by the Prison Outreach Program poster presentation entitled "Breaking the Cycle Phase 1: HIV, IDU, and Prison Recidivism." The poster looked at the problem faced by HIV-positive drug users who leave the prison system in BC, only to become enmeshed in the same cycle of drug use, lack of access to health services, and criminal activity networks. The research was conducted by a panel of volunteer peer-researchers as a community-based model.

Francisco Ibáñez-Carrasco, the research technical assistant in community-based research, gave the second BCPWA Society presentation. He presented his findings on the environmental scan which assessed the capacity-building needs and challenges for HIV/AIDS organizations in BC to conduct community-based research.

These are just some of the interesting snapshots of the CAHR conference. For more information, go to the abstracts page of the CAHR Web site at <www.pulsus.com/cahr2005/main.htm>. ⊕

Carole Lunny is the treatment outreach coordinator for the BCPWA Society.

Clinical research goes public

by Maia Joseph

Transparency, accessibility, plain language: these are the guiding principles of the Canadian HIV trials database, a public database that helps PWAs stay informed about Canada's clinical trials in HIV.

Managed by the Canadian HIV Trials Network (CTN) in collaboration with the Canadian AIDS Treatment Information Exchange (CATIE), the trials database provides information on all studies operated by the CTN, and many private industry and investigator-driven trials with sites in Canada. The database also lists the results of all completed Network trials, and efforts are underway to include the results of other Canada-based trials.

The CTN first developed the trials database as a way to make its own research activities transparent; over time, the project evolved to include other Canadian trials in response to an expressed need by HIV community advocates.

The database can be accessed on-line through the CTN's website, where information is updated regularly. The Network also distributes a quarterly list of trials, in poster format, to clinics and HIV organizations across the country. The database's plain-language descriptions offer PWAs a clear overview of each study's objective, design, and eligibility requirements.

The trials database has grown considerably over the past few years, reflecting the increased willingness of many pharmaceutical companies and investigators to provide information about their research. However, some remain less than forthcoming. Confidentiality is still a major concern in the pharmaceutical world, where novel treatments (and sometimes innovative study designs) are key to bigger profits. Another problem, particularly for non-industry trials, is a lack of time and resources: sometimes, making trial information publicly available is low among a researcher's list of priorities.

But the trend—both in Canada and internationally—is toward openness and accessibility. The World Health Organization has launched an International Clinical Trial Registry Platform, with the aim of improving access to clinical trial information. And Health Canada is now in the early stages of consulting with community organizations, researchers, industry, and other interested groups in order to develop Canadian regulations for clinical trial registration.

In the meantime, the CTN continues to work closely with researchers, pharmaceutical representatives, and community advocates in order to make trial information accessible and meaningful. The Network invites your contributions, too: if you hear of a new trial at your local clinic, please e-mail the database coordinators at ctn@hivnet.ubc.ca.

To view the Canadian HIV Trials database on-line, visit <www.hivnet.ubc.ca/e/clinicaltrials/>. You can find more information on the World Health Organization's initiative at <www.who.int/ictrp/en/>. ⊕

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, Providence Health Care, Vancouver

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

CTN 169 — DAVE: d4T or Abacavir plus Vitamin Enhancement
BC site: St. Paul's Hospital, Vancouver

CTN 178 — Effect of Rosiglitazone (Avandia) on Blood Vessels
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

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/e/clinicaltrials/> or call Sophie at the CTN 1.800.661.4664.

La iglesia católica

Moralista y dogmática ante el VIH

Por Sergio Plata

artwork by Sergio Plata

La iglesia católica con su conservadora posición moralista y dogmática dictada desde el vaticano, continua siendo un obstáculo para hacer frente a la pandemia del VIH/sida, rechazando el uso del condón y la educación sexual. La Santa Sede es tan radical que se opone al uso del condón entre parejas, aún cuando uno de ellos tenga VIH, declarando que la única y absoluta manera de evitar el VIH es la *"abstinencia total."*

La iglesia con su lenguaje estigmatizador y excluyente, lejos de ser parte de una solución, se ha convertido en parte del problema, obstruyendo el derecho a la salud y a la sexualidad, contradiciendo las normas culturales, sobre todo en el comportamiento sexual.

El estigma, desde el punto de vista antropológico, se interpreta como un castigo infligido a un individuo o grupo social, que es señalado por haber violado las normas de una comunidad. A la persona estigmatizada se le atribuye la responsabilidad de males terribles, reales e imaginarios, que afligen a la comunidad. Se ve a la persona estigmatizada como una amenaza, se le excluye, se le castiga y se le utiliza como un chivo expiatorio: "ha pecado y ahora la persona estigmatizada constituye una amenaza, no solo a la comunidad, también al orden divino."

Es la misma iglesia quien condena, juzga y estigmatiza a las personas portadoras del VIH. La iglesia con su postura conservadora e hipócrita sigue empeñada en *salvar almas y no vidas*, aún cuando el VIH/sida también esta dentro de la iglesia. Curas y pastores son despedidos cuando se descubre su estado serológico VIH. Para la iglesia hablar de VIH es una confesión sobre la sexualidad de la persona infectada, es el miedo secreto, es algo indecente y peligroso.

La iglesia emitió una declaración referente a la provisión de anticonceptivos de emergencia a mujeres kosovares que habían sido violadas por los paramilitares y las fuerzas de seguridad serbia, clamando que proveer a esas mujeres de anticonceptivos de emergencia era equivalente a promover el aborto, aún cuando la Organización Mundial de Salud clasifica el método de emergencia como un anticonceptivo, no como un aborto. El papa Juan Pablo II llegó a declarar que las mujeres violadas en Bosnia deberían aceptar al enemigo y hacer de él "carne de su carne."

Los que discriminan se pueden ver moralmente superiores y la iglesia con su silencio y continuo rechazo incrementa el sufrimiento de las personas que viven con VIH/sida al tacharlos de pecadores, describiendo al sida como un castigo divino a la promiscuidad.

Si el VIH tiene que ver con el sexo, la adicción a las drogas y la muerte prematura, ¿cómo puede ayudar la iglesia? Si la misma iglesia con sus injurias no permite que se reaccione con respeto ante el VIH, ¿cómo romper con el silencio? ¿Cómo abordar el tema del sexo, la adicción a las drogas, el pecado y la muerte sin afectar la esencia misma de los que proclaman su teología, su lenguaje, su liturgia y su interpretación de las sagradas escrituras? Ni el moralismo, ni el fervor religioso podrán detener el VIH/sida. ⊕

BCPWA Treatment Information Program (TIP)

Ofrece información en español 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

Hail to our leaders!

by Alasdair Hooper

The WALK for LIFE team leaders are key volunteers who assist with every aspect of the WALK. They lead teams of up to 80 fellow volunteers whose work covers every aspect of the WALK. The event wouldn't happen without these dedicated and skilled volunteers.

From a local Starbucks manager, to a grandmother who's volunteered with the BCPWA Society for years, team leaders are committed organizers and stewards of the WALK. Some have volunteered with us since the very first WALK, while others join us for the first time this season!

Team leaders oversee the following teams:

Ambassadors Team: makes sure the event site is safe and secure before and during the WALK; they also act as information officers, since they're the most visible on-site volunteers.

Clean Team: looks after recycling and keeps the WALK site litter-free.

Cheerleader Team: encourages walkers en route.

Route Team: coordinates water distribution and donation collection, as well as quick access to first aid attendants.

Information Tent Team: hosts first aid, the lost and found, and distributes lunches for volunteers.

Hospitality Tent Team: looks after VIPs and people scheduled to appear on stage.

Kids Tent Team: makes sure kids have a safe and great time at the WALK.

Logistics Team: sets-up and tears down the WALK site, manages traffic, parking, and lots more!

Registration Team: collects pledges from all the individual, team, student, and dog walkers who register.

Merchandise Team: looks after the sale of t-shirts and other WALK keepsakes. ⊕

Alasdair Hooper is the director of development for the BCPWA Society.

Back row, left to right: Thomas Canty - Registration Tent, Mike Verburgt - Information Tent, Brad Moore - Ambassador, Ken Coolen - Logistics, Carey Bridgeman - Hospitality Tent, David Sundquist - First Aid,
Front row, left to right: Jana & Brie Grey-Noble (Kids Tent Coordinators), May McQueen - Merchandise Tent (Co-Captain), Lyn Slater - Merchandise Tent (Co-Captain)
Not Pictured: Nicole Krossa - Clean Team, Katherine Nthenge - Awareness Tent, Kevin Sarrazin & James Ong - Route Team (Co-Captains), Trigger Segal - Entertainment/ Stage Management and Kath Webster - Complementary Health.

where to find **help**

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

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 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

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

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

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

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
1–1563 2nd Ave,
Prince George, BC V2L 3B8
t 250.562.1172 ***f*** 250.562.3317
e info@positivelivingnorth.ca
www.positivelivingnorth.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 HIV/AIDS organizations and services please visit www.bcpwa.org.

Upcoming BCPWA Society Board Meetings:

Date	Time	Location	Reports to be presented
September 14, 2005	1:00PM	Board Room	Executive Committee — Director of Treatment, Information & Advocacy
September 28, 2005	1:00PM	Board Room	Written Executive Director Report — Standing Committees Financial Statements – August, Director of Prevention

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

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

BCPWA Standing Committees and Subcommittees

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

Board & Volunteer Development
Contact: Adriann de Vries
t 604.893.2298 e adriannd@bcpwa.org

Community Representation & Engagement
Contact: Ross Harvey
t 604.893.2252 e rossh@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: Ross Harvey
t 604.893.2252 e rossh@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

Name _____

Address _____ City _____

Province/State _____ Country_____ Postal/Zip Code_____

Phone _____ E-mail _____

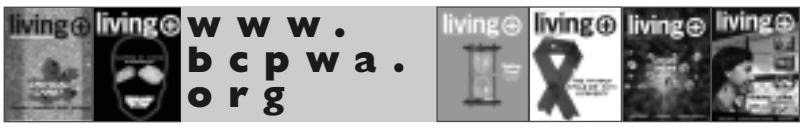
I have enclosed my cheque of $_____ for *living* ⊕

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

❍ 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
2nd Floor
Vancouver BC
Canada V6B 5S8

For more information visit
www.bcpwa.org
e-mail to living@bcpwa.org
or call 604.893.2206

Don't rain on my parade

Or, the year I met Goo Spoo Park

by Jeff Anderson

Anyone tasked with chairing a major fundraising event hopes to make his or her experience unforgettable. You hope for great media, show-stopping entertainment, and record-setting fundraised revenue. You leave nothing to chance: every contingency is covered, every minute scripted for the best effect. Late at night, juggling the doubts, you finally turn to faith itself to salve your fear. You believe if you stage the event, they will come; if you believe enough, it will succeed.

This strategy works—for a while.

With an event as large as the 1997 AIDS Walk, which I chaired, I expected a few bumps in the road. When small disappointments began to crop up, I held to the mantra: believe in your team and yourself and success will come.

First, the TV station cut away to cover the death of an important personality—instead of interviewing me. Just like the famous to hog the limelight. I chalked it up to chance and moved on.

When the Vancouver Parks Board unexpectedly switched the location of the Walk festivities from a manicured field over to an alternate venue known euphemistically as the "meadow"—home to numerous squawking and squatting ducks and swans—I converted lemons to lemonade: "Sure we have to redesign the brochures, but now we're closer to the washrooms!"

When the quirks and fickles of fate piled up in disorder, I couldn't help but sweat a bit. I tried some self- hypnosis: I had the best volunteer teams, a history of successful events, and my mother's love. Sooner or later, though, no amount of Mercury opposite my rising sign could stop the little doubts from creeping up the back of my shirt.

On the morning of the big day, the drizzle turned to a full "wet coast" downpour. And the stage crew was late. When the carefully arranged booths had to be removed to place plywood atop the rising mud, little tremors made my knees quiver. Then my favourite volunteer fell in the mud and quit, the electrician refused to wire the rear speakers in the rain and, finally, an unkind question from the media sent me flustered and muttering to the back of the volunteer tent. All, indeed, could be lost.

Before my favourite volunteer departed, she asked me: "Have *you* met Goo Spoo Park yet?"

The tremors grew. Who was Goo Spoo Park, and why hadn't the team leader introduced her? Or him?

My eyes were now little black holes. "Umm, not yet," I faked.

In the flurry and fury of activity, I'd lost my guest list, couldn't think straight, and tried to steady myself for my on-stage speech as chair of AIDS Walk. The stage crew began to fear electrocution as the downpour doubled. The volunteers were muddy to the knees. I began to dread the headlines swirling, film noire-style in my head: "PWAs catch pneumonia at AIDS Walk," "Stage hands recover from electrocution at fundraiser," "Park event cancelled when lightning strikes 14!"

By the time I hit the stage apron, I could hear my words echoing from the speakers, but all I could see was the microphone and the dribbling sweat from my forehead. I suppose the speech went all right. When I stopped, they applauded, and no projectiles of overripe fruit met the front of my trousers. It wouldn't have mattered really—they were soaked anyway.

But the tremors grew. Who was Goo Spoo Park, and why hadn't the team leader introduced her? Or him? I'm sure the event manager could hear the panic in my voice as the walkers prepared to leave the starting gate. When I pleaded with him to find me Goo Spoo Park, a broad grin creased his lips.

"Oh," he chuckled, "Goose Poo Park is here at your feet."

I had to laugh, too.

When the drizzle finally slowed, we netted more revenue from the Walk than we had in years and, finally, the sun broke through to dry the mud-caked volunteers. The sun would rise another day—on another AIDS Walk. ⊕

Jeff Anderson was treasurer of the BCPWA Society from 1997-2002.