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**British Columbia
Persons With AIDS Society**

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

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opinion & editorial . . .

A celebration of life

by Paul Lewand

Sunday September 25 marked the Twentieth anniversary of our newly branded AIDS WALK for LIFE. A huge thank you to the hardworking team that organized the WALK and to all the participants that made it an incredible success. This year's WALK is evidence that we have reversed last years' decline in revenue: to date we have raised \$410,000, and this figure will likely grow by another \$5,000 to \$10,000. This is an increase of \$23,000 from last year. Considering how many high-profile fundraising events now compete with our event, this is a great accomplishment.

We particularly want to congratulate the best fundraisers in each category: David MacLean, Top Individual WALKer; Kodak, Top Team; Positive Woman's Network, Top Community Partner Team; Heidi Rogers, Top Student; and Ryan Berhauser (with Scout), Top Dog WALKer.

The weather was spectacular—sunny with a clear, blue sky, with the beautiful scenery and natural splendour of Stanley Park. Over 3,000 people showed up, many with their dogs. The event included families, individual walkers, teams, corporate groups, and others donating their time and energy to make this year's WALK exceptional. Stanley Park was alive with activity and everyone had a fantastic time.

The morning started out with messages of encouragement from political representatives from all levels of government, including MPs Hedy Fry and Bill Siksay, BC Leader of the Opposition Carole James, MLAs Jenny Kwan and Lorne Mayencourt, and Vancouver

Councillor Jim Green. Ujjal Dosanjh, Federal Minister of Health, cut the ribbon at the start of the route.

The walkers returned to a full afternoon of great entertainment, with Ash Riot and the group Betty from New York highlighting the day. The energy and the feel of the crowd was as high or higher than it has ever been.

Vancouver is the best place on Earth. It was the first city in Canada to walk for AIDS, and this year's WALK showed our community's continued caring and dedication to our cause. It was truly a celebration of life. ⊕

Paul Lewand is the chair of the BCPWA Society.





REALITYBITES

News from home & around the world



Tom Mountford



Tom Mountford, a long-time treatment information volunteer for the BCPWA Society, passed away in September. An active member of BCPWA for many years, he was one of the founders of *PWA News*, the precursor to *living +* magazine. In recent years he continued to write for *living +* as an expert on complementary and alternative therapies. He will be greatly missed.

Meth use increases risk of HIV

Gay men who use methamphetamine (crystal meth) are three times more likely to test positive for HIV than non-users of the drug, according to a study conducted in San Francisco. The investigators also found that gay men who use crystal meth are more likely to report unprotected anal sex.

Investigators from the US Centers for Disease Control, San Francisco Department of Public Health, and University of California designed a study to determine the frequency of crystal meth use among gay men seeking an anonymous HIV test; the social, demographic, and behavioural characteristics associated with crystal

meth use; and the association between crystal meth use and HIV seroconversion. A total of 2,991 gay men were included in the analysis.

Even when the investigators controlled for the use of other recreational drugs, alcohol, and poppers, they still found a strong association between crystal meth use and recent infection with HIV.

Source: Aidsmap

Serono pays settlement for Serostim fraud

Swiss biotechnology company Serono has agreed to pay \$704 million to settle a US Department of Justice (DOJ) investigation into the company's sales and pricing practices of its drug Serostim, which is used to treat AIDS-related wasting. The settlement amount is the third largest for health care fraud and the largest-ever settlement for Medicaid fraud.

In April 2005 Serono said it would pay up to \$725 million after the DOJ indicted four former Serono executives for allegedly bribing physicians to prescribe Serostim, which many HIV/AIDS patients receive through joint federal-state Medicaid programs that include the medication in their drug formularies

Source: The Body

Low HIV load for hep B vaccination success

Successful hepatitis B vaccination in HIV-infected patients appears to be dependent on a low plasma HIV RNA level, researchers report in the October 1 issue of *Clinical Infectious Diseases*.

"Our data reinforce that HIV-infected adults respond poorly to hepatitis B vaccination and that responses are improved with controlled viremia," said

lead investigator Dr. Edgar Turner Overton of Washington University School of Medicine in St. Louis.

Investigators retrospectively reviewed the records of 194 HIV-infected patients who underwent hepatitis B vaccination. Only 34 developed a protective antibody response. The sole factor associated with a successful response was a plasma HIV RNA level lower than 400 copies per mL at the time of vaccination.

The researchers note that the responders were protected against hepatitis B and none subsequently developed the infection. However, 10 percent of non-responders became infected.

Source: Medscape

Genital tract a "sanctuary" for HCV in co-infected women

Hepatitis C virus (HCV) appears to be compartmentalized in the genital tract of women coinfecting with HIV, and may replicate independently, according to a recent study.

Researchers from the University of California, the Mayo Clinic in Scottsdale, Arizona and the Medical Academy in Warsaw, Poland, sought to examine factors that correlated with HCV genital shedding as well as examine HCV quasispecies composition in a group of HCV/HIV-coinfected women.

They undertook a cross-sectional study of 71 women within the Women's Interagency HIV Study, a prospective, multi-centre study that has been examining the impact of HIV infection on women since 1993.

The study, which also found that HIV interacts with HCV in the genital tract, may help to explain why mother-to-child transmission of HCV occurs at a



REALITYBITES

News from home & around the world



comparatively higher rate in co-infected women than in women who are mono-infected with HCV, and suggests that the risk of female-to-male sexually transmitted HCV infection may be increased in co-infected women.

Source: *Aidsmap*

Safety information on tenofovir and ddI

In June, Bristol-Myers Squibb Canada and Gilead Sciences issued safety information regarding the co-administration of ddI EC (Videx EC) tenofovir (Viread), and either efavirenz (Sustiva) or nevirapine (Viramune). Co-administering tenofovir and ddI should be undertaken with caution, and people should be carefully monitored for efficacy for ddI-related adverse events.

Reports from recent trials indicate a potential for a high rate of virological failure and emergence of resistance associated with the co-administration of ddI and tenofovir with a non-nucleoside reverse transcriptase inhibitor (NNRTI) in antiretroviral treatment-naïve HIV-infected adults with high baseline viral loads and low CD4 cell counts.

Hope for eliminating 'latent' HIV

Early research suggests a potential way to eradicate dormant HIV infection. A University of North Carolina team has shown valproic acid—used to treat bipolar disorder—can prevent HIV persisting in this latent phase. The findings may boost HIV treatment and be a step towards preventing HIV from being a chronic disease, they say.

But experts caution against premature

optimism, and say much more research into the drug's effects was needed.

It is already known that an enzyme called histone deacetylase 1 (HDAC1) helps HIV to persist in a latent phase of infection. Valproic acid is known to inhibit this enzyme.

Researchers studied four PWAs who were already on HAART. They were given enfuvirtide (Fuzeon) to give them added protection against HIV. A three-month, twice daily course of valproic acid was then added to their treatment. The researchers found a 75 percent reduction in latent HIV infection in three of the four patients.

Source: *BBC News*

NNRTIs and risk of resistance after treatment break

Patients who take a non-nucleoside reverse transcriptase inhibitor (NNRTI)-based regimen after a break from HIV treatment are significantly less likely to achieve an undetectable viral load than patients reinitiating HIV therapy with a protease inhibitor-containing combination, according to a recent study.

According to investigators of a retrospective Spanish study, published in the September 15 edition of *Clinical Infectious Diseases*, the resistance barriers and pharmacokinetics of NNRTIs could explain these findings and suggest that resistance tests should be performed before a patient recommences NNRTI treatment after a break from HIV therapy.

The investigators suggest that NNRTI-containing regimens should be used "cautiously in the face of active viral replication, especially in patients who have been previously exposed to

nucleoside analogues." They add "resistance testing may be helpful for choosing the best candidates for NNRTI-based therapies, who, ideally, should be persons without HIV containing reverse-transcriptase resistance mutations."

Source: *Aidsmap*

Metabolic disorders, puberty, and ART

Metabolic complications caused by anti-retroviral therapy (ART), such as lipid elevations and insulin resistance, are more likely to emerge with the onset of puberty in children, say French researchers in a report to the October 1 issue of the *Journal of Acquired Immune Deficiency Syndromes*. They recommend that screening for body fat and metabolic changes should be stepped up at puberty.

The study recruited 130 children—64 boys and 66 girls—from Paris hospitals in 2000 to track the progression of lipodystrophy in children and identify risk factors. Eighty-nine participants were available for follow-up two years later.

Almost one-quarter of them had some evidence of lipodystrophy at the beginning of the research, and this proportion did not grow significantly over two years of follow-up. Lipodystrophy was most strongly associated with duration of nucleoside reverse transcriptase inhibitor (NRTI) exposure and ethnicity, with African children much less likely to suffer fat changes.

Source: *Aidsmap* ⊕

FIGHTING WORDS



Looking after our seniors

by Jane Talbot

Anyone familiar with the BCPWA Society's history is aware of the ongoing battle known originally as Schedule C and more recently as the Monthly Nutritional Supplement Benefit (MNSB). When the fight began nine years ago, few applicants, if any, worried about turning 65 and what might happen to their health benefits once they became senior citizens. While it still may not be on the collective conscience of the HIV/AIDS community, more and more we are becoming familiar with and committed to the growing population of HIV-positive senior citizens in British Columbia.

In the May/June 2005 issue of *living +*, writer Melissa Davis highlighted the topic of aging and HIV, and specifically the need for, and vulnerability of, the continuation of Schedule C health allowances for HIV-positive seniors. The allowance is an additional \$225 per month for PWAs receiving welfare, to cover the costs of additional nutritional food, bottled water, and vitamins and minerals.

At the time of the article, it appeared as though all HIV-positive individuals receiving Schedule C could lose the grandfathered benefit once they turned 65 years old and their benefits shifted from provincial assistance to federal assistance. However, as has been the case throughout the entire Schedule C battle, our efforts to advocate for BCPWA Society members have proven successful and will hopefully set a new precedence for the aging members of the PWA population.

While no actual changes to legislation have occurred, early signs indicate that some seniors will continue to receive the provincially-allocated Schedule C once they turn 65, stop receiving welfare, and start receiving benefits through the federal Old Age Security program.

"The ministry is now looking at each individual file and applying an income test, so if the recipient is receiving more from Old Age Security Programs than previously paid by welfare,

that person will not get to keep their Schedule C grandfathered nutritional benefit," says BCPWA Society advocate Suzan Krieger. "If, however, the recipient is receiving less from Old Age Programs than previously paid by welfare, that person will get to keep their Schedule C benefit up to a maximum they were previously receiving under welfare. In other words, that person would receive a top up to their old age programs."

Seniors will continue to have their HIV medications covered through the BC Centre for Excellence in HIV/AIDS and they will still be entitled to receive enhanced medical coverage including benefits for dental, medical equipment, and prescription drugs.

"Being able to keep the enhanced medical coverage is nothing new from the ministry's perspective, however, it is surprising how many seniors are unclear as to whether this benefit will continue and are stressed by the idea it may not," says Krieger. "It is therefore always recommended that anyone within six months of turning 65 should see a [BCPWA Society] advocate so we can help ensure seniors in

need receive the maximum allowable benefits under all income security programs."

With a new focus on seniors, the Schedule C story continues. And one day, with the gift of hindsight, we'll pause, take a deep breath, and look back with pride at our efforts and accomplishments. Perhaps then we will see with even more clarity what battles lie ahead; for now, BCPWA Society will continue to fight for our seniors—for their health, their well-being, and the quality of life they so deserve. ☺

Early signs indicate that some seniors will continue to receive the provincially-allocated Schedule C benefit once they turn 65 and start receiving benefits through the federal Old Age Security program.

Jane Talbot

is currently on contract with the BCPWA Society Advocacy Department.



BCPWA members elect 2005/06 Board of Directors

At the BCPWA Society's Annual General Meeting (AGM) on Saturday, August 20, Society members elected the 2005/06 Board of Directors. Board members then elected the executive on September 14.

The 2005/06 Executive is chair Paul Lewand, vice-chair Glyn Townson, treasurer Wayne Campbell, and secretary Derek Bell. All are returning board members. Other returning board members are Malsah and Stuart Hossack. New members are Ken Buchanan, Damien Callicott, Carrie Carpenter, Gordon McKillop, and Neil Self.

Individuals elected to the board are HIV-positive, full-voting members of the Society.

Members also passed a special resolution at the AGM to elect the Society's directors for two-year terms, rather than the current one-year term. The terms of office of the directors will be staggered. The objective of the resolution is to strengthen the continuity of the Board of Directors and facilitate good governance of the Society. ⊕



(From left to right) Ken Buchanan, Stuart Hossack, Derek Bell, Malsah, Neil Self, Damien Callicott, Glyn Townson, Wayne Campbell, Paul Lewand. Missing are Carrie Carpenter and Gordon McKillop.

photo John Kozachenko

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

Web site maintenance > Communications

Administration > Internet research, filing, database management, reception, etc.

Special events > AccoAIDS Awards Gala and WALK for LIFE

Writers > *living* ⊕ magazine, Communications

Workshop development and delivery > Communications and *living* ⊕ magazine

Benefits of becoming a volunteer:

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

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

volunteer @ BCPWA

Pharmas get fatter

A new US free trade act could restrict access to antiretrovirals in Central America

by David Harvey

With the successful vote in the US House of Representatives on July 28, American pharmaceutical companies are one very large step closer to profiting from sick people in Central America. Passing by a mere two votes, opposition to the Central American Free Trade Agreement (CAFTA) within the House was not concerned with the potentially devastating impact this bill will have south of the US; rather, criticism was primarily aimed at the bill's impact on American jobs.

Yet Central Americans have reason to worry. Thousands of poor people in Central American countries are currently dependent on accessible medical treatment. This is especially true of Honduras and Guatemala, which have the second highest per-capita HIV rates in the Northern hemisphere (the Caribbean is the highest), according to the Voice of America.

CAFTA could heavily constrain Central American access to medical treatment, including HIV/AIDS medications. This is likely to result from the agreement's intellectual property rights, which may entail limitations on compulsory licensing. Compulsory licensing allows governments to create

generic versions of patented products, in order to provide essential, life-saving drugs at much lower costs. Without generic versions, drug costs in these countries are expected to increase 15-fold, according to AIDS Healthcare Foundation president Michael Weinstein. That means, for example, Guatemalans receiving medical treatment could see an increase from \$400 per patient annually to over \$10,000. Few Central Americans could afford these increases—so perhaps a better indication of the true cost of CAFTA is the potential lives lost.

Aside from the limitations on compulsory licensing, CAFTA will also create patent-like barriers to the marketing of generic drugs, due to the agreement's data exclusivity provision. This provision would require generic drug makers to either conduct their own clinical drug trials (which is not likely due to the high cost involved) or wait "at least" five years after the creation of brand-name drugs in order to use the brand-name companies' trial results. In the US, this requirement is set strictly at five years, thus CAFTA's inclusion of the vague words "at least" raise more questions about how long that really means.

Proponents of CAFTA are brushing these concerns aside, claiming that a side letter attached to the agreement protects government-based AIDS programs from these intellectual property rights provisions.

The sincerity of these claims is questionable—after all, if CAFTA is not meant to get in the way of government-based AIDS programs, then why did the US Embassy and Trade Representative put up a fuss a year ago when a new law was passed in Guatemala which greatly increased the accessibility of generic drugs to Guatemalans? On top of that, they used the CAFTA negotiations as fuel for their concern.

Now that President Bush signed the agreement on August 2, it is only a matter of time before we begin to see the actual costs of these protective measures for drug makers. One thing is certain: the costs, however atrocious they may be, will undoubtedly be most devastating for those already suffering—the poor and sick of Central America. ☺

David Harvey

is a fourth-year Simon Fraser University student and a volunteer at the BCPWA Society.



The BCPWA Society's Advocacy Program continues to work hard to secure funds and benefits for our members. The income secured for June 2005 and July 2005 is:

- **\$43,030,59** in debt forgiveness.
- **\$130,022.78** in housing, health benefits, dental and long-term disability benefits.
- **\$39,540.00** monthly nutritional supplement benefits
- ***\$1350.00** in ongoing monthly nutritional supplement benefit for children

**New benefit secured for HIV-positive children in BC.*

What's in a NAME?

The implications of redefining HIV as an episodic disability

by **Francisco Ibáñez-Carrasco**

There are key distinctions between defining HIV as a permanent disability and an episodic disability, and it can make a big difference for PWAs.

A disability is a restriction in routine activity caused by an impairment, such as missing a limb or neuropathy. A handicap is the disadvantage imposed by an impairment in a particular social context. For example, HIV has contributed to my facial lipodystrophy, which, in turn, is a psychological impediment for my social participation. HIV thus becomes a social handicap for me.

An episodic disability is a serious mental or physical condition characterized by fluctuating periods and degrees of wellness and impairment. Episodic means that the condition is like the television soap opera *Days of Our Lives*—some days are good, some are bad, others are pedestrian, and uncanny things can happen. An episodic disability includes periods that are often unpredictable in severity and duration, and these factors can contribute to HIV illness as much as specific opportunistic infections do.

Changing how HIV is defined is not just a matter of splitting hairs—it has major implications in government policies, workplace issues, income support, and, ultimately, how people perceive the illness. That's why the Canadian Working Group on HIV and Rehabilitation (CWGHR) is defining HIV as an episodic disability.

Examples of episodic disabilities include mental illness and mood disorders, various kinds of cancer, lupus, multiple sclerosis, diabetes, HIV/AIDS, long-term pain (including back pain), chronic fatigue syndrome, and spinal cord injury (with episodic bouts of serious urinary infection, depression, etc.). An episodic disability can be permanent or temporary, life threatening or chronic, progressive or stable.

Defining HIV as an episodic disability might help to decrease the stigma, fear, and ignorance surrounding the disease. Historically, HIV has been anchored to human activities such as sex, queer sexuality, and drugs, which elicit conflicting attitudes and feelings within our society. By contrast, if we identify HIV as an episodic disability, it pulls us out of the paralyzing roles of innocent or guilty victims.

HIV can also be anchored in other human activity such as labour. This redefinition of HIV might therefore help us review our policy and practices regarding paid and unpaid labour, which need to be more flexible to address episodic disabilities. Current definitions used in legislation, by government disability insurance,

and by third-party insurance providers tend to focus on “severe” and “prolonged” conditions. The redefinitions might encourage PWAs to become employable, if and when they are able.

Because of the unpredictability of episodic disabilities, some people with HIV may want to—and be able to—move in and out of the labour force as their health permits. But they may be afraid of being permanently cut off the income support programs and other benefits that sustain them. That risk creates a disincentive to return to work. That's why many people make alternative arrangements as volunteers or workers in an “informal” job market, so they don't lose their disability or insurance safety network.

Defining HIV as an episodic disability might help to decrease the stigma, fear, and ignorance surrounding the disease.

Full-time employment for a 30-something person with HIV, visible facial wasting, and limited schooling requires a great deal of workplace planning, but it is not impossible. Part-time and flexible work arrangements are important options. But it isn't just about middle-aged PWAs: there's a young generation of people with HIV who need to be able to plan to go to school, volunteer, and work.

Calling HIV an episodic disability directly challenges the system of legislated poverty in which persons with disability are inscribed. It takes into consideration treatment and other social determinants of health such as stigma, housing, and workplace.

What's in a name? A lot, apparently. It's not just about language, but also about changes in attitudes and our institutional and collective practices. ☯

Francisco Ibáñez-Carrasco
is co-chair of CWGHR and HIV/AIDS
research technical assistant for the
Community-Based Research
Capacity Building Program.





A failing grade

by Laurence Cattoire

In the fight against AIDS, is Canada one of the good guys? The country's international commitments are significant, and its contribution substantial; yet, there are a few shadows hanging over Canada's high profile. Is Canada doing all it can to fulfill its commitment?

continued on next page

What Canada has pledged so far

The highlight of Canada's action against AIDS is probably the New Partnership for Africa's Development (NEPAD). Launched at the 2002 G8 summit in Alberta, the purpose of NEPAD was to give 54 African countries access to development assistance.

When Canada passed the Jean Chrétien Pledge to Africa Act (Bill C-9), it became the first country to enact legislation in response to a World Trade Organization (WTO) decision to allow compulsory licensing of patented drugs, so that generics could be exported to countries unable to manufacture their own.

"It shows that WTO trade rules—in this case, on patents—can be changed if enough pressure is brought to bear out of concern for the negative impact they have on the access to medicines," says Richard Elliott, director of policy and research for the Canadian HIV/AIDS Legal Network.

Elliott notes that Médecins sans Frontières (Doctors Without Borders) is currently encouraging a major Canadian generic drug maker to produce a fixed-dose combination pill that at present is not easily available. The company is expected to complete the regulatory process for the product in early 2006, and, using Bill C-9, obtain a licence to export it. This will be the first test of the legislation.

A key supporter of 3 by 5

Canada is also contributing to the worldwide AIDS effort through United Nations agencies such as the World Health Organization (WHO). Two years ago, WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) launched the 3 by 5 Initiative, which aims to ensure that three million people living with HIV/AIDS in low- and middle-income countries are receiving antiretroviral treatment (ART) by the end of 2005. Canada funded one-third of the 3 by 5 budget with a contribution of \$100 million CDN. As of June 2005, one million people were receiving ART.

Together with Europe, the US, and Japan, Canada is also providing resources for bilateral and multilateral initiatives such as the Global Fund. The Global Fund has been in operation for over three years and has committed more than \$3 billion US to the fight against AIDS, malaria, and tuberculosis. It has helped provide 220,000 people with ART and more than 2.5 million persons with voluntary HIV testing.

Among other contributions, in 2004 the Canadian International Development Agency (CIDA) made the single largest donation from a government to the International Partnership for Microbicides when it invested \$15 million CDN toward the development of female-controlled prevention methods. Canada also supports the International AIDS Vaccine Initiative and the South African AIDS Vaccine Initiative.

It's not enough

All these initiatives may sound impressive, but the demand for treatment still outstrips its availability in the poorest countries. What's more, the 3 by 5 Initiative will not reach the target of getting ART to three million people by the end of 2005. According to UNAIDS, an additional \$18 billion US is needed for global HIV/AIDS assistance over the next three years.

Without sufficient funding, the UN Millennium Development Goal of halting and reversing the spread of HIV by 2015 won't be attained. How can the richest nations maintain any credibility if they don't provide the means to reach the goals that they defined themselves?

This summer, three board members of the Global Fund—two representing developing country non-governmental organizations (NGOs) and one representing communities living with HIV/AIDS, TB, and malaria—issued a call for action to their supporters worldwide.

"According to our understanding of current donors' intentions, there will be enough money pledged to cover the renewal of ongoing two-year grants that have proven to be successful," they stated, "but there will not be enough money pledged to enable the fund...to launch one new round in 2006 and two in 2007. Indeed, the total number of new rounds over those two years may be one or even zero."

After the Third Voluntary Replenishment Mechanism Meeting in London in September 2005, the Global Fund received pledges for \$3.7 billion US from governmental donors. Canada committed to substantially increase its contribution. But the commitment fell short of expectations: it will allow the renewal of grants during 2006 and 2007, but won't cover the cost of any new rounds of grant applications.

Only a small percentage of Canada's GDP

In 1969, former Canadian Prime Minister Lester Pearson recommended that donor countries pledge 0.7 percent of their gross domestic product (GDP) to official development assistance. While Scandinavian countries are giving 1 percent or more of their GDP, the US, Japan, and Canada are at the bottom of the list. In spite of a huge surplus, the Canadian government is only donating 0.24 percent of its GDP.

“While Canada has taken some very important initiatives on responding to HIV/AIDS globally, on the issue of reaching the development assistant target of 0.7 percent of gross national income, they are inexplicably dragging their feet,” says Elliott. “It’s surreal that [federal] Finance Minister Ralph Goodale says it’s hard for us to reach this target when we have surplus after surplus. This is a target that we can easily afford to meet, but they choose not to make a commitment.”

Without sufficient funding, the UN Millennium Development Goal of halting and reversing the spread of HIV and other communicable diseases by 2015 won’t be attained. How can the richest nations maintain any credibility if they don’t provide the means to reach the goals that they defined themselves?

The need for a more comprehensive effort

And it isn’t just money that’s needed. “The situation is very complex and so are the needs,” says Michael O’Connor, executive director of the Interagency Coalition on AIDS and Development. “We need more infrastructure, more doctors, and not only first but second-line treatments. This complexity calls for coordination at an international level, which is what UNAIDS is pushing for.”

The Canadian community is overall supportive of the fight against AIDS but “the problem is the cyclical nature of people’s attention span,” says O’Connor. “In Canada and abroad, many grassroots groups are raising money and organizing help, but in order to achieve sustained commitment, the general public has to be constantly reminded of these issues.”

Apparently, the official development efforts are still below what we can afford. “Governments do what voters tell them to do,” says Richard Burzynski, executive director of the International Council of AIDS Service Organizations. “Canadians should be more acutely aware of their role in the world. It is not just about ‘those people living in Africa’—the environment does not stop at your door. We need a broader vision of things and Canada has a responsibility to invest in the rest of the world *now*. With thousands of people dying of AIDS everyday, we cannot afford to be complacent.”

“Canada should do more in advocacy, technical support, and money,” says Burzynski. “Canada should play a much larger role as a major country and as a member of the G8, who have the world economy in their hands.”

Concerns about how the funds are used

Some questions have arisen about how certain countries are using the pledges. The Global Fund, for instance, suspended its grants to Uganda, after learning of alleged serious mismanagement by the unit of the Ministry of Health that was set up to administer them.

“This is a legitimate concern of Canadians,” says the Canadian HIV/AIDS Legal Network’s Elliott, “but people have an overblown sense of the problem and easily jump to the conclusion that corruption means the money is going astray.” He finds this attitude simplistic, noting that many NGOs are accomplishing a great deal with just small amounts of funding and that there are mechanisms in place to reduce the possibility of misused funds.

“CIDA, for instance, has an incredible level of control and oversight on funds that are disbursed to NGOs,” he says. “Actually, a lot of time and energy are being spent on reporting on where the money goes, instead of doing the work itself.”

“We must build the ship and sail her at the same time, no matter the levels of corruption,” adds Burzynski. “We must make sure that volunteers are working, that orphans are taken care of, that meals and therapy are available. We must not shy away from problems, regardless of the obstacles. But we must do it through different channels and not put all our eggs in one basket.”

A persistent lack of political will

While global awareness of the disease has increased, there is still a lack of political will. “Politicians often see short term only—there is no deep-rooted commitment and when they do something, they usually do it cynically, when they feel it will make them look good,” says Elliott.

In the end, the keystone of the fight against AIDS is political commitment. It is about forcing governments to get involved with minorities and hard-to-reach populations and ensuring that there is a plan to deal with issues.

“The Canadian government needs to make a firm commitment,” says Elliott. “It needs to increase the general fund dedicated to AIDS, it must proactively promote generic medicines, it must take a strong stand on human rights and promote the harm-reduction approach.”

These issues must be kept front-and-centre on the international stage. We need strong direction from the very top in order to change the way we look at an epidemic and to follow their lead, with commitment. In that respect, expectations are high for the International AIDS Conference in Toronto next year.

But Canada can’t do it alone. In order to make a real difference, the whole world needs to rally under the banner of international commitment. ☯



Laurence Cattoire
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Finding faith

2006 AIDS conference organizers have appointed a major religious leader as co-chair

by Jari Dvorak

If everything continues as planned, next year's XVI International AIDS Conference (IAC2006) in Toronto will have an unlikely new satellite presence: religion.

Have the organizers sold out to George Bush's pro-life evangelicals? The truth is the opposite: the conference will become a forum where progressive religious leaders from around the world will scrutinize the religious moral dogmas.

Their presence is partially a reflection of increasing pressure within religions to change their ways. Only some of the pressure is coming from AIDS activists—think of the recent public criticism by Stephen Lewis, the UN's envoy for HIV/AIDS in Africa.

At last year's XV International AIDS Conference in Bangkok, a small number of international religious leaders came together in a kind of interfaith dialogue about the moral stigma surrounding HIV/AIDS prevention and treatment. They wrestled with the dire warnings of epidemiologists that efforts to halt the AIDS epidemic are not meeting targets. Asia, with its huge population, is seen as the tipping point for the epidemic; if the virus cannot be contained there, the epidemic could spiral out of control.

As we reported in the March/April 2005 issue of *living+*, the religions are increasingly seen as an underutilized asset in the fight against AIDS. Religious leaders are well suited to deliver care and to address the social factors underlying the spread of HIV/AIDS.

The organizers of the IAC2006 have wisely decided to nurture and expand the potential of the interfaith contribution. The key to their groundbreaking approach is the appointment of a major religious leader, The Most Reverend Gunnar Stålsett, Bishop of Oslo, Norway, as a co-chair of the conference.

This is the first time a religious leader has been appointed to a leadership role in the AIDS conference. For many in the religious movement, his appointment demonstrates international recognition of the importance of religion in combating HIV and AIDS.

Bishop who?

Bishop Stålsett is one of a rare breed of progressive religious leaders who are also politically savvy. He has a proven ability to bring together different faith organizations. After years of being the head of the Norwegian Church, he served as the general secretary of the Lutheran World Federation from 1985 to 1994. Later, he became rector of the Practical Theological Seminary at the University of Oslo until his appointment as Bishop in 1998.

The Bishop is currently an international co-president of the World Conference of Religions for Peace and co-moderator of its affiliated European Council of Religious Leaders. He is also the religious advisor of the Norwegian royal family.

In heavyweight political circles, the Bishop is well known as the forthright member of the Nobel Prize nominating committee. The buzz is that Pope Jean Paul's II's failure to be awarded the highly coveted Nobel Peace Prize might have something to do with Stålsett's progressive views.

Bishop Stålsett attended last year's International AIDS Conference in Bangkok where he spoke passionately about the role of religious leaders in addressing the AIDS issue. "In this, we see that it is not easier for religious people than for others," he said. "I think, in fact, that we who speak about discrimination and stigmatization as representatives of faith and religion are often the very ones who bring about that sentence of stigmatization. This is not just a matter of personal attitudes, but also because our dogmas and our ethics are formulated in such a way that those, against whom these statements are addressed, feel that they are being condemned.

"We have turned HIV/AIDS into a matter of guilt and shame. This means that in the Christian churches—and I suggest this is the same within the Muslim and Buddhist and other religious communities—our social and sexual ethics are still in a pre-AIDS age."

Bishop Stålsett is humble but upbeat about his work on the 2006 conference. "As co-chair [of] the Leadership Committee, I will have the opportunity to encourage all manner of churches, religious communities, and volunteer organizations to join the front line in planning a strategy to halt the spread of HIV."

How organizers will incorporate this discussion into conference programming still needs to be determined. Religious groups need not be marginalized in the discussion. We should not be afraid of a process marked both by consultation and confrontation in the pursuit of a broader consensus on local, national, regional, and global levels.

Enter the interfaith

Thus far, most of the faith organizations planning to participate in IAC2006 are interfaith. In religious terms, these organizations are relative newcomers. At the end of the nineteenth century, some people in the western world began to explore eastern religions. Thus began the historic search for ways that religions can overcome their differences and enrich each other. Out of this search came the first World Parliament of Religions, established during the 1893 Chicago World's Fair.



“I believe that religious leaders on all levels, and from all faiths, have a moral obligation to reinterpret their positions when confronted with the needs of those whose lives are threatened by the HIV/AIDS endemic. The situation calls for a new understanding of moral tenets that have wrongfully been interpreted in such a way that it hinders the use of condoms to protect human life and existence.

“I believe that exposure to the facts on the spread of the disease in the long run will impact more religious authorities to join the global strategies to protect life. I pray that they do not come too late to save lives of untold numbers whose conscience is formed by their religious authorities.”

**– The Most Reverend Gunnar Stålsett,
Bishop of Oslo, Norway**

The interfaith movement has mushroomed and fragmented since then. Today, hundreds and perhaps even thousands of interfaith organizations of all sizes operate around the world. Some organizations are aligned with a particular mix of religious traditions, while others are all-inclusive large networks. The interfaith priorities vary from the purely spiritual to those that tackle global problems. Only some have a special interest in fighting AIDS.

Moving ahead

So far, two major interfaith networks are working with Bishop Stålsett, the Ecumenical Advocacy Alliance and the World Conference on Religions for Peace. The Geneva-based Ecumenical Advocacy Alliance represents more than 300 Protestant organizations worldwide. Here in Canada, the Alliance members include the United Church, the Presbyterian Church, and the Anglican Church of Canada. Although the Roman Catholic Church is not a member, several Catholic organizations are in the alliance, such as the Canadian Catholic Organization for Development and Peace. The two main issues the Alliance tackles are the fight against AIDS and eradicating poverty through fairer global trade.

Based in New York, the World Conference on Religions for Peace is active on every continent, creating multi-religious

partnerships among Buddhists, Christians, Quakers, Confucianists, representatives of several streams of Hinduism, Indigenous faiths, Shiites and Sunni Muslims, Jainists, Reform Jews, Shintos, and Sikhs. It seems to be particularly well connected with United Nations and UNAIDS. The organization's top priorities include conflict prevention and peace building, advocacy for children, and training religious leaders on HIV/AIDS-related stigma and discrimination.

Karen Plater from the Presbyterian Church of Canada is serving as the liaison between the IAC2006 committee and the religious organizations. Several meetings are planned and the satellite locations have been booked. So far it hasn't been decided which religious leaders will be invited.

In the meantime, faith-based groups planning to participate in the conference are encouraged to submit abstracts that deal appropriately with stigmatization and that encourage the use of condoms. ⊕

Jari Dvorak

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



Common ground

Healing retreats build community and offer a break from day-to-day worries

Jumping off a dock into a cold mountain lake, rappelling down a cliff, making lanterns in a Luminaries workshop, learning yoga, joking around a fire pit, sleeping in rustic cabins with other HIV-positive campers...these are just some of the activities at BCPWA Society's peer-driven healing retreats at Loon Lake Camp near Golden Ears Park. The three-day retreats for members have been held since 1987.

The retreats change lives, instill hope through others' stories, and build friendships.

The experience helps people see that they are not alone, that other HIV-positive men and women who initially seem different, share the same fears and dreams.

Participants run the gamut: grandfathers, youth, moms, singles, couples, Asian, Hispanic, Aboriginal. They are gay, straight, and transgendered. But they have one thing in common: they are all HIV-positive.

For many, the highlight of the retreat is the daily group discussions. Participants gather in small groups facilitated by trained peers. Group members share their personal stories and discuss chosen topics. This small group process builds lasting relationships and assures no one is lost in the dynamics of the larger group of up to 50 participants.

An energetic Opening Circle and a more introspective Closing Ceremony bring the entire group of participants,

volunteers, facilitators, and staff together to honour the community experience and reflect on time spent in nature.

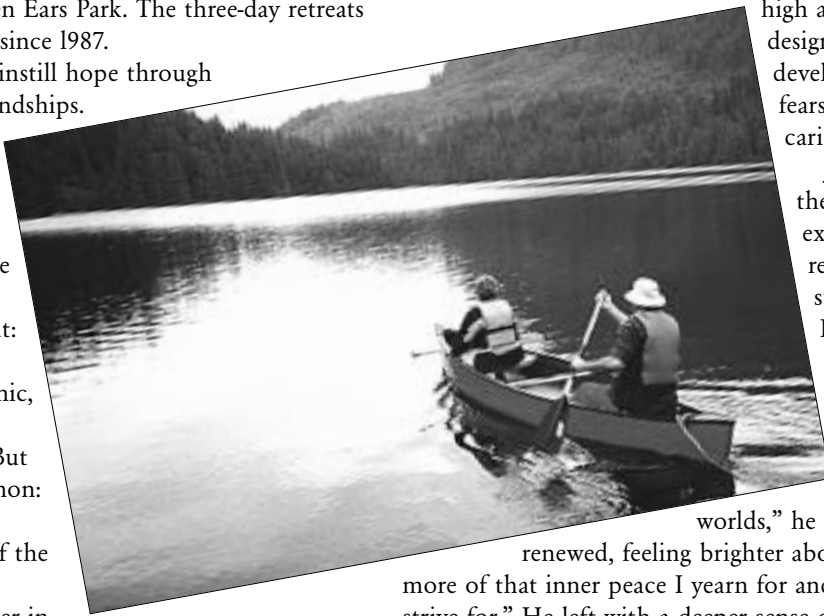
In addition to activities such as hiking, swimming, canoeing, and healing workshops, volunteer professionals offer various types of healing bodywork. This year, there was also a

high and low ropes course, designed to help participants develop trust and face fears in a supportive, caring environment.

John Bishop describes the retreat as a "five-star" experience, thanks to the retreat team and beautiful surroundings. "Loon Lake offered me the chance to explore the peaceful, natural world surrounding me, as well as my inner spiritual and emotional

worlds," he says. "I came away renewed, feeling brighter about life and with a bit more of that inner peace I yearn for and that outer grace I strive for." He left with a deeper sense of communion from sharing a larger experience with friends and peers.

"It's a remarkable life-enhancing experience," says Mark Leonard, a seasoned retreat camper. "I made lasting friendships and was moved by remarkable stories of courage—and found hope at seeing so many with a renewed strength and vitality." ⊕



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Not guilty

There's a glitch in drug testing in prisons, causing problems for some HIV-positive inmates on Sustiva

by Terry Howard

HIV-positive inmates in drug-free units are testing false positive for drug use. A recent case presented to BCPWA Society's Prison Outreach Program (POP) has brought this problem to light.

Federal inmates who wish to stay clean and live with other inmates who make the same commitment can stay in drug-free living units. Participants undergo voluntary urinalysis on a regular basis to test for the presence of illicit drugs. The test used is a quick, inexpensive, easy to use litmus strip that shows a simple positive or negative presence of drugs in urine.

This test has limitations in that it renders false positives for many reasons other than illicit drugs. Prescription medications, over-the-counter allergy and asthma medications, stomach ulcer medications, and even poppy seeds and herbal teas have caused a positive reading with this rudimentary test. Even ibuprofen, which is often the only pain relieving medication available to inmates, has rendered a false positive result.

A false positive drug test can ruin the plans of inmates who choose recovery while in prison and/or make release plans to go to a recovery house or drug-free halfway house when they return to the community.

Corrections Canada has clearly defined regulations about the process for random urinalysis of inmates. These regulations may not apply to programs such as drug-

free living units, where inmates sign an agreement to undergo voluntary urinalysis on a regular basis, not random.

The HIV-positive federal inmate who sought help from POP was removed from the drug-free unit after he had positive readings from urinalysis tests. Officials told him that he showed positive for marijuana use. He maintained that he was not using illicit drugs and requested that his sample be sent for a confirmatory gas chromatography-mass spectrometry, which returned with a negative result, thus confirming his claim. However, prison administration refused confirmatory testing for his second false positive test, stating that cost was an issue. The inmate's mother offered to pay for the test but the deputy warden denied her request. The unit manager then told her that her son should just admit his drug use.

When POP discovered the possibility of false positive testing with the HIV medication efavirenz (Sustiva) and confirmed the inmate had been on Sustiva for some time, this information was provided to institution officials. The officials gave the inmate the benefit of the doubt on this occasion, but told him to reapply to the drug-free unit when he was able to provide multiple negative urinalysis tests—using the same method that rendered the false positive test in the first place.

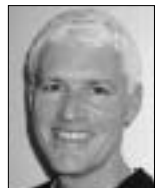
After several months of fighting to return to the drug-free unit and clear his record of any future negative consequences, he was reinstated in October. He hasn't had any problems since his return. But this begs the question: how many inmates have just stopped taking their Sustiva, or worse, given up recovery and returned to drug use from peer pressure in the regular living units?

Inmates undergoing random urinalysis in prison receive confirmatory testing when a known prescription medication causes a false positive, but this isn't the case for voluntary testing in the drug-free unit. A known false positive result from HIV medications will only encourage inmates who take their medications responsibly to stop taking them, which will jeopardize their health and provide the opportunity for HIV mutation.

When an inmate chooses recovery under difficult prison circumstances, that inmate should be supported in every possible way to attain his/her goal to be drug free. After all, wouldn't we prefer a drug-free inmate to return to our neighbourhood? ☺

Terry Howard

is the coordinator of the BCPWA Society's Prison Outreach Program.



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



Restless legs & restless nights

When your legs have a life of their own

by Derek Thaczuk

Have you ever laid awake at night, kicking and thrashing, wishing the awful feeling in your legs would stop so you could get some sleep? Did you assume you had peripheral neuropathy—the nerve condition that affects so many people with HIV?

Not necessarily. You may be suffering from a distinct condition known as restless legs syndrome.

At first glance, restless legs syndrome (RLS) might sound a little dubious, and not exactly medical. After all, it's not like there's a roving eye syndrome, or excessive nose hair disorder. Rest assured, though, it's quite real.

Actually, if you suffer from RLS, you certainly aren't resting. RLS is a neurologic

(nerve-related) disorder that causes maddening, unpleasant sensations in the legs, usually worst at nighttime. These feelings make it difficult or impossible to sleep, and people with RLS will kick and thrash their legs to try to get relief. Ongoing sleep disruption is no joke. It takes a severe toll on well-being, mental health, and the ability to function normally.

The specific kinds of feelings experienced vary among individuals, but people often describe them as:

- ▶ itching or burning
- ▶ creeping, crawling, or feeling "like bugs"
- ▶ tugging, pulling
- ▶ aching, painful
- ▶ like an electric current
- ▶ like water flowing on the skin

These symptoms can range from mild and occasional, to intolerable and nearly constant. Symptoms usually surface when you least want them: in the evening and at nighttime, when you're trying to lie still, relax, and sleep. However, RLS can also be triggered by periods of sitting or lying still, such as during car rides, or sitting at a desk. Although you'll usually feel symptoms in your legs and feet, they can sometimes occur elsewhere, such as in your arms.

RLS is understood to be a fairly common condition that is under-recognized and undertreated. It may affect between two percent and 15 percent of the general population. (Like lipodystrophy, this estimated wide range of prevalence results from not having a precise, universal definition.) Many people probably do not realize the symptoms are a legitimate medical problem, and don't report them to their doctors.

The causes of restless legs syndrome

Although RLS is a neurologic condition, it does not actually seem to involve the nerves in the legs and feet. It originates in the central nervous system (CNS)—the brain and spinal cord. It is not a psychiatric condition, and it is not caused by stress, although stress can make it worse. It seems to run in families, suggesting a genetic cause.

There are secondary causes that seem able to worsen or "unmask" RLS (that is, in some people a dormant condition may be awakened by these factors). These include:

- ▶ iron deficiency (anaemia)
- ▶ neurologic lesions (in the spinal cord or peripheral nerves)
- ▶ pregnancy (up to 19 percent of pregnant women are affected)
- ▶ uremia resulting from kidney malfunction
- ▶ medications, notably the use of certain antidepressants (including selective serotonin reuptake inhibitors, lithium, and tricyclics), antiseizure and antipsychotic drugs, and even cold and allergy medications.

Not the same as peripheral neuropathy

The prevalence of RLS in the HIV-positive population is not known. RLS is not the same as peripheral neuropathy (PN); neuropathy does not generally get worse at night, is not relieved by movement, and does not cause you to want to kick or move.

It is not known whether RLS and PN interact in any significant way, though it seems unlikely, except for the possibility of mistaken diagnosis. Since symptoms are similar, it's important to get a correct diagnosis. It's possible to have either or both conditions, and the same treatment approach won't necessarily work for both. For instance, the "d-drugs" (d4T, ddC, and ddI) that often cause PN are not necessarily culprits for causing RLS.

Treatment options for RLS

It's often possible to treat mild or moderate RLS, and at least improve the symptoms of more severe cases. You should have your blood chemistry checked for iron deficiency or kidney problems; since some HIV medications can be kidney-toxic, this should be a routine test anyway. Iron deficiency is easily

treated, and may be enough to control the symptoms of RLS. B vitamins, sometimes recommended for peripheral neuropathy, may also help to control RLS. (You should only take iron supplements under medical supervision.)

Other options for treating RLS include:

- ▶ medications for Parkinson's disease. One such drug, ropinirole (Requip)—originally approved for Parkinson's in 1997—was approved by the U.S. Food and Drug Administration in May 2005 for RLS. At this point, although other Parkinson's drugs may also be useful, Requip is the only drug specifically approved for RLS. Although not specifically indicated for RLS in Canada, it is an approved drug and doctors can prescribe it. (Note, however, that there is no direct connection between RLS and Parkinson's, and people with RLS are no more likely to develop Parkinson's than the rest of the population.)
- ▶ muscle relaxants, sleep medications, and painkillers. These do not address the underlying condition, but may dull the symptoms enough to allow sleep.
- ▶ epilepsy medications such as gabapentin (Neurontin).
- ▶ baths and massages, and warm and/or cool packs
- ▶ regular exercise. Most sources recommend moderate exercise, earlier in the day, however there is a lack of consensus. Some people find that exercising earlier in the day makes their legs worse, while others find mild exercise right before bed helps, and others find any exercise makes their legs worse.
- ▶ avoiding caffeine and medications that may worsen RLS, such as antidepressants. This, however, raises the issue of finding alternatives to those medications.

There is a great deal of information about RLS available on-line (see below). Most important, if you've identified it, you can start taking steps—calmer steps—to ease the condition. ☺

Derek Thaczuk

is a freelance consultant and medical writer with 11 years involvement in the HIV community.



Check out these ON-LINE resources

<www.rls.org>

Restless Leg Syndrome Foundation

<www.mayoclinic.com>

Mayo Clinic: search on "RLS" or look under "Diseases & Conditions"

<www.requip.com>

Information on Requip and RLS

STDs to watch out for

They may sound obscure, but LGV and shigellosis are popping up in industrialized countries

by Zoran Stjepanovic

Earlier this year, there were news stories about yet another sexually transmitted disease, lymphogranuloma venereum (LGV). LGV isn't new—it's more common in tropical regions like Africa, South America, and the Caribbean. What is new about this disease is that it is now finding its way into industrialized countries like the US and Canada. The current outbreak of this infection was first reported in the Netherlands a couple of years ago among gay men, most of whom were HIV-positive. Currently there are about 22 cases in Canada.

LGV usually involves the anus and rectum

LGV is caused by bacteria very similar to the type that causes chlamydia, though the infection caused by LGV appears to be more invasive. It is transmitted through unprotected anal, oral, and vaginal sex, including unprotected fisting and sharing of dildos. (In fact, most of the men diagnosed in the Netherlands participated in fisting parties.) Almost all cases involve the anus and rectum.

The current outbreak of LGV was first reported in the Netherlands a couple of years ago among gay men, most of whom were HIV-positive.

Once you've been exposed to the infection, symptoms may start to appear anywhere from between three to 30 days later. Symptoms may involve rectal bleeding, constipation, or a creamy discharge, consisting of mucus and pus, from the anus. A sore or lump may also appear where the bacteria entered your body. Importantly, the sore or lump can be painless, and you may not even know that you're infected. Other possible symptoms include a low-grade fever, chills, fatigue, and muscle and joint aches.

If you have any of these symptoms, see a doctor. Your physician may take samples or swabs from your anus, or other areas where symptoms appear—the penis, vagina, or oral cavity. A blood test may also be performed to make an accurate diagnosis, and to determine if you're also infected with any other sexually transmitted diseases. Most people diagnosed with LGV also had another sexually transmitted disease such as gonorrhea, syphilis, herpes, or hepatitis.

If you're infected with LGV, it is important to get treatment as soon as possible or the infection can spread to the lymph nodes and intestines. Antibiotics to treat LGV include 100 mg of doxycycline twice daily for 21 days or 500 mg of erythromycin four times daily for 21 days. Erythromycin can potentially interact with protease inhibitors and non-nucleoside reverse transcriptase inhibitors (NNRTIs); for more information about potential drug interactions, speak to your pharmacist or contact the treatment information office at the BCPWA Society.

Shigellosis is highly infectious

Shigellosis is another sexually transmitted disease that is making news again in other parts of the world, with cases reported in London, Australia, the Netherlands, the US, and Germany. There was a shigellosis outbreak in Vancouver a few years ago, so it's definitely something to watch out for.



Electron Micrograph of Shigella in a membrane-enclosed endosome of an epithelial cell.

Shigellosis is caused by bacteria called *Shigella sonnei* and is highly infectious. It is transmitted by contact with very small amounts of human feces and it can occur from sex or poor hygiene. Activities such as rimming, fingering, fisting, and anal sex may all involve small amounts of feces, so it's important to wash your hands — and to use condoms for anal sex. This infection can cause severe diarrhea and it can be treated with antibiotics such as ciprofloxacin. If you do find you have severe diarrhea, see a doctor as soon as possible. While it just could be a side effect of certain HIV medications, it could also be a case of shigellosis. ⊕

Zoran Stjepanovic

is the treatment information coordinator for the BCPWA Society.

The heart of the matter

As PWAs get older, risk of cardiovascular conditions becomes an increasing concern

by Zoran Stjepanovic

These days, people living with HIV are living longer due to highly active antiretroviral therapy (HAART). Statistics show that more than 85 percent of PWAs will survive for more than ten years. Prior to HAART, the median survival rate after HIV infection was only about ten years. While people may be living longer, treatment is much more complex in 2005: individuals now face numerous other health concerns, many of them associated with normal aging processes.

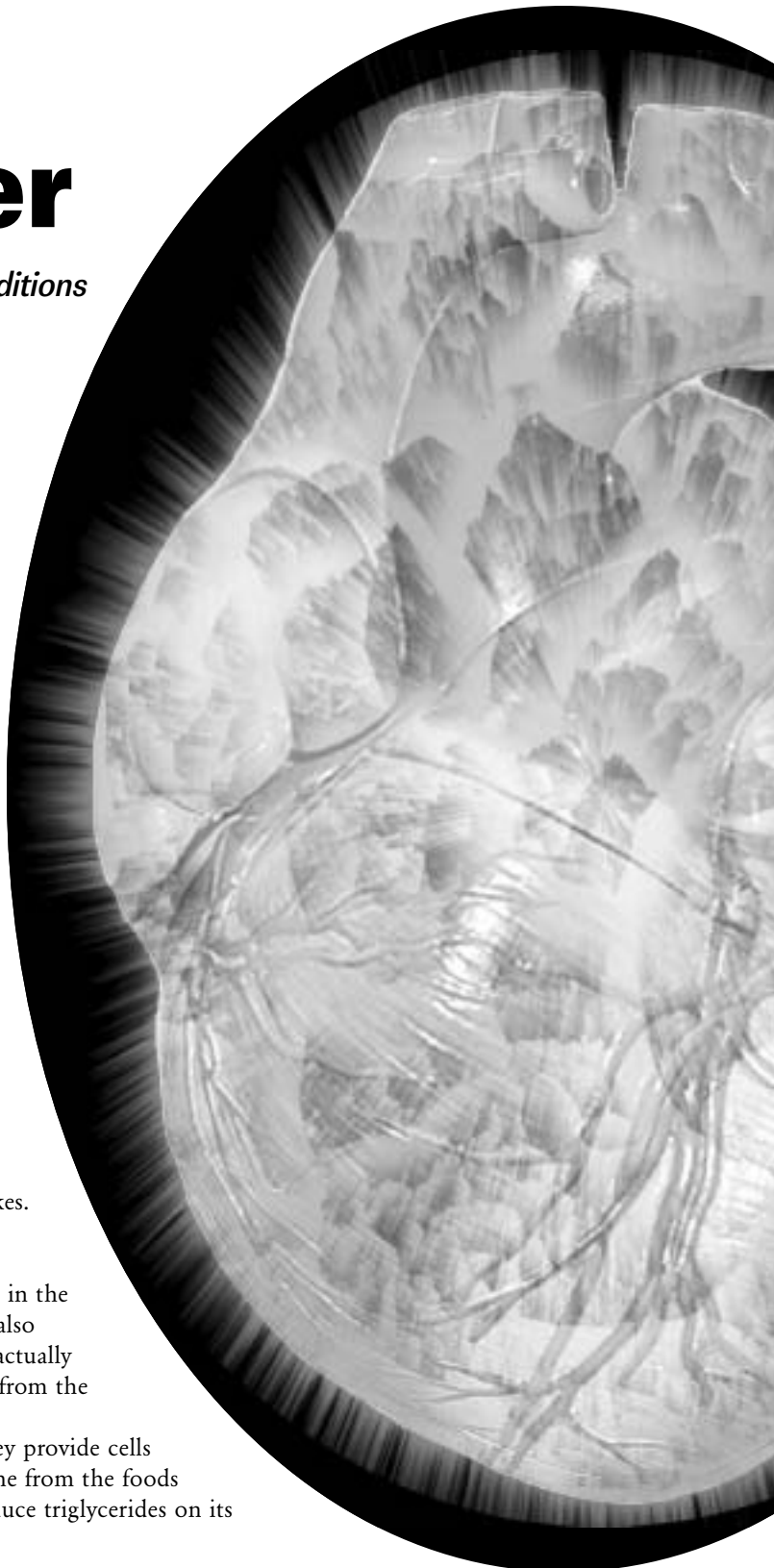
HIV-positive individuals are increasingly concerned about cardiovascular conditions—heart attacks and strokes. What are the risk factors for cardiovascular disease? Do protease inhibitors (PIs) lead to heart conditions? How can you prevent cardiovascular problems? These are just some of the questions PWAs are now asking.

Cholesterol and triglyceride levels

First, some background information. Cholesterol and triglycerides are two major lipids (types of fat) that circulate in the blood and can contribute to cardiovascular disease when lipid levels are high. When people think about cholesterol, they often think about all the bad things it can do, such as clogging arteries and increasing the risk of heart attacks and strokes.

But cholesterol is important to the body. There is good cholesterol (HDL) and bad cholesterol (LDL). Cholesterol is necessary for the production of sex hormones and plays a role in the production of bile salts that assist in the digestion of food. It also helps cells to form and maintain their membranes. Our body actually produces 85 percent of the cholesterol, and 15 percent comes from the foods we eat.

Triglycerides also play an important role in our bodies. They provide cells with the fuel they need to function properly. Triglycerides come from the foods we eat, mainly sugar and saturated fats. The liver will also produce triglycerides on its own if triglyceride levels are in short supply.



Usually it's a combination of elevated triglycerides and bad cholesterol that causes cardiovascular disease. Table 1 outlines blood lipid levels and associated risks. It's important to have your lipid levels monitored if you are taking antiretrovirals.

Next time you have your bloodwork done, check your lipid levels and whether you're at risk for cardiovascular disease based on cholesterol and triglyceride levels.

(Note that there have been reports of HIV-positive individuals experiencing increases in cholesterol and triglyceride levels even if they have never taken antiretroviral therapy, so HIV itself may contribute to these increases.)

HIV, antiretroviral therapy, and cardiovascular disease

Over the years, many studies examining cardiovascular disease and HIV have shown conflicting evidence on whether antiretrovirals increase the risk of heart problems. One investigation, the California Medicaid Study involving 28,513 HIV-positive individuals, revealed a greater risk of myocardial infarction (heart attack) with protease inhibitors. Other studies, such as the Veterans Administration Study involving 36,766 HIV-positive individuals, showed no greater risk of heart attack with antiretrovirals.

A more recent study, the Data Collection of Adverse Events Study (DAD), involved 23,468 HIV-positive individuals from Europe, Australia, and the US. Many of the participants had been on antiretroviral therapy for many years, and results from this study showed a small incidence of myocardial infarction (heart attack) associated with exposure to antiretrovirals. This study reported a 26 percent increase in the relative risk of heart attack for each year of exposure to HAART. The incidence of heart attack in this study, however, was low at 0.5 percent (126 individuals out of 23,468).

Keep in mind that these studies have limitations: short duration of HAART exposure, low incidence of cardiovascular events, and study design. Investigations into cardiovascular disease and HIV need to take place over a longer

Table 1. Blood lipid levels and associated risks

Lipid	Blood level (mg/dl)	Risk level
Total cholesterol	<200	Desirable level
	200-239	Borderline risk
	>240	High risk
LDL (bad cholesterol)	<100	Optimal
	100-159	Borderline risk
	>160	High risk
HDL (good cholesterol)	<40	High
	>60	Desirable
Triglycerides	<150	Normal
	150-199	Borderline
	200-499	High
	>500	Very high

period. Some of these studies did not look at other risk factors for cardiovascular disease and these can be even more predictive of future cardiovascular problems.

Cardiovascular risk factors include obesity, high blood pressure, high cholesterol and triglyceride levels, a family history of heart disease, diabetes, smoking, and age. All these factors increase your risk of heart disease, whether or not you're HIV-positive.

Switching therapies is sometimes an option

How to manage cardiovascular risks is another burning issue. Protease inhibitors (PI) are often blamed for causing elevated cholesterol and triglyceride levels. Switching to a non-nucleoside reverse transcriptase inhibitor (NNRTI, or non-nuke) is one option for some individuals. Some studies have shown that switching from a PI to nevirapine (Viramune) has reduced both triglycerides and total cholesterol and raised HDL cholesterol (good cholesterol).

Switching to efavirenz (Sustiva) may result in a triglyceride increase, however it may raise LDL cholesterol as well. The goal is to increase HDL cholesterol (a good thing) and decrease the bad cholesterol (LDL). Atazanavir (Reyataz) is the only PI that does not cause elevated lipid levels, so you may wish to take it if you require a PI-based regimen.

Some studies have demonstrated that d4T (Zerit) is linked to elevated lipid levels. If you're taking d4T, you may want to consider taking an alternative nucleoside reverse transcriptase inhibitor (NRTI, or nuke) such as abacavir (Ziagen) or tenofovir (Viread). These are just some options; however, if you are considering switching therapies, you need to discuss it with your doctor and consider the ramifications before making a decision. Switching therapies can present other unwanted side effects as well.

continued on next page

Lipid-lowering drugs can help manage cholesterol

Many people use lipid-lowering drugs to manage their cholesterol and triglyceride levels. Unfortunately, there's little research on the effectiveness of these drugs for HIV-positive individuals also taking antiretrovirals. We're still learning about interactions between HIV medications and lipid-lowering drugs.

There is, however, some research on one lipid-lowering class of drug called statins (or HMG-CoA reductase inhibitors). Statins block the activity of the HMG-CoA reductase enzyme, which controls the rate of cholesterol production in the body. For people living with HIV, these statins are broken down in the body by the same enzyme that metabolizes PIs and the NNRTIs. This then causes the levels of either the PIs, or the NNRTIs and statins, to fluctuate, thus increasing the risks of side effects from these drugs.

Some statins, such as simvastatin (Zocor) and lovastatin (Mevacor), should not be used with any PIs or with delavirdine (Rescriptor). The statins that appear to be the safest in combination with HAART are pravastatin (Pravachol) and fluvastatin (Lescol). Some doctors may prescribe atorvastatin (Lipitor). If your doctor prescribes atorvastatin, it's advisable to start with a low dose and then increase doses if necessary— atorvastatin levels can increase in the bloodstream when taken with PIs or delavirdine.

Managing cardiovascular disease

Switching therapies or taking lipid-lowering drugs may be one way to manage cholesterol and triglyceride levels, thus reducing your risk of cardiovascular conditions. Making lifestyle changes is another way to reduce the risk—for example, quitting smoking. Check out the May/June 2005 issue of *living + magazine*, which discusses the adverse effects of smoking for PWAs.

Other key lifestyle factors to consider include:

- ▶ **Diet.** You'll need to establish a low saturated fat, low cholesterol eating plan. Foods low in saturated fat include fat free or 1% dairy products, lean meats, fish, skinless poultry, whole grain foods, fruits, and vegetables. Limit your intake of foods high in cholesterol such as liver, red meats, egg yolks, and full-fat dairy products. Eat good sources of fibre such as oats, dried peas, and beans.
- ▶ **Sugar and alcohol.** If you're HIV-positive and also have elevated triglyceride levels, consider reducing or even eliminating sugars. Sugars to watch out for include concentrated sweets (table sugar), desserts, baked goods, and sweet beverages (fruit juices and sodas). Also, limit your alcohol consumption, or stop completely if your triglyceride levels are high.
- ▶ **Weight management and physical activity.** If you're overweight, it's a good idea to try to lose some weight. One way to achieve that is through exercise or physical activity such as walking, plus some weight lifting.

As people are living longer with HIV, it's important to be aware of cardiovascular risk factors and to monitor blood lipid levels on a regular basis. The key is to manage your risk.

Stay tuned for nutritional recommendations for cardiovascular disease in the next issue of living + magazine. ⊕



Zoran Stjepanovic
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Know the signs of a stroke and heart attack

Signs of a stroke:

- ▶ Numbness, weakness, or paralysis of the face, arm, or leg, on one side of the body
- ▶ Vision problems in one or both eyes, double vision, or loss of vision
- ▶ Confusion, trouble speaking or understanding
- ▶ Trouble walking, dizziness, loss of balance or coordination
- ▶ Severe headache

Signs of a heart attack:

- ▶ Pain that spreads from the chest to back, neck, jaw, upper abdomen, one or both shoulders or arms (left shoulder and arm are more commonly affected)
- ▶ Dizziness or light-headedness
- ▶ A fast, slow, or irregular heartbeat
- ▶ Sweating
- ▶ Shortness of breath
- ▶ Nausea or vomiting

If you have any of these symptoms, it is important to call emergency right away at 911.

Source: BC Health Guide

Cold busters

Try some of these herbal remedies to beat winter congestion and sore throats

by **Katolen Yardley**

Winter is just around the corner—and so is congestion and sore throats. The cold virus thrives in lower temperatures and can set in when our defenses are low. For people with HIV/AIDS, there is further concern that a cold can progress to bronchitis or *Pneumocystis carinii* pneumonia (PCP). Raising the body's natural defenses can decrease the likelihood of catching an infection.

A fever is the first line of immune system defense, meaning the immune system uses heat to attack foreign pathogens and to mobilize its army of immune system troops to fight against viruses and bacteria. At the onset of a cold, don't suppress a fever. The increased heat in the body is a sign that the body is attempting to fight infection. Instead, allow it to run its course and watch that the fever does not exceed 103°F–104°F.

Increased sweating accompanies a rise in body temperature. A cold can be an opportunity to remove wastes and expel toxins through the pores of the skin. Diaphoretic herbs such as ginger, peppermint, and elderflowers assist in this process.

A traditional cold remedy is grated ginger and green onion. To make the tea:

- ▶ Boil 2 cups of water
- ▶ Grate 1-2 teaspoons of fresh ginger and chop 3-4 green onions
- ▶ Add to water, reduce heat, cover, and simmer for 10 minutes. Drink two to four cups daily.

You can also take an Epsom salt bath at the onset of a cold. In addition to being a welcome relief for whole body aches and chills, it can encourage elimination of wastes through the skin, improve circulation, and support lymphatic drainage. Draw a hot bath and add two to four cups of Epsom salt. Stay in the water for about 15 minutes. Get out of the bath slowly (you might feel dizzy), and go straight to bed. If whole body soaks are not possible, then footbaths are also effective.

For a sore throat, check out the herbs and spices in your kitchen cupboard. Sage, thyme, and rosemary are all antiviral and antiseptic; their astringent nature is ideal for treating laryngitis or a sore throat. For the strongest medicinal effect, ensure the bulk herbs have a strong characteristic scent and have been stored for less than one year. Use one teaspoon of herb mixture per cup of boiling water. Cover and steep for 15 minutes, then strain and use as a gargle.

My favourite herbal ammunition for winter viruses and bacteria include:

- ▶ Elderflowers (*Sambucus nigra*): Used for all upper respiratory infections and sinus headaches. It promotes sweating and can

help break a fever. High in vitamin C, this herb is ideal for chills and nasal congestion.

- ▶ Wild indigo (*Baptisia tinctoria*): A powerful antiseptic for viral and bacterial infections. It is also used for fevers, a sore throat, and laryngitis.
- ▶ Mullein (*Verbascum thapsus*): An expectorant and respiratory tonic for bronchitis and for soothing inflamed mucous membranes.
- ▶ Thyme (*Thymus vulgaris*): An antiviral, anti bacterial, antifungal and anti-cough remedy, thyme helps to liquefy and loosen mucous from the lungs. It is also an expectorant for a dry spastic cough.

Similar to the sore throat remedy, the standard adult dosages for dried herbs as a cold remedy is one teaspoon of herb for each cup of hot water, steeped for 15 minutes. Drink three to four cups daily. For a liquid tincture, take 5ml (one teaspoon) three to four times a day diluted in hot water. ☺



Katolen Yardley, MNIMH, is a medical herbalist in private practice at *Gaia Garden in Vancouver and the Tri-City Natural Health Clinic in Coquitlam.*

Cold buster tips

- ☑ Increase your intake of fluids (water, herbal teas, and broth) to six to eight cups daily
- ☑ Ensure you are getting fresh air
- ☑ Increase your intake of vitamin C and bioflavonoids
- ☑ Wash your hands often—the cold virus can survive on the hands, tissues, and other surfaces for several hours
- ☑ Increase your consumption of garlic and onions and avoid mucous-forming foods such as sugar, dairy, and processed foods

Biomedicine boom

Biomedicines are offering PWAs a new lease on life. Here's a list of several of these immune-boosting supplements

by Kenn Blais

The biotechnology industry is booming. Around the world, people are recognizing the benefits of using nutritional immune-enhancing therapy in conjunction with regular medicine. Biotech and biopharmaceutical companies are creating a new class of nutritional therapies that will explode onto the market within the next decade and forever change the practice of drug-dominated medicine. The premise is simple—strengthen the immune system on a cellular level using formulated plant-based extracts.

These new formulations go through rigorous testing. The new plant-based extracts are designed specifically to enhance cell-mediated immunity, which is the most effective way of treating a dysfunctional immune system.

Increasing cell-mediated immunity is the ultimate goal in treating HIV. But drug cocktails are toxic to living cells; besides the intended target, the cocktails kill other cells, including those of the sensitive immune system. Current HIV treatment focuses on viral suppression, but despite lowered viral loads we are not seeing damaged immune systems rebound.

That's where the biomedicines fit into the picture. Biomedicines are showing results in repairing and restoring normal immune function in various degenerative, inflammatory, and autoimmune conditions. Beyond simply suppressing symptoms, they're designed to work on a cellular level where restoration of cell-mediated immunity begins.

The following are some of the new supplements, both general formulations and brand name products, available to help with your immune building strategy:

Colostrum: Recently rediscovered, bovine colostrum is recognized as a potent immune system stimulator. It's the first secreted mammary nourishment that all mammals provide their newborn in the first 48 hours of life. It triggers numerous processes that develop the immune system to ensure the vitality of the newborn.

The main two components of colostrum are immune factors and growth factors including interferon, gamma globulin, growth hormone, insulin-like growth factor-1 (IGF-1), and protease inhibitors, all of which have been used in the treatment of cancer and viral and degenerative diseases. Bovine colostrum is identical to human colostrum except it contains these factors in significantly higher quantities.

Green tea extract: In 2003, a BBC newscast touted that "green tea could form the basis of a new generation of HIV drugs." Scientists in Japan found that a component of green tea could stop HIV from binding to healthy immune cells.

Long known for its health benefits, green tea is comprised of a class of chemicals called catechins, the most abundant of which is epigallocatechin gallate (EGCG). Studies show that EGCG protects the membrane structures of cells and increases cell receptivity to hormones and enzymes, thus increasing cellular communication. Its ability to enter the cell helps reverse

cellular degeneration, making it effective in conditions such as cancer, heart disease, and arthritis.

This is just the tip of the iceberg for EGCG. As more green tea extracts become available, its benefits become apparent for more health conditions.

Resveratrol: Another extract that works at the cellular level, resveratrol's biochemical activity shows great promise. It is made from the skin of grapes where it is used by the plants to ward off fungus. Recent headlines report that red wine—high in resveratrol—helps prevent cancer, and people who drink a moderate amount of red wine have less heart disease. The population of France has lower rates of heart disease despite a traditionally high fat diet.

Studies show that resveratrol has a unique anti-aging or longevity quality. It also inhibits the growth of cancer in all three stages of the disease. As a powerful antioxidant, it protects cells from the damage of free radicals associated with degenerative disease and inflammation. It reinforces the strength and elasticity of collagen in connective tissue, thus improving tendons, joints, blood vessel walls, and skin. It protects the liver, is antifungal, and improves eyesight and night vision.

Chicolin: This mild natural sweetener that tastes like cotton candy is made from the root of the chicory plant, one of the richest sources of fructo-oligosaccharides (FOS).

FOS is an excellent growth medium for probiotics (friendly bacteria in the gastrointestinal tract), increasing the beneficial lactobacilli (*acidophilus*) and bifidobacteria of probiotics. Better probiotic companies add FOS to increase the potency of their product. FOS strengthens most strains of bifidobacteria so that they withstand the presence of pathogenic bacteria (such as *cryptosporidium*, *shigella*, and *E. coli*), preventing them from adhering to and entering the mucous membrane.

As an indigestible polysaccharide, FOS acts like fibre and slows the absorption of sugars, thereby providing constant blood sugar levels for up to ten hours, which is especially good for diabetics. In Japan and Europe, FOS is used in over 1,000

processed food products as sweetening and bulking agents to replace sugar and fat.

Studies show that FOS reduces bowel toxins and improves symptoms of inflammatory bowel disease, improves assimilation of vitamins and minerals, and helps the manufacture of B vitamins. It also improves immune function, has anticancer and liver protection effects, and increases energy reserves and athletic performance.

Recovery: This unique formulation combines the active properties of green tea and grape, including EGCG and resveratrol, into a potent complex called Nutricol. This extract is combined with complementary ingredients—including FOS, dimethylglycine, methylsulfonylmethane (MSM), glucosamine, and vitamin C—specifically formulated for a synergistic effect.

Recovery has advantages for people with HIV in that it comes in powder form and is mixed in water to ensure higher absorption. Chronic malabsorption in HIV causes decreased assimilation of drugs and nutrients.

Extensive studies show that Recovery enhances drug delivery when used with pain medications, anti-inflammatories, corticosteroids, antibiotics, and antioxidants (vitamin A and C and beta-carotene). It has also demonstrated increased anticancer effects in breast cancer when used with Tamoxifen.

Immune Fx: Traditional Chinese Medicine has used medicinal mushrooms for over 2,000 years. Recent studies support their antiviral, antitumor, and anticancer effects. Continued studies in Asia provide evidence that properties of medicinal mushrooms enhance cell-mediated immunity and show promising results with combination therapy in HIV-positive persons.

Immune Fx is made by the same company that makes Nutricol and combines Nutricol with extracts of six medicinal mushrooms, including shiitake, reishi, and maitake, which are known for their immune-enhancing effects.

Cold Fx: This formulation, derived from panax ginseng, is gaining popularity for the prevention and relief of colds and flu. It activates macrophages, which stimulate

T-cells and increase natural killer cells. It activates acquired immune responses by increasing interleukin-1, -2, and -6, increasing B cell proliferation in the spleen, and circulating IgG and interferon-gamma, a regulator of cell-mediated immunity.

Studies show that Cold Fx can reduce recurrent infections by 56 percent, reduce the total days of symptoms from 10.9 to six, and reduce the severity of symptoms by 31 percent.

Trinovin/Promensil: Made from red clover, probably the oldest known cancer remedy, these male- and female-specific formulations consist of four isoflavones. Isoflavones are derived from legumes such as clover, beans, and soy and are known for their anticancer effects, especially in hormone-related diseases.

HIV adversely affects the hormones of the body's hypothalamic-pituitary-adrenal (HPA) axis, a major part of the neuroendocrine system that is considered the body's stress system and has important functions in regulating the immune system.

The hormone-protecting effects of Promensil have been shown to reduce symptoms of menopause—bone loss, hot flashes, night sweats, and mood swings. For men, Trinovin increases prostate health and relieves symptoms of benign prostatic hyperplasia.

Biomedicines such as these can be taken in conjunction with regular medicine to help restore the immune system and to create a personal immune-enhancing program. HIV doctors tell us that PWAs who take charge of their own health care fare better with the disease. The basis of your immune-enhancing program is that decision to take charge; it's the first step on the path to a longer, healthier life. ⊕

Kenn Blais

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





Fuel up for exercise

Make sure you're getting enough nutrition when you work out

by Michele Blanchet

Exercise is important to maintain your health, and it should be considered a basic treatment if you're HIV-positive. Exercise offers many benefits. It maintains muscle mass and increases your appetite and energy levels. It also boosts the immune system: exercise increases T4 helper cells, increases good cholesterol, lowers blood pressure, and helps to lower blood sugar levels. On a psychological level, exercise reduces stress, regulates sleep patterns, helps with depression, and enhances your self-image.

Optimize your exercise by giving your body the proper mix of nutrients. Exercise increases the body's need for energy and depletes it of important nutrients. It's important to consume a well-balanced diet that supplies adequate energy in a variety of foods; this will help you maintain your weight, achieve maximum performance, and supply the energy needed for exercise and to fully recover after.

Before you exercise, concentrate on getting fuel-efficient (fairly low glycemic) complex carbohydrates such as dried, canned, and fresh fruits; vegetables; whole grained breads and cereals; and dried beans, peas, and lentils. Include a protein source such as eggs, nuts, seeds, lean meat, or canned fish.

Both HIV infection and exercise increase your needs for calories (energy) and nutrients. Increase your stamina by snacking during exercise. Eat a variety of easy-to-carry, low-fat snacks. For longer, more intense exercise or endurance sports, try to eat 30-60g of carbohydrates each hour.

When you exercise, your body burns oxygen, creating highly unstable molecules called free radicals. These molecules can be destructive to your body. Eat a diet rich in antioxidants such as beta carotene, vitamin C, vitamin E, and selenium to protect your cells.

Food sources are the best way to get antioxidants, especially by eating dark green, bright orange and yellow fruits and vegetables. Although there is no consensus on the use of antioxidant supplements with HIV and exercise, in clinical practice vitamins C and E are widely recommended. You may want to take a complete vitamin/ mineral complex, 400-800IU of vitamin E and up to 1000mg of vitamin C daily.

After you exercise, eat a food source of carbohydrates to replenish your glycogen stores. A light meal combined with a small amount of protein within 1/2 hour after your workout allows for fastest regeneration

Drink up!

Make sure you keep your body well hydrated. Limit alcohol, coffee, tea and other caffienated beverages as they are dehydrating. Drink plenty of fluids 24 hours before exercise, then drink two cups of water both a few hours and 15 minutes before you start.

Aerobic exercises and endurance sports increase fluid loss. Sweating and heavy respiration can lead to dehydration. Drink a half to one cup of fluid for every 20 minutes of exercise. Your individual requirements may be higher.

Restore fluid losses after a workout. Water is fine. Although the sports drink versus water debate continues, water is the best fluid replacement for exercise less than 90 minutes long. Sports recovery drinks containing electrolytes help replenish fluid more rapidly when you do more than four hours of moderate to high exercise. For a homemade sports drink, mix equal parts of juice and water. ⊕

Michele Blanchet

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



Snacks that are easy to eat & carry when you're exercising

15 g carbohydrates

crackers

3 stone wheat thins,
6 saltine

bread (1 slice)

whole wheat
rye
multigrain
pumpnickel

cookies

2 - 3 digestive
5 arrowroot
3 graham crackers
3 ginger snaps

fruit and vegetables

1 small orange
1 small apple
1 cup grapes,
15 baby carrots
3/4 cup blueberries

30 g carbohydrates

1/2 bagel

1 pita pocket

dried fruit

5 dates,
2 - 3 figs
1/3 cup raisins

fruit

1 banana

dairy

1 small container
of fruit yogurt

fluids with carbohydrates

1 cup clamato juice
1 cup hot chocolate
1 cup low fat eggnog

Dietitians dish it up



Aging and renal disease were emerging issues at the recent Association of Nutrition Services Agencies conference

by **Diana Johansen**

The Association of Nutrition Services Agencies (ANSA) works to enhance the quality of life of people with HIV/AIDS and other life-threatening illnesses by strengthening community-based nutrition support programs. ANSA held its annual conference in Washington, DC in September. The nutrition track covered areas of emerging importance for HIV-positive persons: aging, renal disease, HCV co-infection, exercise, and lipoatrophy. The presentations were sobering reminders of the complexity of HIV disease.

In the presentation entitled “Senior-Focused Nutrition Care,” dietitians Lisa Zullig and Theresa Kinsella reminded us that many people living with HIV/AIDS are becoming seniors and dealing with all the issues that accompany aging. They reviewed Alzheimer’s disease (AD), a progressive brain disorder afflicting up to three percent of people over 65.

AD has seven stages, ranging from no impairment to severe cognitive decline. Risk factors include genetics, age, female gender, chronic inflammation, elevated homocysteine levels, and head trauma. Regular physical and mental exercise (such as crossword puzzles) may help prevent the development of AD. Vitamin E, B6, B12, folate, omega 3 fatty acids, and ginkgo biloba can help delay cognitive decline.

Dietitian Mary Griffin gave an excellent review of renal (kidney) disease and HIV-associated nephropathy (HIVAN). She claimed that HIVAN is underdiagnosed in people with HIV and that it may occur in up to ten percent of PWAs. Causes include the virus infecting kidney cells directly, or such secondary causes as street drugs, HBV/HCV, opportunistic infections, medication toxicity (including antiretrovirals), or other diseases (such as diabetes, hypertension, or cytomegalovirus/CMV).

Griffin said it is imperative to screen for kidney function annually and in some cases biannually. The most commonly used test is glomerular filtration rate (GFR) but a renal biopsy is the only method to definitively diagnose HIVAN.

If you’re diagnosed with HIVAN, highly active antiretroviral therapy (HAART) is the first-line intervention. Blood pressure control is essential and you may require medication. There are no specific nutrition guidelines but it is prudent to limit your

salt and protein intake. If your kidneys fail altogether, you’ll require dialysis, a process that cleans the blood mechanically.

Glenn Preston, a dietitian and certified personal trainer, reviewed exercise guidelines. He stated that the ideal program includes aerobic exercise, resistance training, balance training and flexibility training. He emphasized that something is better than nothing—the most important thing is to do something active every day. When exercising, keep several fitness principles in mind:

- ▶ Warm-up and cool-down: don’t begin or end exercise abruptly
- ▶ Specificity: exercising a certain part of the body develops primarily that part
- ▶ Overload: push you beyond your limits to increase your capability
- ▶ Progression: gradually increase or progress your workload over time
- ▶ Reversibility: results can be undone through disuse

Preston suggested that flexibility training (stretching) might be the easiest way to get started if you’re a non-exerciser. If you’re very overweight, even starting with five minutes of exercising at a time is helpful. Also, you can exercise in small increments throughout the day and achieve the same benefits as if you did them all at once.

The conference ended with “Grace Under Pressure” by Cate Scaffidi, a yoga teacher and psychotherapist. Scaffidi discussed mind-body connections and how to deal with stress. Stress is an inevitable part of life and we can’t eradicate it but we can learn to cope better. She also taught some exercises to reduce the body’s stress response. My favourite is the mantra: “May I be peaceful. May I be joyful. May I be free from harm.” ⊕



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

What's new?



Novel HIV treatments reported at the 12th Conference on Retroviruses & Opportunistic Infections

by Glyn Townson

Since the advent of protease inhibitors (PIs) in the mid-1990s, there have been few major breakthroughs in HIV treatment nor any new approaches to HIV therapies in the works. Most of the Conferences on Retroviruses and Opportunistic Infections (CROI) reported and focused on improvements to existing classes of drugs. Over the last couple of years, however, some exciting developments have opened the door to potential treatments with several new classes of drugs.

The challenge for researchers and scientists is to continue developing drugs and treatments with different mechanisms to control HIV in order to keep a step ahead of drug resistance.

This year's CROI conference was held in Boston. It is a key event on the HIV calendar and highlights the latest developments in the world of HIV Science. Several new classes of antiretrovirals (ARVs) currently under investigation were presented at this year's conference:

Maturation inhibitors

Some of the drugs currently in development include an entirely new class of drugs called maturation inhibitors. PA-457, developed by Panacos Pharmaceuticals Inc., inhibits a protein produced by HIV-infected cells that would normally become a component of new HIV particles. Researchers found that virions (virus particles) from PA-457-treated cultures were non-infectious. Other benefits of this drug include its long half-life of two to three days; studies completed to date indicate it is apparently well tolerated at all dose levels. Phase III trials of this drug will take place in 2006.

Entry inhibitors

Another new drug class includes various experimental compounds designed to block cell surface receptors, such as

CCR5 or CXCR4, as well as other novel compounds that block HIV fusion with the cell surface. Unlike existing HIV drugs that work inside the cell and target viral enzymes involved in the replication of the virus, entry inhibitors work by blocking HIV before the virus enters the cell and begins its replication process. Currently, the only drug available in this class is T20 (Fuzeon), which must be taken by subcutaneous injection.

There are a few other potential candidates under investigation in the entry inhibitor category. TAK-652 is a drug that targets the CCR5 co-receptor and shows promise as an entry inhibitor. Preliminary test tube studies suggest this drug will be effective against resistant strains of the HIV virus. It is a highly potent, orally bioavailable CCR5 antagonist with the possibility of once-daily administration.

Another CCR5 inhibitor, GlaxoSmithKline's 873140 is a compound that binds to the CCR5 receptor on cell surfaces. It appears to have a high rate and prolonged occupancy of the CCR5 receptor following oral administration. It also appears to have synergistic effects with some other antiretrovirals such as nevirapine (Viramune), indinavir (Crixivan), and T-20, and with X4 inhibitors AMD3100 and TE141011. It is currently in phase II clinical trials to establish its tolerability, dosage, and safety.

PRO-542 is an experimental entry inhibitor that can remain in the bloodstream for several days after a single IV infusion. PRO-542 might only need to be infused, through an intravenous line, once a week. There have been small studies showing promising results; larger trials looking at the effectiveness and safety of PRO-542 will be conducted in the future.

A further new class of reverse transcriptase inhibitors (RT) called nucleoside-competitive reverse transcriptase inhibitors (NcRTIs) is under development by Tibotec, a Belgian company. The company presented data on Compound X at CROI.

Antiviral assays and biochemical experiments show this compound could inhibit HIV by a mechanism clearly different from other currently available classes of drugs.

New drugs from existing classes

There are also two new drugs from existing classes of anti-retrovirals soon to be available in BC through expanded access.

A new protease inhibitor (PI), TMC114, is currently in phase III trials and promises to be effective against other PI-resistant HIV. In one phase II trial, a 24-week study of nearly 500 participants – who had extensive past treatment from three different drug classes and who had developed primary resistance to PIs– showed rapid and substantial reductions in viral load, indicating that this drug may be a potent option for those with multi-drug resistant HIV.

Over the last couple of years, some exciting developments have opened the door to potential HIV treatments with several new classes of drugs.

TMC114 has an advantage over predecessors in that it binds to viral protease more avidly than current PIs. According to results of a new Tibotec study, once bound, it stays bound. Researchers measured the protease-binding affinity of TMC114, a dozen closely related compounds, and seven licensed PIs. TMC114's binding affinity to wild-type protease proved three to four orders of magnitude higher than current PIs, reflecting both a high association rate and low dissociation rate.

TCM114 is administered with low dose ritonavir (Norvir). Some side effects have been reported, including diarrhea and numbness and tingling around the mouth for higher doses of TCM114.

In test tube studies, TMC 278, a new non-nucleoside reverse transcriptase inhibitor (NNRTI), has shown promising effectiveness against HIV that has become resistant to existing NNRTIs. It has an increased genetic barrier to the development of drug resistance. The drug is generally well tolerated; new trials are underway to determine its dosage, safety, and tolerability.

A potential new vaccine

On the vaccine front, Merck & Co. has launched a phase II trial of its vaccine candidate—known as MRKAd5 HIV-1 gag/pol/nef, or trivalent vaccine—that is based on adenovirus, a common cold virus modified so that it cannot reproduce and cause a cold in humans. The adenovirus is used as a vector, or a delivery vehicle, to transport three synthetically produced

HIV genes into the cells. The three HIV genes are known as gag, pol, and nef. The delivery of these HIV genes into the cells stimulates the body to generate a potent cellular immune response to HIV, producing an army of killer cells, called T cells, programmed to recognize and kill cells infected with HIV.

No live HIV is used in the production of the vaccine candidate, so it can't cause HIV infection or AIDS.

The trial is known as a proof of concept study because it enables researchers to test the concept that the vaccine candidate prevents HIV infection, or results in lower HIV levels in the blood of those who become infected with HIV. If the concept is proven—that is, if data generated by the study show that the vaccine candidate provides some protection against HIV, or delays or diminishes the course of HIV infection—this information will guide future research.

The collaborative trial is the first study specifically designed to test the ability of a Merck-developed, adenoviral, vector-based, trivalent vaccine candidate to affect the clinical course of HIV infection. This vaccine candidate is designed to generate a cellular immune response, as opposed to the antibody response typical of most vaccines in use today. The trial is expected to provide vital data about the ability of this vaccine approach to either prevent infection with HIV, and/or to maintain a lower average viral load compared with placebo in individuals who may become infected with HIV during the course of the study.

Information from several different sources, including HIV drug studies and studies of HIV-infected individuals, suggests that maintaining a lower viral load may be associated with clinical benefits to patients. The study will also evaluate whether the investigational vaccine is generally well tolerated by study participants.

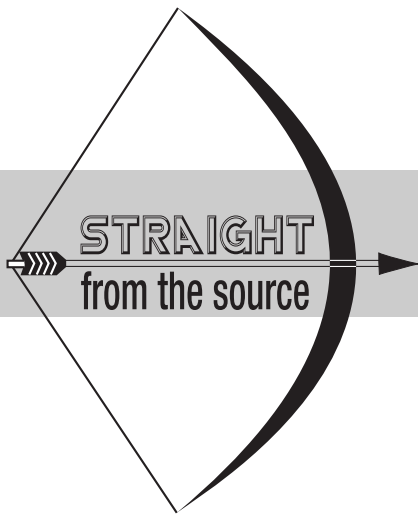
One area that is still overlooked and very important is the research and deployment of microbicides. With over 60 candidate products in the pipeline, an effective microbicide could be on the market this decade. While there is a long history of community advocacy for microbicides in Canada, the federal government has paid little attention to them. There is only one potential microbicide in development in Canada.

Community advocacy for microbicides should continue to ensure sustained governmental commitment to microbicides. AIDS service organizations such as the BCPWA Society and all PWAs should be actively involved in advocating for microbicide research, development, and delivery. ☺



Glyn Townson

is the vice-chair of the BCPWA Society.



Protease inhibitors and changes in lipid profiles

by Anne Drummond

The association between highly active antiretroviral therapy (HAART) and abnormalities in glucose and lipid metabolism was observed soon after protease inhibitors (PI) were included in antiretroviral regimens. In recent years there have been increasing reports of HIV-related lipodystrophy syndrome—a combination of metabolic disorders and morphological changes—among patients treated with PIs. The syndrome has assumed considerable importance because dyslipidemia and other metabolic disorders increase the risk of coronary heart disease in PI-treated persons. In addition, patients experience significant distress and isolation as a result of changes in their body image.

It is well known that nearly half of all patients on PIs show elevated levels of triglycerides, total cholesterol, low-density lipoprotein (LDL, or “bad” cholesterol), insulin, and fasting glucose. These changes begin soon after initiating treatment with PIs, often within a few weeks. The extent of the changes in lipoproteins and triglycerides, however, has not been quantified in an observational setting.

Dr. Adrian Levy and his co-workers at the BC Centre for Excellence in HIV/AIDS set out to explore the direction and magnitude of change in lipid profiles over 12 months in a large group of patients receiving PIs. They conducted the study between August 1996 and January 2002. There were 679 patients; 91 percent of them were male, the median age was 38 years old, and the median baseline CD4 count was 210 cell/mm³. All patients initiated HAART that included a nucleoside analog and a protease inhibitor. Investigators followed patients for a median of 47 months, and patients had at least three blood lipid measurements during this time.

Twelve months after initiation of PI treatment, researchers found statistically significant increases of 20 percent and 22 percent in total cholesterol and triglycerides, respectively.

These, and other results, suggest that persons on HAART including PIs are at an increased risk for cardiovascular disease. This growing body of evidence implicating PIs in metabolic abnormalities also creates a significant clinical dilemma. Protease inhibitor-based HAART is very effective in achieving and maintaining undetectable viral loads, therefore discontinuing PI treatment, even in patients with dyslipidemia is undesirable; yet the effects of PIs on lipid levels are of considerable consequence. A possible solution is to initiate treatment with drugs that lower cholesterol in the blood, such as statins and/or fibrates. Statins have proven effective in preventing cardiovascular disease in HIV-negative patients, but as yet their effectiveness for PI-induced dyslipidemia has not been confirmed.

The demonstrated lipid abnormalities in combination with the predominance of men, high rates of smoking, and aging in the HIV-positive population means the future occurrence of cardiovascular disease in this group is likely to be high. ⊕

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

Tenofovir tidbits

Advantages like once-daily dosing and fewer side effects led to pressure for accelerated approval

by Rob Cair

Tenofovir (Viread) has officially been available in Canada since March 2004. It is the first in a subgroup of NRTIs called *nucleotide* reverse transcriptase inhibitors. All of the other NRTIs—such as zidovudine (AZT), ddI (Videx), d4T (Zerit), lamivudine (3TC), and abacavir (Ziagen)—are *nucleoside* reverse transcriptase inhibitors. Nucleoside NRTIs work inside the CD4 cell to inhibit replication of HIV and all of them must undergo a three-step phosphorylation process—the addition of phosphate groups—before they become fully active. By contrast, tenofovir requires only two phosphorylation steps to become fully active.

Early studies showed that only six percent of patients stopped tenofovir treatment early because of side effects such as nausea, diarrhea, sore throat, and headache.

At the beginning of HIV treatment two NRTIs are generally combined with either a non-nucleoside reverse transcriptase inhibitor (NNRTI)—such as nevirapine (Viramune) or efavirenz (Sustiva)—or a protease inhibitor such as lopinavir/ritonavir (Kaletra). Such NRTIs are considered the backbone of HIV treatment. With time however, the potency of the NRTI backbone is often reduced by poor medication tolerability or development of HIV resistance. Early studies in patients who were failing treatment showed that adding tenofovir led to re-suppression of the virus. This result, together with advantages like once-daily dosing and the appearance of relatively few side effects, led to pressure for accelerated approval.

In October 2001 tenofovir gained approval in the US but authorization was delayed for another two years in Canada, mostly over a dispute with the manufacturer about the cost, which at \$16.25 per day was considered extremely high. Nevertheless, during this process as many as 750 patients in BC began tenofovir under an investigational access program.

Early studies suggested that tenofovir was well tolerated: only six percent of patients stopped treatment early because of side effects such as nausea, diarrhea, sore throat, and headache. Studies in animals showed decreased bone mineral density (osteoporosis), which investigators thought was related to reduced phosphate levels caused by tenofovir. Human trials lasting up to one year have showed no bone abnormalities, however further monitoring is currently underway.

Many side effects do not appear until after a drug is used in the wider population. Perhaps the most serious emerging side effect for tenofovir is the development of kidney failure in some patients. This possibility is not surprising since cidofovir (Vistide) and adefovir (Hepsera), which are related to tenofovir, are known to cause kidney toxicity. Nevertheless, the problem seems to be relatively rare in people receiving tenofovir and it appears to reverse when they stop taking the drug.

The most clinically significant drug interaction for tenofovir has been the one associated with ddI. Early on it was observed that blood concentrations of ddI were significantly higher when given with tenofovir. At the time this was deemed good news because ddI was not generally well tolerated at the usual recommended doses and it had to be taken on an empty stomach. Combining tenofovir with low-dose ddI (250 mg/day or less) was supposed to provide a potent NRTI backbone with improved ddI tolerability and no food restrictions.

Experience showed, however, that the interaction likely causes greater ddI accumulation within the CD4 cell than expected; this buildup can lead to problems, mostly in the form of low CD4 counts. As a result, tenofovir/ddI is no longer considered a preferred NRTI backbone. People using these medications together should discuss it with their doctor or pharmacist. ⊕



Rob Cair
is a pharmacist at the
BC Drug and Poison
Information Centre.

Banish those blues

Three simple suggestions to help you beat holiday depression

by Mark Smith and Ken Buchanan



Quick quiz: During the Christmas holiday season—from the second week of November until the second week of January—which of the following do you find more depressing?

1. A. the Christmas song *It's the Most Wonderful Time of the Year*
B. the theme music from the film *Love Story*
2. A. *It's a Wonderful Life* on television on Christmas Eve
B. a root canal
3. A. an acquaintance asking if you finished your Christmas shopping
B. an acquaintance asking how you became infected

If you answered “A” more than once, you’re probably one of the many HIV-positive people who suffer from the seasonal holiday blues.

While the holiday blues can hit you at any time, they usually occur sometime between the second week in November and the second week of January. This is the time when people experience added pressure, stress, anxiety, and/or depression in their lives. People living with HIV/AIDS should try to limit any holiday situations that cause mental, physical, financial, and spiritual exhaustion.

Here are three simple suggestions that may help you feel good again during the holiday season. In time, you’ll have enough good memories associated with the holidays that you’ll look forward to future Christmases.

① Rewrite the holiday rules

A great goal is to get through the holidays without becoming overwhelmed, uncontrollably anxious, or depressed. One of the best ways to do this is to rewrite those unwritten holiday rules that drag you down.

Here are some examples of rules you can draft to be good to yourself this year:

- I will choose who I spend the holidays with, rather than

spending it with people out of obligation. It may be my family of origin, friends, or people from my support group. It’s healing, empowering, and calming to share a meal with people who truly love me and accept me for who I am.

- I will surround myself with a group of supportive, non-judgmental people. Good friends take time to make, but I will look into possible group situations that can contribute to my mental health. Getting together with people who have similar issues could make a big difference this year.
- I will structure my schedule to keep holiday stress and drama to a minimum. I will limit the events I attend to those that are meaningful to me. I won’t overload myself trying to live up to the expectations of others.
- I will set one day aside as my own personal holiday. It will be a special day devoted to my enjoyment. Maybe I’ll go for a hike in the mountains with a motivated group or with one other friend. Maybe I’ll go ice skating or take photographs at a beach. Or maybe I’ll just watch rented movies at home and eat a different flavour of ice cream with each movie. The key point is celebrating and rewarding myself for being me and making it through another year. I will begin today by starting an idea list and adding to it as ideas come to me.

② Create new opportunities for yourself

For people living with life-threatening illnesses, the holiday season may bring on a sense of isolation and loneliness. It’s a natural process for people to review the past year and to make long- and short-term goals in an attempt to better their present situation. This doesn’t have to be depressing if you’re determined to move in a positive direction. You can use this time to start implementing a better social life, which can lead to new possibilities.

A great way to do this is to volunteer. The holiday season is a good time to give back to the world. The added benefit is

you'll be joining others who volunteer as their holiday activity. Look for volunteer opportunities within your local or HIV community where your help may be needed. Perhaps volunteer at a coffee service or assist at a Narcotics Anonymous or Alcoholics Anonymous function. Volunteering at a homeless shelter or community centre during the holidays will not only enrich the lives of others, it will provide you with structure and a sense that you're being useful to those in need.

You can reduce your holiday isolation and depression when you create strategies that help you develop a more rewarding social life. One such strategy could be to improve your socialization skills and broaden your knowledge of local volunteer outlets. Staying home due to the fear of rejection based on your HIV status, age, past choices, or your sexuality is a no-win situation. Inviting a friend to be a "volunteering-buddy" may make reaching out feel safer.

③ Be a hero

Many of us living with HIV/AIDS have experienced the sense of isolation and loneliness that intensify during the holidays. Now imagine that you were one of the HIV-positive people living in the US Gulf region that was devastated by Hurricane Katrina.

Those people have virtually lost everything. A letter of support and compassion will make a world of difference to them. Just let them know that they are not forgotten.

You don't have to divulge your name or address, but it would be more meaningful if you included how long you've lived with HIV. They will see that there's a community that cares about them. Consider enclosing an inspirational poem, prayer, or picture.

To send words of encouragement to the Louisiana AIDS community:

Acadiana C.A.R.E.S.

P.O. Box 3865, Lafayette, LA 70502, USA

To send words of encouragement to the Louisiana AIDS community evacuees now located in the Houston, Texas area:

Montrose Clinic

P.O. Box 66308, Houston TX 77266, USA ☎

Mark Smith (r) is a member of the BCPWA Society and a community volunteer who has already seen 22 positive holiday seasons.

Ken Buchanan was diagnosed with HIV last year and was recently elected to the Board of the BCPWA Society.



WHERE TO FIND SUPPORT DURING THE HOLIDAYS

Canadian Mental Health Association —

Call 1.800.555.8222 to find a health unit in your area.

Or visit their Web site at <www.cmha.ca>

Thursday Support Group in Vancouver —

St. Paul's Hospital, 1081 Burrard Street, tel:604.806.8694

For other HIV/AIDS support,

check "Where to find help" on page 38

Average Joes Christmas Party

Wednesday, December 7th 7:00 - 10:00 PM

Numbers @ 1042 Davie Street

Come out and enjoy the company of others where HIV is not an issue.

Created by gay poz guys, run by gay poz guys.

No cover



The young and the restless part 2

HIV-positive youth tend to be at higher risk of sexually transmitted diseases—so here's what to do about it

by Sarah Fielden and Melanie Rusch

Part 1 of this article on HIV-positive youth and sexual health appeared in the September/October 2005 (Issue 38) edition of living +.

The average age that Canadian youth first have intercourse is 16 years. The highest rates and increases in sexually transmitted infections (STIs), also known as sexually transmitted diseases (STDs), are in young people, including youth living with HIV. These HIV-positive youth are in an awkward position of social vulnerabilities, sexual risk behaviour, biological susceptibility of young reproductive systems, and possible STI/HIV interactions.

Teaching youth about sexual risk behaviours

Ideally, HIV-positive youth should be involved in programs that seek to inform and build skills in young people regarding sex and sexual risk taking. In a recent review of behavioural interventions to reduce the incidence of HIV, STIs, and pregnancy among adolescents, investigators from the Division of Adolescent and School Health of the National Center for Chronic Disease Prevention and Health Promotion in Atlanta, Georgia suggested that four overall components make programs more effective. These components include: teaching specific skills for decreasing risk behaviours, creating programs that are longer and more spread out, targeting program content, and focusing on facilitator training.

Programs for youth can take place in schools, community-based organizations, or through outreach to street youth. For youth with HIV, there are organizations such as YouthCo in Vancouver that can lend support and education as well as connect them to other appropriate services in the community that provide testing and treatment.

Providing them with services and condoms

Young people who have a history of STIs are more likely to get another STI in the future, suggesting that knowledge and experience are not sufficient prevention measures. Youth with

HIV need to have access to, and feel comfortable asking for, condoms and other contraception in order to prevent STIs and unwanted pregnancies.

They also need services that support them in decision-making around reproduction and partner disclosure. This can be achieved through initiatives such as youth-friendly and HIV-friendly healthcare services. To maximize the health of HIV-positive youth, healthcare and community programs need to be multidisciplinary, culturally sensitive, and age appropriate. Programs also need to address them at their stage of sexual development in a respectful and non-stigmatizing way.

To maximize the health of HIV-positive youth, health-care and community programs need to be multidisciplinary, culturally sensitive, and age appropriate.

In addition, HIV-positive youth have special needs. They tend to be disenfranchised and at higher risk for such social factors associated with sexual risk activity in youth as sexual violence, mental health issues, substance use, poverty, and marginalization (such as sexuality and culture). They are also more vulnerable to STIs than other Canadian youth, both biologically and socially. Creating and promoting effective programs that target these indirect causes of sexual risk-taking could go far in preventing the spread of STIs.

Programs that target relationships with parents, peers, and partners could also help in prevention since the health of these relationships can have negative or positive effects on young people's sexual risk behaviours.

Access to regular STI testing and treatment

After effective prevention, one of the best ways to lower the spread of STIs within a population is through testing and treatment. Many STIs can occur without causing any noticeable symptoms, so sexually active youth (and adults) need to be encouraged to take initiative in their sexual health by talking to their doctors about protection options and to insist on regular testing. Healthcare providers can assist in this process by suspending assumptions and promoting testing to all young people in their care.

While there is research underway on vaccines for some of these STIs, these are still years away from being available to the public. Currently, only hepatitis B, a blood-borne virus that can spread through sex, has an effective vaccine. Most infants now get the vaccine, as well as high-school students who were born before the vaccine was available.

HIV-positive youth need information about other STIs, which have effective and relatively non-invasive treatments. Bacterial STIs such as chlamydia, gonorrhea, and syphilis are easily treated with antibiotics, and early treatment can prevent serious long-term complications, especially among young women.

Other STIs like the human papilloma virus (which can increase the risk of cervical or anal cancer) and the herpes simplex virus (which can cause recurrent ulcers) aren't curable with medications, but it's still important to identify and treat them. Careful monitoring and removal of abnormal cells before cancers develop will reduce the chances of needing more invasive procedures. For herpes, there are treatments to lower the number of ulcer recurrences and to reduce the risk of transmitting the virus to a partner.

STIs during youth aren't just the responsibility of young people themselves. STI prevention in youth, including HIV-positive youth, can be best achieved through a combination of empowering and educating young people about sexual health, working to eliminate the stigma of HIV and other STIs, making sure there is access to appropriate safe sex materials (such as condoms, dental dams, and contraception), and establishing and supporting public health programs. ☺

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.



Some general tips for young people to decrease the risk of STIs

Use condoms. Use them consistently when having sex, including oral and anal sex.

Avoid sex when you're being treated for an STI.

Avoid douching.

Douching can put you more at risk for getting STIs and can raise your risk of other diseases and reproductive problems.

Wash your genitals with soap & water. Also, urinate soon after you have sex.

Have regular Pap smears.

That includes anal or vaginal Pap smears.

Be honest with your doctor.

Let your doctor know about your sexual behaviours and insist on being tested for STIs if you're sexually active.

Ask your doctor for shots against Hepatitis A and B.

Ask your doctor about microbicides.

Check in with your doctor about progress in the development of microbicides—those are films, gels, foams, or vaginal rings inserted in the vagina or rectum. They hold future promise for additional protection against HIV and STIs. Microbicides are currently being tested in clinical trials.

Know your sex partner.

If it's safe, tell your sex partner about your HIV and if you have an STI and ask your partner if he or she has one. Talk about whether you've both been tested, which STIs you've been tested for and whether you should be tested.

Know your own body.

Identify any changes in your genital regions and to your overall health while remembering that STIs don't always have symptoms.

Un condón nunca esta demás

Por Sergio Plata

En el siglo XVI, Europa fue azotada por dos epidemias importantes de sífilis y gonorrea. En esa época, el médico *Gabriele Fallopio* (1532-1562) recomienda el uso de tiras de lino medicadas para salvar a la humanidad de estos males. Tales tiras debían sujetar el pene con la ayuda de un lazo. Casi un siglo más tarde, el rey Carlos II de Inglaterra (1630-1685) encarga algún tipo de dispositivo que ayude a evitar el embarazo entre sus concubinas. Se cuenta que la fabricación de tal dispositivo recae sobre su médico de cabecera, un tal doctor *Quandum* o *Condom*, y que de ahí surge el nombre del condón. Otros atribuyen el nombre condón a sus raíces de origen latino, ya que provendría del latín *condus - recipiente*, o *condere-esconder, proteger*.

Fue en el siglo XVI y XVII cuando aparece en Inglaterra la primera tienda especializada en condones. Cada condón se vendía en estuche de cristal y perfumados con aromas florales. Por su parte, el Marqués de Sade (1740-1814), envolvía su pene con tiras de tocino, mientras que Casanova, el famoso italiano, usaba cáscaras de naranja que introducía en la vagina con la finalidad de evitar embarazos.

Algunos investigadores señalan que el primer condón de caucho se fabricó en 1844. Los primeros condones de caucho eran reusables, y se vendían con instructivo para su correcto lavado y mantenimiento, hasta que se rompiera por el uso. Fue Alfred Trojan quien inventa en 1921 el condón desechable, que se comienza a comercializar en 1930.

Actualmente existen tres tipos de condones, de látex, poliuretano y de tejidos de animales. El condón de látex es biodegradable; está hecho de una sustancia que se extrae de plantas como el caucho. Los condones se pueden deteriorar con la exposición a la luz ultravioleta, el calor, luz solar, la humedad, ozono y aceites minerales y vegetales. El condón funciona como una barrera mecánica que impide la transmisión de bacterias, como la gonorrea o clamidia y virus como el herpes, hepatitis B y VIH.

La posibilidad de que el condón se rompa durante el acto sexual vaginal es de 0.5% al 3%, posibilidad que aumenta hasta el 5 y 10% en relaciones anales. El uso correcto del condón protege en un 90 a 95% de los casos contra la transmisión del virus del VIH. Según estudios realizados por el Food and Drug Administration (FDA) el condón reduce diez mil veces la transferencia del fluido.

De acuerdo a las estimaciones del programa mundial contra el sida de Naciones Unidas (ONUSIDA) en una relación se tiene el 0.1% de posibilidades de infectarse con el VIH o sea, 1 posibilidad en 1000. Si el condón reduce el 90% o más las posibilidades de infectarse, esto quiere decir que de 90 000 personas que se expongan al riesgo sólo 1 o menos se contagiara del VIH si usa el condón contra 1 de cada 1000 si no lo usan. En un análisis realizado de doce estudios de seroconversión siguiendo a parejas sexuales que viven con el VIH se ha demostrado que el condón, cuando se usaba siempre y de manera correcta, protegía entre el 93 y el 100% de los casos.

Actualmente la variedad de condones, de diferentes tamaños, colores, y texturas, permite hacerlos parte de nuestra sexualidad. Aprendamos a jugar con él, aprendamos a erotizar el condón. La capacidad de disfrutar la relación no tiene nada que ver con el condón, sino que más bien tiene que ver con la comunicación con la pareja y el compromiso afectivo. ☺

BCPWA Treatment Information Program (TIP)

Ofrece información en español sobre tratamientos del VIH/SIDA.

Todos los miércoles 1:00PM a 5:00PM.

1107 Seymour Street, 2nd Floor, Vancouver, BC V6G 5S8

Llame a la línea directa: 604.893.2243

email: treatment@bcpwa.org

Volunteering at BCPWA

Profile of a volunteer:

Dominic Baril



Dominic was a hard worker and a gentleman. He added second-hand glamour to all our fundraising garage sales.

Jackie Haywood
Director of
Support Services



Volunteer history

I started volunteering at the age of 13 within a hospital setting. Since then I have been volunteering for different causes. At BCPWA, I have found a perfect fit with Polli & Esther's Closet.

Started at BCPWA

I started with BCPWA about three years ago.

Why pick BCPWA?

I had a family member who devoted a lot of time to BCPWA before they passed away. I wanted to do something that would help carry on the good work that my family had started.

Why have you stayed?

I believe that the services available here at BCPWA are not only unique but also life changing.

Rating BCPWA

I would rate the Society an 8 out of 10.

Strongest point

The strongest point of BCPWA is definitely the member-driven support.

Favourite memory

The annual flea markets. We use this opportunity to put ourselves out in the community and sell some of our wares to support Polli & Esther's. We always have a lot of fun and it builds our team skills within our volunteer family.

Future vision of BCPWA

I see us having to pull together tighter than ever and having to think outside of the box when it comes to fundraising and also in the delivery of services. We have always come together as a community and I have faith that we will come through this challenge with our heads held high.



Interested in writing?

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

Volunteers should possess the following skill sets:

- Ability to analyze and distill information
- Excellent research and writing skills
- Ability to work independently

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

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

where to find help

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

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 V6C 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 pro- gram

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 V6C
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
November 23, 2005	1:00	Board Room	Written Executive Director Report
December 7, 2005	1:00	Board Room	Executive Committee / Financial Statements — October / Director of Communications & Education
December 21, 2005	1:00	Board Room	Written Executive Director Report / Standing Committees
January 4, 2006	1:00	Board Room	Financial Statements — November
January 18, 2006	1:00	Board Room	Written Executive Director Report / Executive Committee

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

☎ 604.893.2298

✉ adriann@bcpwa.org

Community Representation & Engagement

Contact: Ross Harvey

☎ 604.893.2252

✉ rossh@bcpwa.org

Education & Communications

Contact: Lisa Gallo

☎ 604.893.2209

✉ lisag@bcpwa.org

Positive Gathering

Contact: Stephen Macdonald

☎ 604.893.2290

✉ stephenm@bcpwa.org

IT Committee

Contact: Ruth Marzetti

☎ 604.646.5328

✉ ruthm@bcpwa.org

living+ Magazine

Contact: Jeff Rotin

☎ 604.893.2206

✉ jeffr@bcpwa.org

Prevention

Contact: Ross Harvey

☎ 604.893.2252

✉ rossh@bcpwa.org

Support Services

Contact: Jackie Haywood

☎ 604.893.2259

✉ jackieh@bcpwa.org

Treatment Information & Advocacy

Contact: Tarel Quandt

☎ 604.893.2284

✉ 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)

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The s**t list

Some suggestions for the next time you have to describe your dumps to your doc

by Derek Thaczuk

A friend of mine once hit Sarah Polley in the foot with a piece of his poo. Not on purpose, obviously. They were both standing in line at a coffee shop when his bum chose to have a “medication moment.” To make matters worse, the poor fellow was wearing baggy shorts. Before he could ask for the washroom key, some poop came flying out. (Apparently it was just a little bit. Thank heaven for small mercies.) The marble-sized nugget hit the floor and *rolled*, coming to rest against our beloved film star’s foot. He won’t describe her reaction in detail, but I doubt that it was appreciative.

While few can claim to have actually shat at movie stars, I bet most of us have similar—if less glamorous—tales to tell. After all, in the HIV community, we pass around Imodium like most people hand out Tic Tacs. I can barely think of a single person I know who hasn’t had an, er, incident. (Personally, I’ve had to leave too many pairs of underwear in public washroom trashcans—and not for erotic reasons.)

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Odd, then, that with all the ultra-personal stuff we talk about on a daily basis, we still shy away from, well, shit. You can see it in support groups: one minute it’s “hi, I’m Bob and I’m a fisting queen,” deadpan as can be. The next minute they start to hedge: “Well, there’s this thing, it’s kind of embarrassing.”

Somebody has to say it for them: “Diarrhea?” Gosh, <blush>, how’d you know?

Because *everybody* gets it, that’s how.

It’s often far from funny. But once you do start to laugh about it, there’s no going back. Pardon the expression, but the floodgates open up. (Admit it: didn’t you love watching TV news anchors say “anal leakage” when Olestra came out?) It’s become a “running” joke amongst my friends: “Can we not talk about this during breakfast?!”

I like to think it’s not an unwholesome personal obsession, just well-rounded concern for each other’s health. If I’ve nagged you into taking Bowel Buddy psyllium fibre, I wanna know how it all came out!

Whether or not you blab about ’em to your friends, at some point you’ve probably had to describe your dumps to your doctor. (Gooney? Oatmeal?) A while back, rumour had it that a pharmaceutical company was actually working on a chart, complete with graphics, to help you rate the squishiness on a scale. Imagine being a fly on the wall in *that* art department. Sadly, though, I never heard any more about the chart.

Purely in the interests of healthy public discourse, I’ve compiled a little list of my own. Far from comprehensive or medically rigorous, I still hope you find it useful for your next visit to your doctor, or—what the heck?—for spicing up a dull brunch with friends:

- ▶ **Klingons:** also known as willnots (they just “will not” wipe away) or dingleberries.
- ▶ **Okra-ettes:** wrinkled, raisiny pellets, disturbing little models of exactly where they came from.
- ▶ The intriguingly two-toned **Reece’s Feces**.
- ▶ **The Play-Doh:** long doughy ropes that epitomize the words “extruded” and—in a way—“decorative nozzle.”
- ▶ **The hydraulic-lift stool:** the day after getting overzealous with fibre, having to actually stand up to make room for your business in the toilet. A true story, according to a friend of mine.
- ▶ When you’ve run out of Imodium, the self-explanatory **espresso**, your basic high-pressure jet of hot liquid.

▶ Its near twin, the **cappuccino**, with its distinctive, if peculiar and unexplainable, foamy finish.

(Sorry if this ruins Starbucks for anyone, but the chai lattes are probably still safe.)

Obviously, this list only begins to scratch the surface—or plumb the depths. Do yourself a favour and get creative; while the tap is running, you might as well let your imagination run along with it. ☺



Derek Thaczuk is a freelance consultant and medical writer with 11 years involvement in the HIV community.