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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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think ⊕

opinion & editorial . . .

The media monster

by Paul Lewand and Wayne Campbell

Recently, an HIV-positive Canadian Football League player, who allegedly had unprotected sex without disclosing his HIV status, was charged with aggravated sexual assault. The story made unprecedented headlines with local and national media, some of which vilified HIV-positive people. They compared PWAs to convicted child molesters and blamed the football player's employer for not publicizing his HIV status, even though it would be illegal to do so.

Sensationalized media stories such as this one are irresponsible and reinforce the negative stereotypes that were prevalent in the 1980s. Imagine if this were another communicable disease: would it have made the media spotlight? Would the public be as interested or as scared?

More than 20 years into the pandemic, you have to wonder if anyone learned the basics of HIV transmission. Are stigma and discrimination the culprits? And is it appropriate for someone's personal health information to become the subject of public scrutiny?

In Canada, we have witnessed the criminalization of HIV transmission with the Cuerrier and Williams cases. The Supreme Court of Canada decision imposes a duty to disclose one's HIV-positive status in instances where intimate or dangerous behaviour—including activities like unsafe sex and sharing injection needles—may place another person or persons at significant risk of HIV transmission.

The BCPWA Society encourages HIV-positive individuals to reveal their HIV status before engaging in unprotected sex (or needle sharing), and recommends condom use in each and every instance of sexual contact.

Disclosure of your HIV status is a complex issue. It can be very stressful to even think about disclosing your status, never mind actually discuss it. Considering disclosure can evoke fear of rejection, stigma, and discrimination, not only to you, but also to your partner and family. If you are having difficulty deciding how to disclose, it may be helpful to join a support group to learn how others have dealt with the challenges.

Once you disclose your HIV status, you can have safer sex and help reduce HIV transmission by: accepting personal responsibility to use condoms; speaking with your sexual partner about limits and creative sexual options; suggesting safer options such as massage, fantasy, petting, kissing, and mutual masturbation, which don't involve an exchange of sexual fluids. Be aware, though, that alcohol or drug use can impair your decisions regarding sex—you may forget to use protection.

Whether or not you decide to disclose, the recent media frenzy makes it clear that, sadly, more education is required to change ignorant media and public perception. ⊕

Paul Lewand *is the chair and* ***Wayne Campbell*** *is the treasurer of the BCPWA Society.*

REALITYBITES

News from home & around the world

HIV-positive man charged with murder

A B.C. jury has decided an HIV-positive man knowingly spread the virus to his sexual partners. The 36-year-old man was found guilty on five counts of aggravated sexual assault, one count of attempted aggravated sexual assault, and one count of sexual assault.

The charges relate to the man's failing to disclose his condition and engaging in unprotected sex with seven women between 2000 and 2003. He was accused of having sexual contact with the women after he was informed that he had the HIV virus. Three women he had sex with now have HIV and claim he never told them about his condition and did not use condoms.

Source: The Globe and Mail

New combination therapy available in Canada

Kivexa, a new combination therapy by GlaxoSmithKline in partnership with Shire BioChem, is now available in Canada.

Kivexa is a single tablet taken once daily that combines two nucleoside reverse transcriptase inhibitors (NRTIs): 600mg of abacavir (Ziagen) and 300mg of lamivudine (3TC). Kivexa can be taken with or without food or fluids, unlike many other HIV treatments. In addition, it can be taken with other antiretroviral drugs.

New STD may not be so new

In 2003, an outbreak of lymphogranuloma venereum (LGV) rectal infections was observed among men who have sex with men (MSM) in Europe and North America. In all cases, LGV was caused by an aggressive strain of chlamydia called L2b.

At first L2b was believed to be a new strain, only seen in developing countries. However, a recent study from the Netherlands found the same L2b variant isolated in men in San Francisco in the early 1980s and in MSM from Amsterdam in 2000. The authors conclude that these cases of LGV may represent a "slowly evolving epidemic" rather than a new outbreak.

Symptoms of LGV proctitis include swollen glands in the groin, rectal pain, ulceration, and bleeding. Delays in diagnosis or treatment can lead to permanent scarring. Using condoms during sex will reduce the risk of getting LGV.

Rob Gair

PWAs shouldn't take Amevive, says FDA

The US Food and Drug Administration and the pharmaceutical company Biogen Idec have announced that HIV-positive individuals should not take the company's skin drug Amevive because it might lower their CD4 T cell counts. The drug is approved to treat moderate to severe psoriasis, an autoimmune skin disorder.

Source: The Body

Low CD4 cells in mothers means greater risk for their babies

HIV-negative infants whose mothers have advanced HIV disease have an increased risk of hospitalization and death within the first few months of life, a study published in the December 1st edition of *Clinical Infectious Diseases* reports. In particular, the investigators found that the uninfected infants of mothers who had a CD4 cell count below 350 cells/mm^3 had a risk of death almost three times greater than that of children whose mothers had stronger immune systems. The investigators suggest that their study has identified "an overlooked population of children at high risk for mortality and morbidity."

Advanced maternal HIV infection is known to be associated with an increased rate of mother-to-child transmission of HIV and faster disease progression amongst infected infants.

Source: Aidsmap

Severe muscle damage from abacavir and lipid-lowering fibrate

Doctors from Paris have described a case of severe muscle damage in an HIV-positive patient taking abacavir (Ziagen) and the lipid-lowering drug ciprofibrate (Modalim).

Although hypersensitivity to abacavir is known to occur in five to eight percent of patients, this case raises fears that it may be aggravated by a drug commonly used to treat high blood fat levels—itself a side-effect of antiretroviral therapy. However, the report only describes one patient's experiences.

The man had been taking ciprofibrate for almost three years. After a two-year treatment interruption, he began treatment with Trizivir (AZT, 3TC, and abacavir).

After eight days, the man complained of fever. Two days later, he had a temperature of 40°C, skin rash, high heart rate, high breathing rate, kidney failure, and evidence of damage to muscle and liver cells.

The patient stopped both antiretroviral therapy and ciprofibrate. Although the markers of muscle damage increased over the next few days, the fever and skin rash disappeared after 48 hours. Kidney failure resolved after 45 days.

Source: Aidsmap

REALITYBITES

News from home & around the world

Pharmas license drugs to IPM as microbicides

Pharmaceutical companies Merck & Co., Inc. and Bristol-Myers Squibb have each announced that they have signed separate license agreements with the International Partnership for Microbicides (IPM) to develop new antiretroviral compounds as potential microbicides to protect women from HIV. Under the two separate agreements, Merck and Bristol-Myers Squibb will each grant IPM a royalty-free license to develop, manufacture, and distribute their compounds for use as microbicides in resource-poor countries.

The compounds are part of a new class of antiretrovirals known as entry inhibitors. Some of the compounds bind directly to HIV; others bind to the CCR5 receptor. They are designed to prevent HIV from efficiently entering host cells, thus preventing infection.

A study published in ***Nature*** reported that entry inhibitor compounds developed by Merck (CMPD 167) and by Bristol-Myers Squibb (BMS-378806), when used as vaginal microbicides, protected some macaque monkeys from infection with a virus similar to HIV.

Bowel cancer drug works well against KS

A drug which is usually used to treat bowel cancer is an effective treatment for Kaposi's sarcoma (KS), according to Italian researchers. Investigators found that three-quarters of individuals treated with irinotecan (Campto) experienced complete or partial remission of their KS.

New cases of KS have decreased dramatically since the advent of effective antiretroviral therapy, and anti-HIV treatment regimens containing both protease inhibitors and non-nucleoside reverse transcriptase inhibitors (NNRTIs) have been shown to be effective at preventing the development of KS and the treatment of KS if it is present.

Italian investigators designed a trial involving 14 patients with advanced KS where the cancer had developed or relapsed despite the use of antiretroviral therapy. The study ran between summer 1999 and late 2004.

Source: Aidsmap

Flash-heating destroys HIV in breast milk

Two simple heating techniques can destroy HIV and bacteria in breast milk without affecting its nutritional value, researchers report. One of the methods, Pretoria pasteurization, was first reported in 2001 and is now used in parts of Africa. Investigators at the University of California at Berkeley developed the second, newer method, flash-heating.

In Pretoria pasteurization, a container of water is heated to boiling and removed from heat, and a container of breast milk is immediately placed in the hot water for 20 minutes, after which it is allowed to cool to 37 degrees Centigrade. In flash-heating, the water and milk are heated together until the water reaches a rolling boil, after which the milk is removed from the water and allowed to cool. Neither technique significantly impacts the milk's nutritional content.

Flash-heating can be performed effectively using campfires or kerosene stoves, the heat sources most readily available in the developing world.

Source: Reuters Health ⊕

On December 20, Santa and his elves delivered five coffins to Health Minister Ujjal Dosanjh for the five known HIV-positive British Columbians who may die because of his refusal to make AIDS drugs TMC 114 and TMC 125 available in combination therapy. Dosanjh eventually granted early access for the five men.

The criminalization of HIV

by Derek Bell

Could you be charged if you don't disclose your HIV status? Canadian courts are increasingly broadening their definition of what constitutes an HIV crime.

Once again, HIV and criminal activity have been linked by sensational news stories. An HIV-positive CFL player was charged recently with aggravated assault in Surrey and Regina. Also, for the first time in Canada, an HIV-positive person was charged with murder after a sexual partner died, allegedly due to HIV infection.

The courts' view of the scope of HIV crimes has grown progressively broader. AIDS advocates have argued that the implications of such decisions should be considered in light of the need to more effectively slow the spread of the virus.

The major factors the courts consider when charging and convicting a person for not disclosing their positive HIV status are illustrated in the two most eminent cases, ***R v Cuerrier*** (1998) and ***R v Williams*** (2003). In the Cuerrier case, an HIV-positive man was charged with and convicted of aggravated assault after having unprotected sexual intercourse with a woman. The Supreme Court held the lack of disclosure "vitiated" the woman's consent to having sex because she was unaware of the dangers of the act to which she agreed. The court believed that she might not have given the consent if she was aware of the danger of contracting HIV.

Withholding information deemed an assault

So, because the defendant withheld crucial information, he made it impossible for the woman to grant informed consent; accordingly, because he made it impossible for her to consent in any meaningful sense, he committed an assault.

The Court required the prosecution to prove three things beyond a reasonable doubt: that an act that a reasonable person would deem dishonest (that is, the fraud of non-disclosure) had occurred; a harm or risk of harm had resulted from the dishonesty; and the person would not have consented without the dishonest act having been committed. The Court also found that, although absolutely safe sex may be impossible, the careful use of condoms could reduce the risk to the point that it would not be considered significant and, in such an instance, non-disclosure of HIV-positive status would not necessarily constitute an assault.

The BC Court of Appeal had previously accepted the alternative legal argument that there was no legal obligation for a person to disclose ***all*** known risks associated with sex for consent to be valid.

When the case went to the Supreme Court, the Canadian HIV/AIDS Legal Network, BC Persons With AIDS Society, and the Canadian AIDS Society jointly argued against the use of the Criminal Code to criminalize non-disclosure of HIV-positive status. The BCPWA Society and the BC Civil Liberties Association contended that criminalizing HIV status was harmful to the fight against the spread of HIV because it would discourage people from getting tested—you can't fail to disclose information about which you are ignorant. They also insisted that such criminalization would fail to take appropriate cognizance of education and treatment advances. Public health methods are more appropriate for dealing with these matters effectively, they asserted.

The Williams case

The Supreme Court's subsequent decision in the Williams case 2003 further extended how the law addresses non-disclosure. In that case, the Court heard how a man had unprotected intercourse with a woman, before and after he knew he was HIV-positive.

continued on next page

The Supreme Court found that he was not guilty of aggravated assault, because it had a reasonable doubt that he endangered her life (the Court thought it likely the woman had already been infected before Williams found out he was HIV-positive). Still, after he knew he was HIV-positive, he continued to have unprotected sex with the woman without informing her of his HIV status. So the court found him guilty of attempted aggravated assault, because attempting to commit an offence—in this case the offence of aggravated assault arising from the failure to disclose HIV status prior to unprotected sexual intercourse—either by acting or omitting to act, is a crime, whether or not it was possible to commit the offence (in this case, whether or not the woman was already HIV-positive).

The judges covered three other noteworthy issues in their ruling. First, it upheld Williams' conviction of common nuisance—the crime of failing to discharge a duty thus endangering the lives, safety, or health of the public or causing physical injury to any person.

Second, the Court found that the critical moment after which fraud occurs, nullifying consent, is when a person has sufficient awareness of their HIV-positive status. The moment people become aware that there's even just a serious risk that they are HIV-positive is when they are legally required to disclose, if they're engaging in unprotected vaginal or anal intercourse. Non-disclosure at this time is deemed criminal recklessness.

Third, the court stated people may be convicted of aggravated or attempted aggravated assault even if their partner is already HIV-positive. It would depend on evidence whether or not re-infection with HIV further endangers the other HIV-positive person's life. This means that you have a duty to disclose your HIV-positive status before vaginal or anal intercourse to your sexual partner even if you know he or she is HIV-positive, too.

Convictions may force HIV further underground

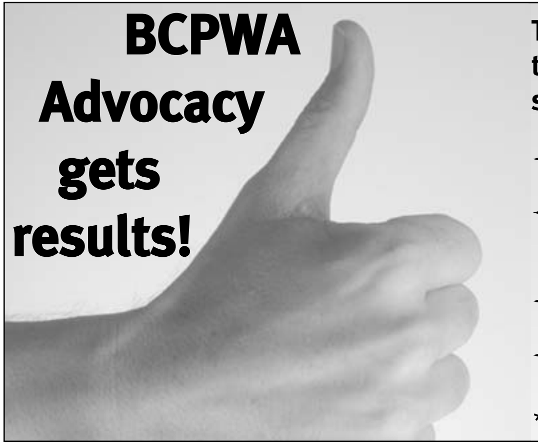
Other Criminal Code offences that are being used against HIV-positive people include criminal negligence causing bodily harm (for example, sharing injection drug equipment), administering a noxious substance (such as injecting others through sex or sharing injection equipment), attempted murder, and murder.

Presently, the courts have focused their attention on the specific criminal code offences relevant to the transmission of HIV between individuals. Although advocates for PWAs and those vulnerable to HIV infection have made a good case for avoiding the criminalization of HIV, their efforts have had little or no effect. With legal changes and convictions mounting, the future for this controversial approach is uncertain. It is likely that changes to the growing pattern of criminalization may not come until clear evidence of consequences emerges. Will the threat of criminal prosecution and associated stigma force HIV further underground? Should we focus on punishing the wicked at the expense of dealing with the cause of the problem? How well has this approach worked with the war on drugs?

While the answers to these questions may lead most reasonable people to conclude that criminalizing HIV status is bad law and worse social policy, Canadian courts so far seem determined to continue down this rocky path. ⊕

The Canadian HIV/AIDS Legal Network was the source for much of this information.

Derek Bell *is the secretary of the board of directors of the BCPWA Society.*



BCPWA Advocacy gets results!

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

- **$24,029 in debt forgiveness.**
- **$115,521 in housing, health benefits, dental and long-term disability benefits.**
- **$40,250.00 monthly nutritional supplement benefits**
- ***$2,250.00 in ongoing monthly nutritional supplement benefit for children**

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

You’re not alone

by Mary Petty and Wallace Robinson

Support groups can help you when you need help the most. You can join existing groups in BC or start your own.

Feeling supported, knowing there are people to count on, being part of a community—these are things that help us feel positive about life. We know that social connections help prevent depression and help us cope with life’s problems and crises. But for many people, creating and maintaining supportive friendships or relationships with people they can count on does not come easily.

Living with HIV can make you feel stigmatized and can make creating new relationships difficult at a time when you need them the most. But support is available and comes in many forms. There are a number of ways to increase your network of social support, including participating in a support group or starting your own support group.

Supported the dying in the early years

Community grassroots responses to the early HIV/AIDS crisis showed how groups could help individuals facing life with HIV. Groups for PWAs were developed in Vancouver and across North America; some, like ACT-UP, were focused on activism, while others were created to provide mutual support at a time of crisis when many people were getting seriously ill or dying.

As the AIDS epidemic changed with the availability of highly active antiretroviral therapy (HAART), many of the original support groups ended. But some groups continued, some changed, and new groups formed to help decrease the sense of isolation of living with HIV, to increase supportive friendships, and to expand a sense of community. There are now a number of successful ongoing support groups for people living with HIV in British Columbia (see sidebar).

One such group has been meeting for about 15 years, every Thursday at St. Paul’s Hospital in Vancouver. We feel fortunate to be the facilitators of this group, which has a long history of bringing HIV-positive people together for mutual support: emotional support, information exchange, and problem solving. As many who have been members over the years say, it’s that sense of being with people who just know where you’re coming from—not having to explain or justify what it means to live every day with HIV—that’s important.

Reconnecting with support networks

People may realize that they are suffering in isolation with an issue that affects others. Often the problem has triggered a crisis that puts their lives on hold and effectively shuts them off from natural support systems—friends, family, and work. Perhaps they identify this situation with the help of a counsellor or healthcare provider who then helps them explore ways of reconnecting with lost support networks.

Support groups may be identified as a structured way of doing this reconnecting. Groups are often built around a problem, issue, or life crisis; they give people the assurance that they will be with others in the same boat. For many people, finding such a group will be the first step in overcoming their sense of crisis and regaining their lives.

For others, structured support groups may not be the fit they’re looking for so it’s important to think about other ways of reconnecting that don’t necessarily involve directly focusing on a problem or life crisis. For example, a person may think about something they enjoy doing or have always wanted to do and find a group of people doing that activity: bowling, running, gardening, reading books, knitting, activism. The list could go on. The effect of reducing isolation by being with others and by feeling part of the community instead of excluded from it, may be what we need to work through the crisis.

Finding like-minded people

Finding groups of like-minded people sharing an interest or of those struggling with the same issues may not be as hard as we think. The challenge is often in making the first step, and taking the risk to meet with a group of people who may be strangers. Sometimes, joining along with someone you already know is helpful. Or you could ask a friend, advocate, or support worker to assist you in finding and actually joining a group or activity.

For people living in and around Vancouver, there are groups and clubs for just about every interest. As well, there are HIV-specific organizational supports for those who want to connect to either a problem-based support group or an activity group. Community organizations such as the BCPWA Society, AIDS Vancouver, and Friends for Life can help individuals find the network they’re looking for or assist in helping start something new. In particular, Gayway has focused on developing support groups and activity groups, and offers training for gay men who would like to learn group facilitation skills.

continued on next page

Some current HIV/AIDS support groups in the greater Vancouver area

Day	Time	Group	Location	For more info call
Tuesday	2:00 - 3:00PM	Surrey HIV/AIDS Support Network		604.588.9004
	7:00 - 9:00PM	Heart of Richmond Support Group for people infected or affected by HIV/AIDS		604.277.5137
Wednesday	3:30 - 5:30PM	HIV/AIDS Support Group at Vancouver Native Health	441 East Hastings, Vancouver	604.254.9937
	7:00 - 9:00PM	Body Positive Support Group at BCPWA Society	1107 Seymour St, Vancouver, 2nd floor	604.253.2284
	8:00 - 11:00PM	Average Joe's Social Group for HIV-positive gay men	Numbers Cabaret, 1042 Davie St, Vancouver	604.608.8885
Thursday	2:30 - 4:00PM	St. Paul's Hospital HIV Support Group		604.806.8223 or 604.806.8694
	6:00 - 8:00PM	Support Group for HIV-positive Women; sponsored by Positive Women's Network		604.692.3006
	6:00 - 8:00PM	Carnegie Centre HIV Drop-In Group	401 Main St., Vancouver	604.665.3003
Friday	12:00 - 2:00PM	HIV Support Group & Potluck Lunch, Purpose Society	40 Begbie St., New Westminster	604.526.2522

Starting your own group

Some people may feel that the right support group just doesn't exist for a specific problem or issue. If you want to organize a support group yourself, here are some things to consider:

Recruiting participants. Think about the purpose of your group and how you might encourage others to join. You might decide to advertise in community newspapers, hand out leaflets in bars, coffee shops, or other places, depending on who you are trying to reach. You can also spread the word through friends or an email listserv, or use healthcare professionals as referral sources.

Group structure. Depending on the type and purpose of your group, you may decide to have an open group that accepts new members as they arrive or one that is more structured and limits the number of members and number of weeks that the group will continue. You may decide to start with a group of individuals and go through a number of sessions with just those participants involved. This can be a way to get feedback about how well the group is working and how it could be improved as the group continues.

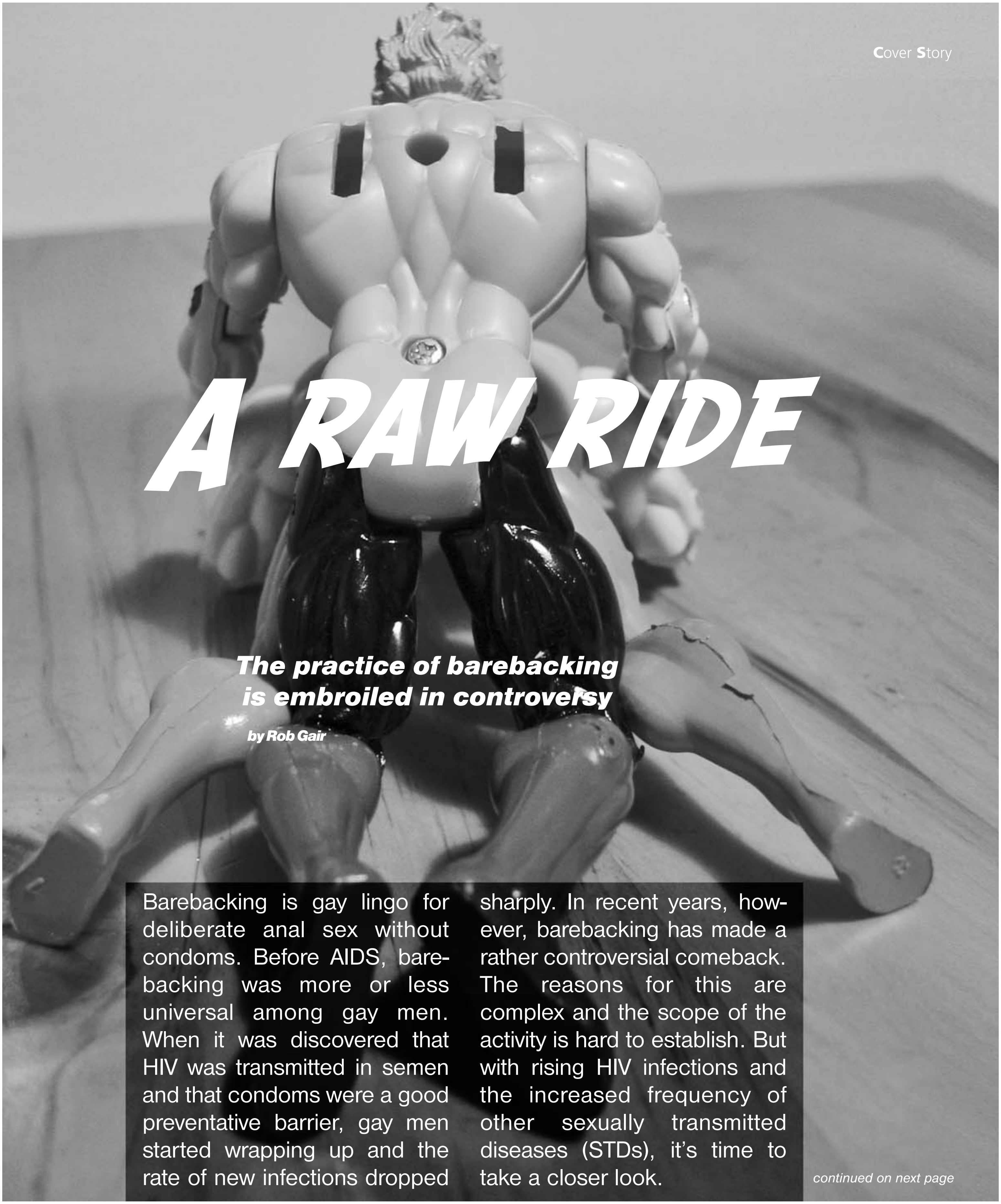
Facilitation. While some groups are led by a trained facilitator, you may want to develop peer facilitation skills within your group.

Other details. Think about where you would like to meet, and about important issues like confidentiality and anonymity. Also consider whether you want to mix problem-solving group meetings with social or other activities.

How to address these issues? Before you get started, talk with the other person or persons who share your interest in starting this group. You could consult with an experienced facilitator or with someone from a community organization and ask them to help you define your purpose and decide how best to address that purpose. Talk about the need for safety: some individuals may feel especially vulnerable around their identified problem and may be unable to participate in a support group without assurance that confidentiality and anonymity are a priority for everyone.

People who have participated in support groups frequently describe the experience as empowering and life changing. The success of Alcoholics Anonymous and other 12-step programs testifies to the power of mutual support and collaboration in solving problems that are too overwhelming to manage alone. And a group may not just provide personal empowerment: individuals who join together as a small, empowered community have the potential to change the greater community in a positive way. As Margaret Mead wrote, "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has." ⊕

__Mary Petty__ and __Wallace Robinson__
are social workers in the Immunodeficiency Clinic
at St. Paul's Hospital, and are the co-facilitators of the
St Paul's Thursday afternoon Support Group.



A RAW RIDE

The practice of barebacking is embroiled in controversy

by Rob Gair

Barebacking is gay lingo for deliberate anal sex without condoms. Before AIDS, barebacking was more or less universal among gay men. When it was discovered that HIV was transmitted in semen and that condoms were a good preventative barrier, gay men started wrapping up and the rate of new infections dropped sharply. In recent years, however, barebacking has made a rather controversial comeback. The reasons for this are complex and the scope of the activity is hard to establish. But with rising HIV infections and the increased frequency of other sexually transmitted diseases (STDs), it's time to take a closer look.

continued on next page

Some sex stats

According to recently published BC data, it looks like most gay men are taking care to practice safe sex. Results from the 2004 Sex Now Survey—which surveyed 2,800 gay men in BC during Pride events in Kelowna, Nanaimo, Nelson, Prince George, Victoria, and Vancouver—are summarized in Table 1. Many men report more than one sex partner in the last year but the majority also report consistent safe sex. A significant number report risk activity—that is, unprotected sex—and smaller numbers report numerous risk events. These risk activity numbers have not changed significantly from 2002.

Table 1. Sex activity for the last year

Sample size: 2,690 men

60% – more than one partner

28% – more than 10 partners

75% – always safe sex

10% – one time unprotected sex with unknown status partner

15% – unprotected sex with more than one guy

5% – intentional unprotected sex with multiple unknown status partners

From the Sex Now Survey 2004

Nevertheless, the number of new HIV infections reported among gay men is rising. According to provincial data, gay men accounted for almost 40 percent of new HIV cases in 2004 compared to only 25 percent in 1999. In raw numbers, 180 gay men tested HIV-positive in 2004 compared to 106 in 1999. These numbers reflect an overall trend of increasing infections in gay men—almost 1000 new cases in five years.

The question remains, if risk activity is not increasing significantly, then what is driving the increased rate of new infections? It may be that the current level of risk activity is enough to drive an increasing rate of HIV infection. And while risk activity does not appear to have increased in the last three years, data from the 2002 Sex Now survey showed that the number of men who had anal sex without condoms had increased by 25 percent since the 2000 survey. There may be other explanations for the increasing rate of infection; a more detailed analysis of the Sex Now data (not available at press time) may shed more light on the local problem.

Who's going rubber-free

Male sex partners generally fall into three groups: both men are HIV-negative; one person is HIV-positive and the other is HIV-negative; and both men are HIV-positive. Of course the lines aren't so easily drawn when it comes to threesomes and group sex.

Still, it would appear that most monogamous, HIV-negative couples rarely use condoms. The same goes for monogamous HIV-positive couples. For casual sex where both men are HIV-positive, the temptation to bareback is usually irresistible, despite the risk of other STDs. Obviously, serodiscordant partners also engage in bareback sex, especially when the other person's HIV status is assumed rather than openly discussed.

For some individuals, drug use plays a crucial role when it comes to decisions about barebacking. For example, a recent San Francisco study showed that gay men who use crystal meth were over two times more likely to report unprotected anal sex compared to non-users. They were 2.5 times more likely to report 10 or more sexual partners in the last year, and they were three times more likely to get HIV compared to those who did not use methamphetamines. While crystal meth is clearly touted as the bad guy these days, softer drugs like alcohol, marijuana, and poppers also impair judgment.

According to the 2004 Sex Now Survey the most popular places for man-to-man sex in BC are the Internet, bathhouses, and parks. The data also shows that risk sex is equally likely to take place at any of these meeting venues.

For sure, risk sex is more likely to take place with casual partners, and the more partners you have the higher the chance of problems, regardless of the activity. In highly sexualized settings, it's unrealistic that HIV status will be discussed and it's naive for people to believe that HIV-positive men are going to disclose in these locations. This doesn't mean that HIV status can't be discussed but it has to be done with openness and respect, and a realistic understanding of the circumstances under which that can take place.

A myriad of reasons and justifications

Why do men bareback? The short answer is because we like it. It's a lot nicer to feel your man ***sans latex***. With no shortage of condom-haters out there—gay, straight, bisexual, positive or negative—we've all heard the various justifications for dropping rubbers from their repertoire.

Recent reviews on barebacking suggest that the decision to engage in unprotected sex has very little to do with knowledge about AIDS. Instead, the practice appears to find roots in gay identity itself—that is, an identity of sexual expressiveness and freedom. It's embedded in a desire for personal gratification but it also fulfills a need to meaningfully connect with one another. In times of isolation or insecurity this need for a strong physical connection may be especially important.

For others, the drug scene plays a pivotal role by reinforcing standards of beauty and feelings of confidence in a setting of sexual intensity. And still others adopt a devil-may-care approach to coping with the anxiety about acquiring HIV.

It's likely that a combination of factors contributes to the decision to bareback in a given situation, and men who bareback in the heat of the moment may feel conflicted about it or remorseful afterward. Furthermore, a few episodes of barebacking without any serious consequences may lead to a false sense of security and an escalation of risk activity. HIV-positive men may feel they've already paid the ultimate price and that barebacking amounts to "membership privileges," despite the risk of contracting other STDs. To speak plainly, lots of men think the benefits of bareback sex, however brief, outweigh the perceived risks.

Increased risk of STDs and HIV

For HIV-negative men, barebacking increases risk of HIV infection. The risk is greatest if you're a bottom with multiple partners but it can also happen if you're a top.

Both HIV-negative and HIV-positive men carry the risk of getting other STDs when they bareback. For example, BC statistics showed a small but steady increase in syphilis infections among men who have sex with men (MSM) during 2003; then in early 2004 there was a large spike of new infections.

Gonorrhea infections have also shown a dramatic rise in the last year. An anal gonorrhea infection can be virtually without symptoms and delays in treatment can lead to permanent health problems. If you're HIV-negative, having another STD increases your chance for getting HIV. If you're HIV-positive, having another STD lowers your ability to fight HIV and other infections.

Anal warts are also a problem. They may not be visible, either on the penis or in the anus, but skin-on-skin contact will pass the wart-causing virus back and forth. If your immune system is healthy, the warts often stay invisible. If your immune system is failing, then the warts will appear and grow. In many cases they're difficult to treat and some men go on to develop anal cancer.

There's been a great deal of discussion about HIV-positive men barebacking with other HIV-positive men and the possibility of HIV superinfection. Superinfection is getting someone else's HIV strain on top of your own. The term superinfection doesn't necessarily mean that the second infection is superior or more powerful than the first (although it could be). Instead it means that the second infection is superimposed on the first.

A high profile case of HIV superinfection in New York recently caught the attention of the media but very little is known about either the occurrence of superinfection in the general HIV population or its long-term consequences. The feeling in the medical community is that HIV superinfections are an added burden to an already overtaxed immune system.

A polarized community

So where do we go from here? Let's keep things in perspective. It's clear that the majority of us are doing a good job when it comes to keeping healthy around sex. There is a smaller group that is firmly entrenched in the barebacking culture. Some suggest this is creating polarized groups within our community that didn't exist in the early days of AIDS when everyone agreed that condom use was necessary to stay alive. All of this is complicated by the changing face of the HIV epidemic, the shifting patterns of drug use, and the variation of our individual sexualities.

Educational programs have to be adapted for a wide range of sexual types within the gay community. This is happening with various initiatives, such as poster campaigns, safe sex guides, and other programs like drug awareness and treatment. Despite this, we cannot deny that MSM are experiencing more new HIV infections than before.

Can we do more? Of course we can. More money for educational and drug programs would be nice and we need to lobby for this.

But education may not be enough to break the barrier of denial that many of us experience. We need to talk more openly about our experiences as gay men. HIV-positive and HIV-negative men need to discuss issues like HIV, sex, serosorting, drugs, and harm reduction–hopefully with candor and without sanctimony. And, keeping in mind that the goal is to create a healthy community of sexually active men, the issue shouldn't be driven further underground. But without strong public discourse on these matters, the chances are slim that we'll make any progress. ⊕

Rob Gair
is a contributing writer for living ⊕ magazine.

"A normal desire"

Barebacking needs a harm reduction approach

by Jeff Anderson

In a scene from the film ***Fire***, directed by Deepa Mehta, a passionate protagonist rebuffs a suitor but she continues to flirt with him.

"Hunt–it's my favourite word," she says. "It means to pursue, to chase for game, or to kill. Whenever we stop hunting, our desire fizzles out. You don't want that to happen to us, do you?"

He shakes his head. "But at what cost?"

Her gaze lowers. "At all costs," she replies.

Sex, ideally, rises from an unconscious, impossible-to-ignore impulse: love. In the bargain, we get thrills and joys. But if you have HIV, sex also brings worry, fear, anguish, the risk of criminal charges and recrimination–and the risk of death for your sexual partner. What, then, could possibly motivate a person with HIV to engage in bareback sex? This quandary troubles all PWAs and angers many who don't have HIV.

> **Despite recent studies that confirm that sexual arousal alters men's values and decisions, barebackers are often considered hateful louts–people who care only for their own pleasure. But that view is too simplistic.**

It is, frankly, easy to see why barebacking PWAs wrestle with self-loathing. They are pariahs around the world, shunned by the uninfected, because it's our fault we're HIV-positive, isn't it? Well it is–and it isn't. For just a moment, though, let's leave right or wrong to another discussion. Let's first ask: "Why?"

There are various reasons why a person who is HIV-negative would engage in condomless sex with an infected partner. Some want to share the burden of HIV with their infected partners, some don't care enough to take precautions, and some are rumoured to want the financial benefits accrued by the infected. Others want, as one newly infected woman told me, "to get it over with." Some people honestly believe their own rationalizations, while others want a convenient excuse for the urge to have passion, not reason, rule their lives.

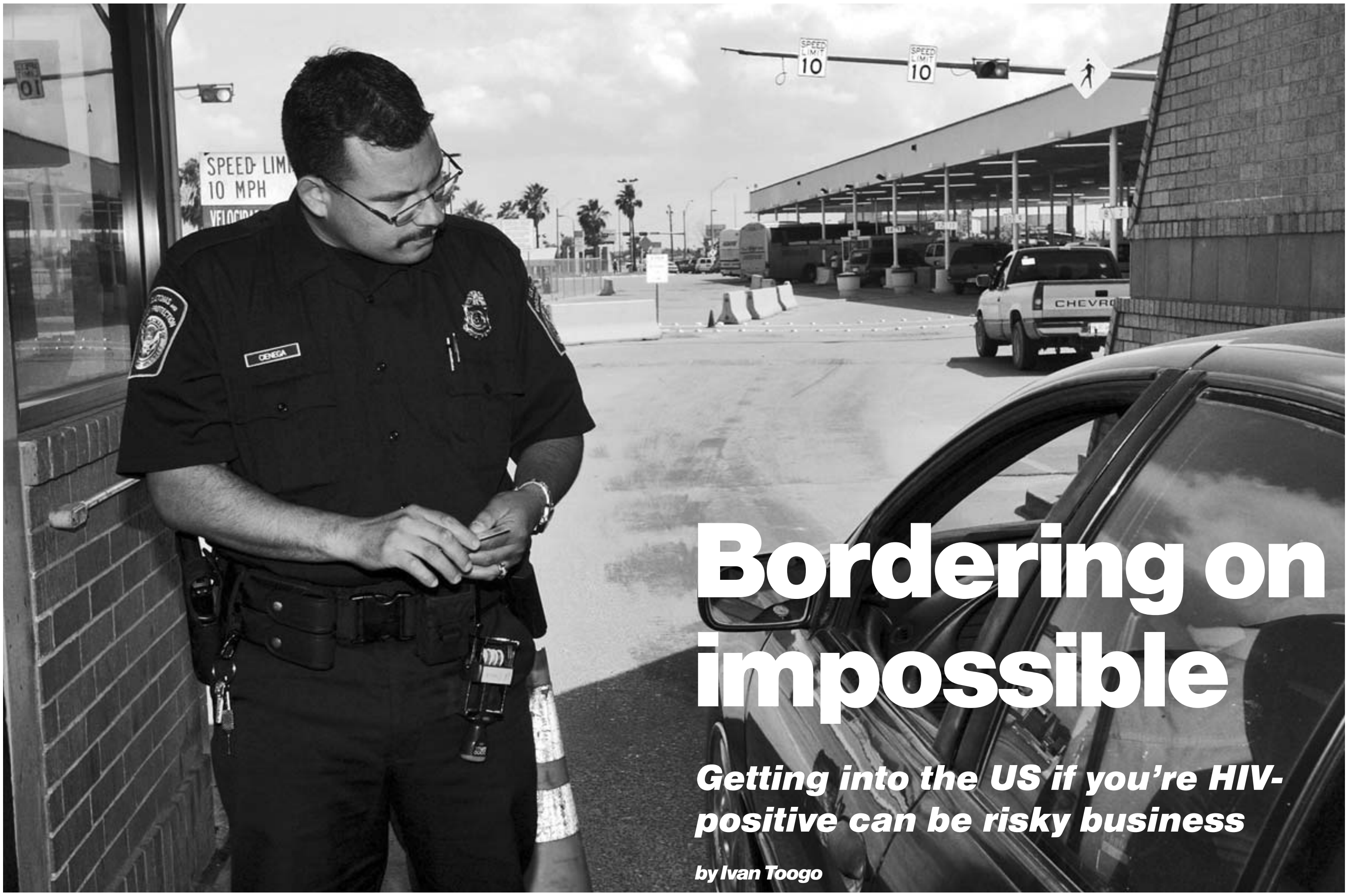
In England, a recent gay men's sex survey showed that last year nearly 45 percent of all survey respondents had condomless sex and about one-third of HIV-positive respondents had sex that could have passed on HIV to their partner. Investigators observed that the days of "use a condom every time" messages are in the past.

And they are. In announcing a recent workshop for HIV counsellors and health providers titled "Without Condoms" based on a book of the same name, gay therapist Michael Shernoff noted, "condoms are still the best way to prevent HIV and STDs. But the data show that a lot of gay men bareback some of the time. It's not a small group of 'bad guys' who do it all the time. You have to start from the point of view that wanting sex without condoms is a normal desire–whether you act on it or not."

Despite recent studies that confirm that sexual arousal alters men's values and decisions, barebackers are often considered hateful louts–people who care only for their own pleasure. But that view is too simplistic. It is widely accepted that there are many contributing factors to HIV, including poverty, powerlessness, and poor self-image. Barebacking is similarly symptomatic of larger social pressures. Because our passions are shaped as much by social forces and conditioning as by instinct, logic, and reasoning, barebacking can be seen as a socially-influenced behaviour like smoking or overeating.

Like smoking and drug addiction, barebacking needs a harm reduction approach to lessen the damage and offer choices for alternate behaviours. Our social and health care responses need to recondition the public, and health providers need to offer compassion and understanding to people who engage in condomless sex. Some health and social care providers are beginning to understand this challenge. And not a moment too soon. ⊕

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



Bordering on impossible

Getting into the US if you're HIV-positive can be risky business

by Ivan Toogo

I travel regularly to the US for work and for personal reasons, especially since I started seeing a man who lives in Miami. Every time I approach the immigration desk at the airport, I practice yogic breathing to control the hyperventilation caused by racing adrenaline. Is this the time the officer will decide to take a closer look and find medication in my baggage? The worst experience I recall was traveling by car when I had to declare three oranges at the border. I was sure it would lead to a thorough cavity search but as it turned out, no such luck.

In preparation for this airport ordeal I pack my medications and supplements into my checked luggage except for a two-day supply I keep with me in case the bags go missing. My pharmacy repackages my HIV medications into neutral plastic containers to which the original prescription labels are attached. Is this officer going to know what tenofovir or abacavir are used for? (I could hide the drugs inside vitamin bottles, but if they find them, it could lead to more questions since all prescription medications must be properly labelled.)

I pray that the immigration officer will remain bewildered by the total number of pills needed by this obvious hypochondriac to get through the day—pills for everything from osteoporosis and herpes to high cholesterol and acid reflux. Not to mention the sleeping pills and assorted antibiotics without which I never leave home. I also carry a letter from my doctor saying I am being treated for every condition—but the letter doesn't mention HIV disease.

I never say that I'm attending a conference that is HIV-related. If I am going to a conference, I say it's related to health and poverty, and that I am a consultant who works with not-for-profit groups. I send HIV-related documents ahead of the meeting so I'm not carrying anything with me that indicates the purpose of my visit.

When questioned by the officer, I keep my answers short, precise, and deliberately vague. I usually say that I'm visiting friends or going on holiday. I can always name those friends, where they live, and how long I have known them. I carry a passport and dress for success. And leave the bling and hair products in my luggage. It's best not to look too sick or too gay.

Brighton Study looked at travel behaviour

Enough about me—a middle-aged, middle-class, white, gay male. The Brighton Study, which was presented at the European AIDS Conference in Warsaw in 2003, looked at the knowledge, attitudes, and health outcomes of some British PWAs after travelling to the US. Three hundred and forty-six patients from a Brighton clinic answered a questionnaire regarding travel to the US. In total, 39 percent of them had traveled to the US since their diagnosis, all but two of them illegally (in other words, they didn't acknowledge their HIV status). Of these "illegal" travellers, over two-thirds told US immigration officials they were traveling as tourists.

The most striking finding of the study was how those who decided to travel without a waiver managed their drugs. Five people reported problems mailing their drugs. Five others chose to stop taking all medications.

One individual developed resistance to non-nucleoside reverse transcriptase inhibitors as a result of this treatment interruption of all his drugs, and he has subsequently run out of options. Some drugs have longer half-lives than others, and you need to decide treatment interruption strategies with a physician. Clearly this mode of entering into the US is also a risky business.

Less freedom of movement

A key development in this border hassle was the human right to freedom of movement that was infringed upon by the US Immigration and Nationality Act that US Congress passed in 1987. The great AIDS crusader, Bill Clinton, reaffirmed it in 1996. I tell myself that he was forced to do it.

The Act excludes anyone from entering the US who has a communicable disease that could be a threat to public health or could place a burden on the healthcare system. The Act specifically refers to AIDS as an example of this type of disease. It would require another act of Congress to repeal the ban on visitors and immigrants.

It is possible, however, to enter the US legally with HIV under the following circumstances:

- to attend conferences
- to receive medical treatment
- to visit family members
- to conduct business

You must apply for a stigmatizing waiver each time you wish to enter. Your passport may be stamped "Allowed to enter the US with HIV waiver only." You can ask to have this stamp placed on a separate piece of paper but most PWAs aren't given that option.

Paperwork and bureaucracy

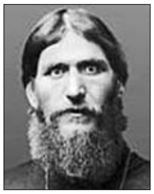
I recently read a listserv posting by a Zimbabwean activist who was given the runaround by the US consulate in Harare, the Zimbabwe capital, when she applied for a visa to attend a meeting of the AIDS Clinical Trials Group in Baltimore. In the end, she was unable to travel, despite spending hundreds of dollars on paperwork and medical reports.

We've all heard horror stories of people who were detained by the US Immigration and Naturalization Service. You may be sent back immediately and told to apply for a waiver if they believe you were ignorant of the law. If they suspect you're making a fraudulent claim, you can be held indefinitely without any right to release on bail. Most likely you'll be banned for life from entering the US.

Many countries, including Canada, reserve the right to ensure that visitors do not place an undue burden on health and social services during their stay. If, however, the purpose is to prevent onward transmission of HIV, the law is counter-productive. It's worrisome to think that PWAs travelling to the US are putting themselves and perhaps others at risk by stopping treatment, getting sick, and potentially becoming more infectious due to a spike in their viral load.

In the September/October 2005 issue of ***living⊕***, we described changes to Canadian immigration requirements for visitors from countries that require a visa. The question of burden to the healthcare system is still there but it is focused on whether a person expects to need treatment and services beyond medications. There is no longer a broad question about having any communicable diseases, or the need to provide details that may require you declare your HIV status. Unlike the US, Canadian immigration policy maintains that people living with HIV/AIDS do not represent a danger to public health.

For AIDS 2006, the Toronto Local Host Organization is considering obtaining a Designated Event Waiver from US Immigration for all attendees who might travel via the US; the waiver would prevent officials from inquiring about HIV status. All scholarship recipients will have the option to overfly the US but the blanket waiver would be there as an additional safeguard. The Conference might be a great opportunity to raise this issue publicly again. Food for thought—and for racing hearts everywhere. ⊕



Ivan Toogo *is a pseudonym for a Canadian AIDS activist.*

Want more info?

For further information, go to www.aidsnet.ch/modules.php?name=Content&pa=showpage&pid=246.

Unsteady employment

With improved health comes the often stressful and unsettling prospect of returning to the workforce

by Glyn Townson

We've come a long way in Canada in the past 20 years with the AIDS pandemic. What began as a fatal incurable disease in the 1980s and early 1990s has shifted to—in many cases—a chronic infection with episodic periods of wellness and unwellness for PWAs accessing antiretroviral treatment. (See the Nov/Dec 2005 issue of ***living*** **⊕** for a discussion of HIV as an episodic disability.) Longer life expectancy and managed side effects have a number of implications for people living with HIV/AIDS, including continuing stigma and discrimination, and the ever-increasing costs of new and powerful medications entering the marketplace.

A key issue is the idea of returning to, or entering the work force in some capacity. What are the barriers for those who were once considered near the end of their lives and now living longer than they thought possible? There are also PWAs who never entered the workforce and may now want to explore employment possibilities.

We need a better understanding of what changes can be made to encourage those PWAs who want to return to work and how to provide them adequate supports. Our society places a lot of value on our occupations and on paid employment in general.

As an episodic condition, however, the unpredictable nature of HIV raises a lot of questions. Each person's case is unique. The challenge is to manage the side effects of often-complex drug regimens, fatigue, diarrhea, and neuropathy, as well as the time constraints of doctors and specialist appointments.

Cut off from disability benefits

Some individual stories illustrate how the climate is changing. In early 1996, a close friend—who had been living with AIDS for a number of years and was receiving private long-term disability insurance—started taking the newly-available highly active antiretroviral therapy (HAART). His health improved. "At this rate I may have to consider going back to work," he said at the time. "How horrible—my old job no longer exists and I would hate to have to start all over."

Later that year, he passed away from Non-Hodgkin's lymphoma, but his concern hit a chord: What do you do when confronted with the possibility of having to go back to work after many years of not working and relying on private or public benefits?

More recently, another friend talked about a general turnaround in his health, currently managed with antiretrovirals. He was weighing the pros and cons of re-entering the workforce after an absence of many years. A paid position came available at an organization where he volunteered. There were a lot of issues to consider, such as being cut off of his housing subsidy. Would the new employer offer extended benefits? What if the situation didn't work out and the stress of working was too much? Would he be able to get back any of the current benefits he now depended upon?

In the end, with no guarantee of benefits or security, he decided to decline the position, even though he was still interested in some kind of employment.

And in another recent incident, a PWA was employed but didn't have access to the same extended benefits packages other HIV-negative employees enjoyed. He questioned his employer about this discrepancy and soon found himself out of a job.

Researching the issues

Despite these troublesome cases, there are many success stories where people returned to the workforce and continue to enjoy full benefits and a safe work environment. Still, there are a lot of issues to consider when you're HIV-positive and contemplating joining, or re-joining, the workforce. Fortunately, there are groups working to address the employment issues of people living with disabilities—including part-time work and flextime—to ensure that returning to work is possible and not loaded with disincentives.

The Canadian Working Group on HIV/AIDS and Rehabilitation (CWGHR) has been researching these issues and has already had a positive impact on how people view HIV/AIDS as an episodic illness. For example, the Canadian Pension Plan (CPP) recently announced a rapid reinstatement program for those who relinquished their disability benefits but need them restored. It's a major first step in identifying some of the barriers to returning to work for periods of time.

continued on next page

Unfortunately, CPP disability is not enough for most to survive on, and provincial income assistance programs and private insurance schemes are inflexible in dealing with issues around income supports and episodic illness.

> **What do you do when confronted with the possibility of having to go back to work after many years of not working and relying on private or public benefits?**

Two major projects

CWGHR has two major projects in progress. The first project addresses issues surrounding episodic disabilities, labour force participation, and social inclusion. The key areas of this multistaged project include researching existing private and public disability income supports and workplace policies, programs, and practices—both nationally and internationally—to determine gaps, strengths, and barriers to full social inclusion. The research will identify and recommend:

- new models and enhancements to existing disability income support plans, and
- workplace policies that will contribute to labour force participation for people living with HIV and other episodic disabilities.

The final stages of the research will establish the cost-benefit analysis of these recommendations, and then develop pilot projects to test and evaluate them.

CWGHR's second project is called "Interprofessional Learning in Rehabilitation in the Context of HIV: Stakeholder Capacity Building through Development of New Knowledge, Curriculum Resources, and Partnerships." This project will build on current interprofessional education initiatives to increase rehabilitation professionals' ability to respond to the rehabilitation needs of PWAs. It will draw on the expertise of clinicians, educators, and researchers to develop interprofessional curriculum resources on HIV for rehabilitation professionals.

In that regard, in June 2005, the University of Toronto's HIV Social Behavioural and Epidemiological Studies Unit completed a study entitled "HIV and Rehabilitation: The Canadian Providers' Survey." Rehabilitation specialists were asked about their knowledge of HIV/AIDS and how they felt they could support PWAs in managing side effects and barriers to employment. The results showed a real disconnect: providers were unaware of the types of services available and were generally unfamiliar with the issues facing people living with episodic conditions. Clearly more education and attention is needed in this area.

Identifying and implementing changes to help PWAs remain at work as long as possible, and assisting those who wish to return to the work force in some capacity, are important initiatives to improve our lives and our self-images. ⊕

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

For more information on these projects, visit the Canadian Working Group on HIV/AIDS Web site at
www.backtolife.ca

Food and the path to addiction recovery

by Sarah Fielden

Alcohol and drug abuse take a major toll on the human body. Recovering from alcohol or drug abuse is a gradual process, and nutrition is one of many issues that require attention and treatment. Food is vital in helping the body rebuild itself and maintain health.

When you abuse alcohol and drugs

- you usually consume less food (except with marijuana)
- you likely choose foods that are less nutritious and/or may skip meals
- you increase the speed at which your body uses up energy
- you increase the loss of nutrients through vomiting and diarrhea
- you damage your gut so that it can't absorb the nutrients in food properly

Food influences the way the brain functions. When your body isn't producing enough brain chemicals (neurotransmitters) or the chemicals are out of balance, you can feel irritable and anxious. You can also suffer from food cravings, anxiety, and an inability to sleep. This stress can also affect your memory and/or make people paranoid, tired, dissatisfied, or depressed.

What to eat during recovery

During recovery, you should eat a diet that will balance the levels of serotonin (a hormone which helps with relaxation) in the brain. This type of diet involves eating foods high in carbohydrates, especially the complex carbohydrates found in starchy foods like, legumes (such as lentils, beans, and peas), root vegetables (such as potatoes

Nutrition tips for recovery

- ❇ Try healthier choices for fast foods (such as salads, grilled chicken burgers, smoothies) if you don't like to cook
- ❇ Eat food high in fibre, such as bran and oat cereals and muffins, legumes, fruits, and vegetables
- ❇ Eat breakfast and try not to skip other meals
- ❇ Limit sugar and sweets
- ❇ Slowly cut back to drinking less than two cups of caffeinated coffee, tea, or pop a day
- ❇ Enjoy some form of activity every day
- ❇ Drink plenty of water
- ❇ Take a multivitamin (talk to your healthcare provider about the options)
- ❇ Eat a variety of foods from all the food groups (fruits/vegetables, grains, dairy, and meat or alternatives)
- ❇ Learn new ways to deal with stress and anxiety
- ❇ Seek support (counselors can help with this)
- ❇ Talk to a dietitian for advice on nutrients, how to manage symptoms such as constipation and diarrhea, and low-cost eating tips

and carrots), pastas, and breads. Eating these foods in combination with a protein in your meals will keep you at your best.

In the first year after you stop using alcohol or drugs, your nutrition needs are higher than normal. You need to make sure you're feeding your body good food on a daily basis. Even if you eat a healthy, varied diet while using drugs and alcohol, fewer nutrients are available to satisfy nutritional needs since a lot of them are being used to detoxify your body.

Malnutrition shows up in several ways. In the short term, you may become very tired and have a weaker immune system—which means that you're more susceptible to infections. Other symptoms include dental problems, digestive problem (such as diarrhea, constipation, and gas), skin conditions, and changes in the way foods taste.

In the long term, there are risks for brain damage, nerve damage, liver disease, heart and pancreas problems, and certain types of cancer. These problems need to be identified and treated—ideally by a team of healthcare professionals—during the recovery process.

When you're going through detoxification in the early stage of recovery, you need to introduce meals slowly, since your body might not be used to digesting food. It's a good idea to start off with small and frequent meals. Some people may start to gain weight. If you want weight management advice, see a nutritionist. If gaining appropriate amounts of weight bothers you, or your eating behaviour seems out of control, you may need professional help for body image and eating disorder problems.

Don't replace one addiction for another

Food shouldn't replace drugs as an addiction and coping mechanism. Sugar and caffeine are common substitutes that people use during recovery because they produce highs and lows. These low-nutrient foods can prevent you from consuming enough healthy food and affect your mood and cravings. However, these foods are preferable to starting alcohol or drug use again.

A diet for recovery should include:

- ► complex carbohydrates (50-55 percent of the calories you consume) with a lot of grains, fruits, and vegetables,
- ► dairy products or other foods rich in calcium (two to three cups a day)
- ► moderate protein (15-20 percent of calories), with two to four ounces twice a day of meat or another high-protein food such as tofu
- ► fat choices (30 percent of calories), preferably rich in good oils like those found in canola and fish.

Healthcare providers and different community-based agencies for HIV and alcohol and drug treatment have free services in mental health, nutrition, and food provision, as well as providing other social services. These are great tools in the recovery process and they can provide holistic care and support if you're recovering from addiction. ⊕

Sarah Fielden is an Interdisciplinary PhD student with the Institute of Health Promotion Research at UBC, a member of Vancouver Dietitians in AIDS Care, and a Michael Smith Foundation for Health Research graduate trainee.

A?k the dietitian

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

A hearty diet for the heart

by Kristen Yarker

"I'm HIV positive and have been on HAART for years. My recent blood test said that I have high triglycerides and high cholesterol. I've heard that vitamin E and omega 3 fats are good for your heart. Should I take these?"

As we learned in the last issue of ***living*** **⊕** PWAs are at increased risk of heart disease, especially if they are on highly active antiretroviral therapy (HAART). High triglycerides and high cholesterol are especially common. The mechanism for this is unknown.

We don't know how effective healthy eating is for PWAs in preventing heart problems, because the heart disease is related to the medications and/or HIV itself. The few studies that have been conducted on PWAs, cardiovascular disease, and nutrition have not had a large enough sample size to provide any clear direction. The good news is that studies with larger sample sizes are currently underway, and they should offer more insight.

So, what should you do in the meantime? Follow general healthy heart eating guidelines. Here's how:

Eat lots and lots of vegetables and fruit. There is no evidence that any single vitamin or mineral (such as Vitamin E) prevents heart disease. But, time and again, studies find that people who eat lots of vegetables and fruit are the healthiest. Veggies and fruit contain vitamins, minerals, antioxidants, phytochemicals, fibre, and many good things we haven't discovered yet. If you aren't eating veggies and/or fruit at every meal, you aren't getting enough fibre!

Replace refined grains (e.g. white bread, white rice) with whole grains. Whole grains provide fibre, which helps lower cholesterol. Reducing refined grains also lowers triglycerides. Choose brown or wild rice and try the many other whole grains out there, like quinoa and oats. Pick whole grain bread: good choices have at least four grams of fibre per slice; look on the label for this information.

Cut down on sugar. Sugar raises triglycerides. One can of regular soda pop (that is, non-diet soda pop) contains about nine teaspoons of sugar.

Cut out trans fat. This is in deep fried foods and hydrogenated or partially hydrogenated shortening and margarine. Trans fat is found in store-bought (bakery or packaged) baked goods like muffins, cookies, and danishes. If you are craving these treats, bake your own using vegetable oil or non-hydrogenated margarine.

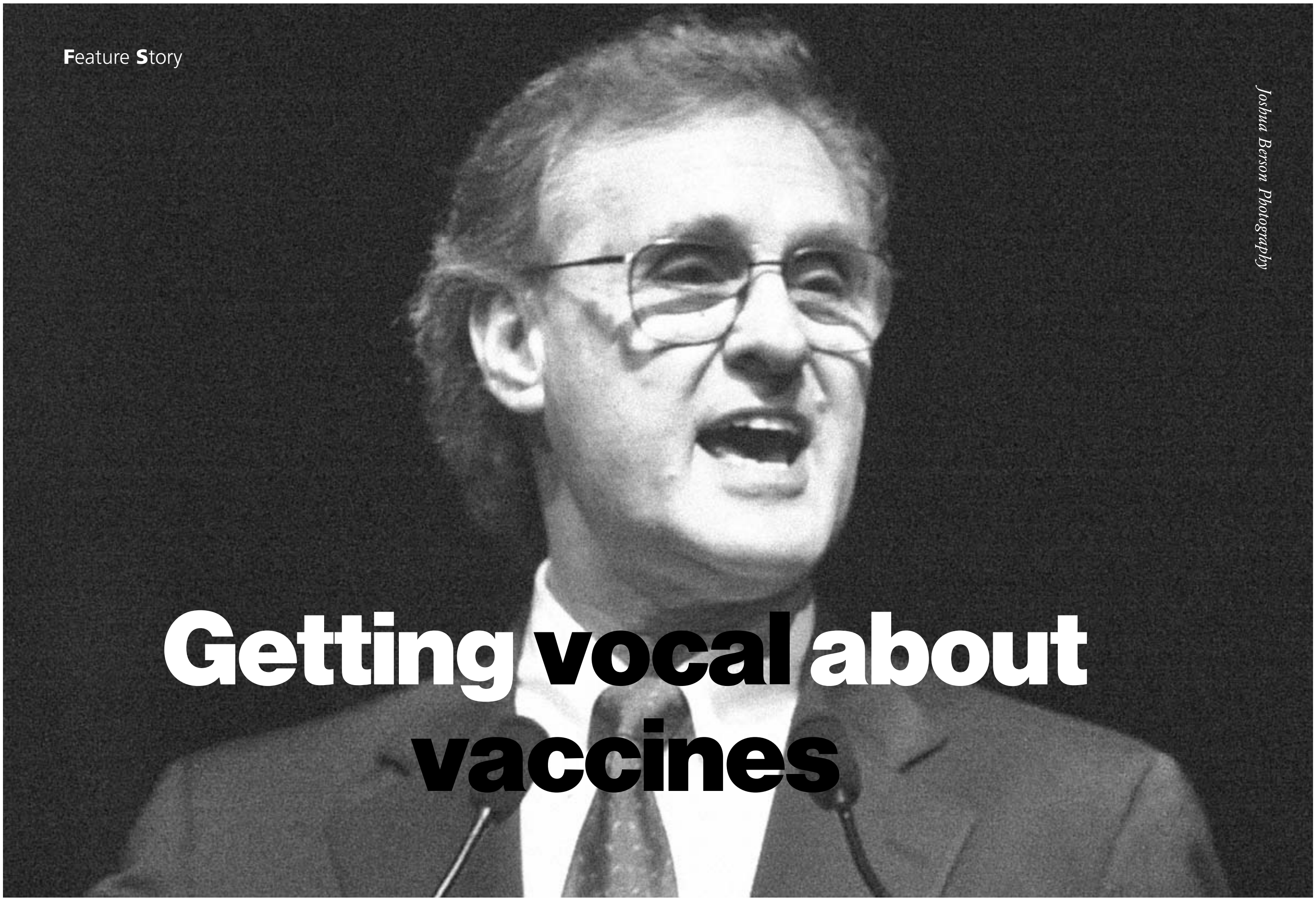
Eat omega-3 fat. Omega-3 fat is found in fatty fish such as salmon, herring, and sardines. Canned fish counts! If you don't like fish, try flax seed oil or hemp seed oil. Don't cook with these oils—instead add a drizzle to dishes once they're already cooked. Some people turn to fish oil supplements; however, there is little evidence to support their effectiveness and they can be costly. It's also easy to take too much omega-3 when buying supplements. If you choose supplements, be sure to talk to your doctor and/or pharmacist ***before*** you start taking them—they can interact with other medications.

Choose low-fat protein foods. Low-fat proteins include soy foods such as tofu, beans and legumes, lean meats, and white-meat poultry.

Cut down (or cut out) alcohol. Alcohol raises triglycerides.

Want to do more to prevent heart disease? Exercise and quit smoking. These two habits have the strongest evidence for PWAs' heart health. **⊕**

Kristen Yarker*, MSc, RD, is a dietitian with the ADAPT program at the Vancouver Native Health Society. She is a member of Vancouver Dietitians in AIDS Care.*



Joshua Berson Photography

Getting vocal about vaccines

An abridged version of the opening ceremony speech delivered by Stephen Lewis at the AIDS Vaccine 2005 International Conference on September 6, 2005 in Montreal

by Stephen Lewis

“Last month, in Maputo, Mozambique, I attended the annual World Health Organization regional meeting of all the African Ministers of Health. Late in the afternoon of the second day of the conference, an hour and a half was set aside for a discussion of HIV/AIDS and prevention. A significant number of African delegations participated, raising all the conventional responses involving behaviour change, and a few responses somewhat unorthodox in content, from male circumcision to biochemical sexual suppressants!

What was not mentioned, by any official delegate, throughout the entire session, was a vaccine. It was as though the preventive technologies had totally fallen off the radar—microbicides and vaccines both. If it hadn’t been for the presence of the former Prime Minister of Mozambique, Pascal Mocumbi, attending as an “observer,” the word vaccine would not have passed anyone’s lips. And do remember, Dr. Mocumbi has a particular interest: he’s now the High Representative of the Clinical Trials Partnership in The Hague.

What was even more interesting than the omission of preventive technologies at the Maputo conclave—peculiar might be a better word—was that the session was based on an actual report, issued by WHO, of a conference on prevention attended by a large number of African and international experts, held in Brazzaville over three days in June. The report contained every aspect of prevention with which we are all familiar, but the word vaccine did not appear from beginning to end. Again, it was as if the preventive technologies were somehow outside the fault lines of AIDS.

How can this be? Africa is the epicenter of the pandemic. Something somewhere is profoundly out of whack. The world needs an AIDS vaccine more urgently than it needs any single medical discovery, and Africa needs it more than any other part of the world. But for some inexplicable reason, the consuming enthusiasm, the obsessive drive, the sheer, unrelenting passion for a vaccine is simply not riveting the world at large as should be and must be the case.

I would argue that the same kind of extraordinary commitment, in country after country, to achieve "3 by 5" [the global target to provide three million people living with HIV/AIDS in low- and middle-income countries with antiretroviral treatment by the end of 2005] and then to progress to universal treatment, is exactly what has to happen in the pursuit of a vaccine....

The need for public-private partnerships

[We need to] broaden the base of scientific enquiry in the search for a vaccine. It seems to be widely accepted that the private pharmaceutical and biotech companies must be brought on board. Their participation hitherto, with one or two notable exceptions, has been, quite simply, paltry.

There are, of course, a number of explanations. The science is supernaturally complex and difficult; the exploratory investments are huge; the monetary risks are great; and undoubtedly the biggest obstacle to urgency of all, the market lies overwhelmingly in the poorest countries of the world. Throughout the AIDS pandemic, pharmaceutical companies have shown a remarkable financial narcissism when it comes to preserving their balance sheets. But clearly, the expertise of the private sector, with its successful history of producing vaccines for a vast range of diseases, is desperately needed in a vibrant web of public-private partnerships.

Thus there has emerged the inventive idea of an Advance Purchase Commitment, designed to guarantee market and price for those companies who discover, manufacture, and distribute a vaccine. It has the imprimatur of the UK Chancellor of the Exchequer, Gordon Brown, and has even been subject...to calculations of the possible numbers of courses of vaccination at a price which would guarantee a respectable rate of return....

The so-called APM is designed to make things attractive enough to engage the multinational drug companies. I will admit that under normal circumstances, this kind of fiddling with market forces to satisfy the private sector (a private sector that pretends to such reverence for the free operation of the market) would seem revoltingly rank. But normalcy is the furthest thing from the present circumstance. We're dealing with a communicable disease that dwarfs every illness since the Middle Ages. In that context, it is legitimate to make room for special privilege in the service of human survival.

I have but one caveat. In my respectful submission, the architects of the APM are aiming too low. The discussions are premised on 200 or 300 million courses of vaccine, requiring three staged injections, with the related costs carefully calculated. Two to three hundred million doesn't begin to meet the need, or recognize the capacity that already exists to provide the vaccine. UNICEF and WHO have legendary experience in immunization: they've learned to orchestrate national immunization days in countries like India where millions are inoculated in one twenty-four hour period. We should be looking at 500 million courses at an absolute minimum. This is not a time to trifle: this is a time to think on a scale worthy of humankind.

> **"Just as the universe of AIDS is filled with the clamour for antiretroviral drugs and behaviour change and home-based care and professional training and solutions for countries awash in orphans, so must it also be filled with the noisy, insistent protagonists of preventive technologies, microbicides, and vaccines alike. It is both troubling and self-defeating when vaccines and microbicides fall off the agenda."**

The liberating hope for women

The pandemic's greatest toll is amongst women. It took us all a staggeringly long time to realize the disproportionate vulnerability of women, but now that we have, much of the work in prevention has turned to that excruciating reality. The problem is that we're making infinitesimal progress. It seems as if every time another ante-natal survey is taken, whether in South Africa or Swaziland, the prevalence rates for women have increased. Indeed, I can say with woeful and desolate confidence that on the ground, the responses to this growing, lethal threat have touched the lives of women barely at all. The inability of women to govern their own sexuality, the sheer degradation of gender inequality, dooms vast numbers of women in Africa to the status of an endangered species.

A vaccine then becomes the liberating hope for women. Assuming for the moment universal access for women, should a vaccine be discovered, women would be able to protect themselves from transmission with no interference or involvement at all by current or prospective sexual partners. Now, there's a prospect devoutly to be wished, cherished, treasured. The millions of women in their teens, twenties, and thirties who stand the gruesome risk of being infected, the millions of orphans left behind when their mothers die, the carnage and devastation visited on one sex in appalling numbers...all of this would have a chance to become a thing of the past.

And because women are the poorest members of society—and AIDS does nothing more efficiently than to make the poor poorer—the availability of a vaccine is a battle won in the war against poverty. There is almost nothing, on the face of it, which is pejorative about a vaccine....

While the search for a vaccine continues, there can be no lessening of our determination to resist the virus on every imagi-

continued on next page

nable front. The 3 by 5 Initiative has unleashed a galvanizing momentum for treatment: it must not be allowed to abate. What the World Health Organization and UNAIDS have done is to provide the greatest single trumpet of hope in the crescendo of treatment rollout. If, as the G8 suggested, we can attain universal treatment by 2010, we will have broken the back of the pandemic, although we will not yet have subdued it.

The Rubicon of political will

What is true for treatment must be made to work for prevention (including targets for voluntary counselling and testing, and targets for the prevention of mother-to-child transmission), and what is then true for prevention must be made to work for home-based care. Despite the millions of deaths and new infections every year, we have psychologically shifted gears. The publics of Africa and of the world seem aware as never before of the need to tackle the pandemic if only we could cross the Rubicon of political will.

I appeal to everyone in this room to make your voices heard. The problems in dealing with the virus are admittedly enormous; the reconstruction of societies, infrastructure, and shortages of human capacity are all overwhelming. But if we keep at it, in unrelenting fashion, we'll succeed....

There is room for champions: political champions, scientific champions. Just as the universe of AIDS is filled with the clamour for antiretroviral drugs and behaviour change and home-based care and professional training and solutions for countries awash in orphans, so must it also be filled with the noisy, insistent protagonists of preventive technologies, microbicides, and vaccines alike. It is both troubling and self-defeating when vaccines and microbicides fall off the agenda.

Let me speak with utmost candour.

I don't think the world yet realizes the carnage that is to come. I don't think the world yet realizes the full, incomparable horror of AIDS, and its inexorable spread around the planet. I don't think the world yet realizes that when we talk of the struggle for survival, it's not some facile phrase: it's the bitter truth for country after country in Southern Africa, and a truth that may spell the death for some of those countries before this century is a quarter complete.

> **"We know that when all is said and done, a vaccine is the ultimate answer to this devilish pandemic, and when all is said and done, human ingenuity will one day trump the Machiavellian mutation of the virus. It always does. My counsel, then, is one of unrelieved hope, and the determination never to give up."**

What happens after the Millennium Development Goals?

It's fascinating how we talk so yearningly of the Millennium Development Goals. And it's right, of course, that we should move heaven and earth to achieve them. But what, I ask you, happens after 2015? What happens to all the countries for whom the goals are a hapless quest? What happens to all the countries still counting the bodies and the infections of a pandemic which has laid waste to their hopes and prospects?

For those countries, a vaccine is the best hope for salvation, because the world doesn't stop in 2015. And if we work collectively, in a fashion at least equivalent to the space initiatives of NASA, then we will launch a working preventive vaccine that will save and protect the lives of millions, right at the point where the MDGs leave off. There can be no greater legacy bequeathed by the scientific community.

I'm an ignoramus when it comes to the nature of vaccines. But I've sat at the feet of Seth Berkeley of the International AIDS Vaccine Initiative, and I've read speeches and articles by Dr. Fauci, and I have a pretty good sense of how incredibly tough the slog will be towards the discovery of a vaccine. We know that when all is said and done, a vaccine is the ultimate answer to this devilish pandemic, and when all is said and done, human ingenuity will one day trump the Machiavellian mutation of the virus. It always does.

My counsel, then, is one of unrelieved hope, and the determination never to give up.

Back on June 2nd, at the United Nations in New York, there was a day-long special session on AIDS to visit the progress (or non-progress) made since the famous Declaration of Commitment of 2001. It was a remarkably mournful, desultory, almost pointless day. It was clear that the virus was running ahead of the response.

But there was one protracted episode of hope. The International Partnership on Microbicides and IAVI jointly sponsored a luncheon meeting on the new preventive technologies. It was attended by many ambassadors and senior members of the secretariat and a large number of interested parties. It was addressed by cabinet ministers of Brazil, India, Rwanda and the United Kingdom. It was also addressed by Kofi Annan, Peter Piot, Zeda Rosenberg (the CEO of IPM), and Seth Berkeley.

The room was electric with interest and commitment. The sense of expectation and of hope was palpable. It was a great moment.

It's that expectation and hope that I beg you to carry forward. ⊕ "

***Stephen Lewis** is the UN Special Envoy for HIV/AIDS in Africa, and author of the Canadian bestseller Race Against Time (Anansi 2005). He is the former Canadian Ambassador to the United Nations and former leader of the Ontario New Democratic Party.*

Kicking the habit

Ibogaine is a controversial drug that helps addicts break the pattern of chemical dependence

by Suzanne Clements

You've probably never heard of it, even though it's been around for 40 years. Ibogaine is a controversial drug that is emerging as a viable therapy option in treating chemical dependency, in particular addictions to such drugs as cocaine, morphine, and amphetamine. It isn't a cure but rather a "chemical interrupter," meaning patients must participate in aftercare subsequent to detox. Ibogaine has no addictive qualities itself and allows for symptom-free withdrawal.

Ibogaine is the principal alkaloid naturally occurring in the West African shrub known as ***Tabernanthe iboga***. Once used as a tribal remedy and initiator of spiritual practice, modern research suggests this unique molecule could be an effective solution to helping curb drug addiction.

It's certainly an intriguing solution. Physicians administer it in capsule form in a clinical environment with proper screening procedures. Forty minutes after ingestion, the drug induces a dream-like state; patients are neurochemically transported into a condition of lucid dreaming, re-experiencing their lives from a pre-addicted condition. Some people experience their own birth, while others relive their childhood. During this time patients may evaluate their habits from a non-addicted standpoint and focus on the underlying causes of their drug addiction.

Two to four hours later, the "waking dreams" fade as patients' chemical states are restructured. Ibogaine's cocktail of alkaloids seems to affect many neurotransmitters, in particular serotonin and dopamine. Reducing dopamine concentration in the body reverses the effects of certain highly addictive drugs that are known to stimulate dopamine production.

Ibogaine also affects serotonergic transmission to the brain, but the mechanisms of this action are not yet completely understood. The result is a molecular key that locks into the addiction receptors in a way that resets patterns and blocks feedback loops that reinforce dependency.

Two to three days after initial ingestion, all dizziness, shakiness, and inability to sleep disappear and patients are fully functional, without any withdrawal symptoms or cravings. After treatment, patients typically follow up with other medications, supplements, and chiropractic or acupuncture treatment.

Despite extensive studies and research, Ibogaine champions have had a frustrating time legitimizing the drug, in part because of its counterculture origins. Its anti-addictive properties were discovered accidentally in 1962, when a junkie, Howard Lotsof, experienced a visionary tour of his memories after experimenting with iboga. Thirty hours later he found he had lost all craving for heroin, without any withdrawal symptoms.

Lotsof patented the molecule, but the US Food and Drug Administration wouldn't approve it for addiction treatment. It was subsequently declared an illegal substance with no medical value and the potential for abuse.

Despite extensive studies and research, Ibogaine champions have had a frustrating time legitimizing the drug, in part because of its counterculture origins.

But Ibogaine is getting closer to legitimacy. In 1998, a University of Miami Medical Center researcher named Deborah Mash opened an Ibogaine clinic on the Caribbean island of St Kitt's. A team of physician counsellors and addiction specialists now collect data that Mash hopes will cement support for US trials of Ibogaine.

As well, US pharmacologist Stanley Glick has researched Ibogaine since 1993. He is currently involved in a project that intends to raise $5 million within two years to fund the first human studies of 18-methoxycoronaridine, a molecular variation of Ibogaine.

Another positive step is the re-opening of the Iboga Therapy House in Vancouver. The clinic will provide Ibogaine-assisted addiction recovery. The initiative began in January 2003 but closed in June 2004 when private funding ran out. Treatment will be expensive, however, at approximately $3,500 for a five-day stay.

With further support and sanctioning, Ibogaine therapy could be more wholly embraced by the medical system and provide an answer for many people who have exhausted all efforts in dealing with their drug addictions. ⊕

***Suzanne Clements** is a young reporter using her seven years of experience in the film industry to pursue a career in broadcast journalism, with a focus on human rights reporting.*

Self-defense

Immune reconstitution is about building the body's own immune system to fight off HIV

by Kenn Blais

Recently, there's been a growing awareness of the immune system and its role in good health. And that awareness is changing the way we look at treating HIV. Until now, most of the attention focused on viral suppression. While viral suppression is an important aspect of the body's defense, it's only one part of a multi-faceted machine. The immune system is like a sports team. Think of it this way: the various players all work together and if one player is injured, it affects the whole team. A poorly managed team may falter if it has an injured player, but a well-coached team knows how to pitch in and cover for the benched teammate. Similarly, by strengthening all the functional components of a weakened immune system, we can increase its effectiveness. This is what immune reconstitution is all about.

As Jay A. Levy, MD, director of AIDS research at the University of California in San Francisco has noted: "We have people who have been infected for more than 25 years and are perfectly healthy and not on any drugs. It is the immune system that controls the virus."

Three different approaches

With the use of immune-based therapies, the idea is to increase the immune system's ability to fight off the virus by itself. Currently, research is underway on three different approaches: cytokine stimulators, HE2000, and vaccine therapy.

Cytokine stimulators are the most popular approach. Cytokines are biochemical messengers, which are said to maintain the cellular immune responses against HIV. Researchers are studying the synthetic versions of Interleukin-2 (IL-2), Proleukin, and BAY 50-4798.

HE2000 is a synthetic agent with similar properties to dehydroepiandrosterone (DHEA). DHEA is an immune-enhancing hormone that regulates cortisol levels. Because DHEA is typically low with HIV, this allows immune-suppressing cortisol to rise.

These two new agents are synthetic and patentable derivatives of interleukin and DHEA. Interestingly, the biomedicine industry already has over-the-counter formulations available that are clinically proven to increase cytokine and interleukin activity (see "Biomedicine Boom," ***living⊕***, Nov/Dec 2005). DHEA is a widely available low-cost supplement in the USA, although it remains illegal in Canada, even by prescription.

The third potential immune-based therapy involves stimulating antibody production, a natural approach known as vaccine therapy. Different from a vaccination that acts to prevent a disease, this therapy uses minute particles of a pathogen already present in the body in the attempt to stimulate an immune response. The agent under investigation is called HIV-1 immunogen (Remune), also known as the Salk vaccine.

Some other traditional systems of medicine

Unani system of medicine:
based on the ancient Greek medical concepts of Hippocrates and Galen

Ayurveda:
"the science of life," an ancient Indian system of preventive health care, based on a harmonious relationship between three humors or doshas

Siddha medicine:
another ancient Indian system of medicine that revitalizes and rejuvenates the organs

Tibetan school of medicine:
developed extensive anatomical knowledge and the famous Tibetan jewel pills, still made and distributed by the Tibetan Medical Institute in Dharmasala at the express command of the Dalai Lama

Patanjali:
a yoga philosophy, this system was extremely disciplined and made considerable contributions in the functioning of the endocrine system, diabetes, asthma, eczema, colitis, psoriasis, hypertension, and curing obstinate diseases

Traditional Chinese medicine:
emphasizes immune-enhancing treatments and reducing the potency of the pathogen

Hahnemann:
the founder of homeopathy, based on the theory that diseases could be cured by medicine which produced symptoms
similar to the disease itself

Qi-Gong medical hospitals:
in China, these hospitals instigate treatments, anesthesia, and immune stimulation solely through Qi energy

Not a new concept

Although immune reconstitution is a new direction in HIV therapy, the concept is anything but new in other medical traditions around the world, past and present. Such schools of medicine teach that the eradication of pathogens alone is not enough to restore total health. In fact, the manifestation of disease is seen as evidence that immunity is already compromised. Therefore various measures to strengthen the immune system are incorporated into the overall treatment. In this way, the importance of treating the disease and strengthening the patient's immune system are simultaneously realized.

But there's more to it than that. Recognizing how the disease takes a toll on the body and uses all its reserves, a third stage of treatment, commonly known as rejuvenation therapy, tonification, or strengthening the constitution, is initiated once the disease is under control. The objective of this third stage is to further strengthen the immune system and renourish and revitalize the tissues and blood. Nutritional and physical therapies are also employed to strengthen the body. Treatment varies depending on the length and severity of the illness. An interesting aspect of the classical forms of rejuvenation therapy is the emphasis on the spiritual component, using prayer, meditation, and reflection to heal the "drama of the soul."

If you pursue immune reconstitution, don't fall into the trap of believing that one system of treatment is superior. We have at our disposal a rich history of all the world's medical systems available to us. What we need now is for healthcare professionals from different disciplines to learn to work together.

Successful immune reconstitution is just plain good coaching. With skilled guidance, consistent practice, and common good sense, your immune system can be part of a winning team. ⊕

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

A supplements toolbox

Here's a handy guide to the most popular supplements for PWAs

by Dr. Jennifer Hillier, ND

With all of the products, medications, and therapies available, where do you begin when you want to improve your health? Well, you can start by learning the basics of supplements. Here's a quick guide to the most popular nutritional, vitamin, and mineral supplements used by individuals with HIV/AIDS.

Multivitamins

Multivitamins contain many vitamins and minerals, which help to supplement a healthy diet while supporting a variety of essential body functions. A quality multivitamin is the basis of any supplement regime. When buying a multivitamin, make sure you check labels to compare the quantities of nutrients in each pill or tablet, and how many pills or tablets are suggested per day: some brands are cheaper, but you need to take more of them to achieve the desired dosage.

Fish Oil
(Omega 3 Essential Fatty Acids)

Derived from a variety of fish, including salmon and cod liver, fish oil helps to decrease inflammation and viral activation. Some studies show that it helps regulate the immune system, though others suggest it may be immunosuppressive. Fish oil may also help with depression. This supplement is available in a variety of capsule and liquid formats. It's also available in many flavours—including lemon, orange, and strawberry—if you don't like the fishy taste. For a vegetarian option, try flaxseed oil.

Antioxidant formulas

Antioxidants formulas usually include vitamins A, C, E, and selenium, and may also contain nutrients such as N-acetyl cysteine, coenzyme Q-10, carotenoids, and alpha-lipoic acid. These components help to decrease the damage from aging and HIV, and help reduce inflammation and nerve degeneration. Since HIV uses up more antioxidants, it's important to take a supplement in addition to eating lots of fruits and vegetables, which are also high in antioxidants.

Acetyl L-carnitine

Acetyl L-carnitine helps to reduce the damage done by HIV by increasing good cholesterol and decreasing bad cholesterol, leading to lower blood fats. This nutrient also provides muscles with energy and there is some anecdotal evidence that it may help to prevent and treat peripheral neuropathy and lactic acidosis. This supplement is very expensive if you purchase a pharmaceutical grade; over the counter versions are less reliable because they allegedly contain variable amounts of carnitine.

Alpha-lipoic acid

This is an antioxidant needed in higher quantities especially when there is nerve involvement, such as in peripheral neuropathy and mental changes.

Probiotics

Probiotics contain potentially beneficial bacteria. One of the most common forms is ***Lactobacillus acidophilus***, the bacteria found in yoghurt. Probiotics provide beneficial bacteria to the gut, which can help to decrease diarrhea or infection. They need refrigeration because the bacteria are living organisms and live longer in the cold.

Glutamine

Glutamine is used in the treatment of weight loss, diarrhea, and intestinal upset. It is used as a fuel by the colon and brain, helping the cells to repair and regenerate. It's especially important for your body during acute stress. Since glutamine is an amino acid, it also acts as a building block for muscle and can help decrease muscle wasting, in conjunction with a proper diet. Glutamine is also very costly.

As the word "supplement" suggests, these products should be an adjunct to a healthy diet that includes at least five servings of fruits and vegetables every day. Exercise is also important to help your body maintain muscle mass, elevate your mood, and decrease blood fats. Supplements are only one step in providing your body with what it needs—a healthy mind and spirit are also key factors to long-term wellness. For more detailed and individualized advice, see a naturopathic doctor and start creating your own supplements toolbox. ⊕

__Dr. Jennifer Hillier__, ND, is a naturopathic physician who founded and volunteered for the BCPWA Society's Naturopathic Clinic. She currently practices in Ontario.

The ABCs of HIV treatment & care is coming to Sechelt in February

The ABCs is a free educational workshop series that covers HIV/AIDS treatments, side effects, opportunistic infections and related topics.

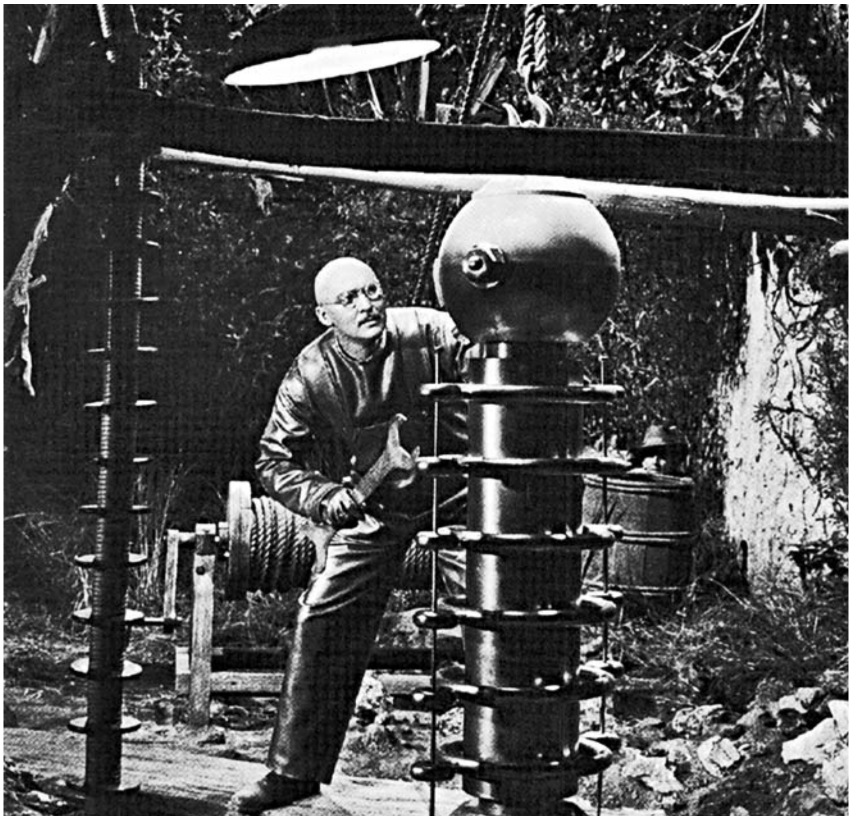
For more information about workshop dates, times and locations, please call our toll free number at 1.800.994.2437 ext. 376.

British Columbia
Persons With AIDS Society

Proving the obvious

Investigators explore duplication in clinical trials and uncover scientific overkill

by Derek Thaczuk



Well into the third decade of HIV/AIDS, research is still frustratingly sparse in all too many areas of this disease—complementary therapies, for example. But what about the converse? Can medical research ever just bog down in too many darn studies?

According to a Canadian research team, the answer is apparently: "And how!" Last year, lead investigator Dean Fergusson from the Ottawa Health Research Institute and a team from McGill University analyzed one specific question in clinical care. The clinical issue itself—how effectively does the drug aprotinin control bleeding after cardiac operations—was selected as an illustrative example. The real question was how many clinical trials had been conducted on the issue, and how much attention had been paid to each of them. (The study, published in ***Clinical Trials***, earned an editorial in ***The Lancet***).

The answers were shocking. Fergusson's group found that no fewer than 64 separate clinical trials between 1987 and 2002 had addressed the single question: how effective is aprotinin? Some key findings:

- Results of all 64 trials were published in 62 articles in peer-reviewed medical journals.
- Cumulative analysis shows that drug effectiveness was clearly established after the twelfth, yet a whopping 52 more studies were conducted.
- Each study, on average, referenced only 20 percent of the previously published studies.

Most study designs were similar

These numbers raise the obvious question: what the hell happened? Several published commentaries and editorials speculated on the reasons. Were previous results unpublished or otherwise unavailable? No luck there: Fergusson's study allowed for a one-year lag in publishing. Did the more recent studies refine the original question? Again, largely no: most study designs were essentially similar.

Were the individual trial results inconclusive? Now we're getting warmer: some of the single trial results do not show a dramatic benefit for aprotinin. However, this needs to be analyzed more closely. First, although some results were ambivalent, many more showed a clear benefit. Second, simply rehashing an inconclusive trial would be pointless: the results, in all likelihood, would be just as doubtful. Conclusive results would require more data, either from a larger trial (that is, with more patients), or by using a technique called "meta-analysis" to compile individual results into a statistically accurate summary.

In fact, larger trials were conducted; the largest one, which studied 1,784 patients, was published in 1992. However, only seven out of the 44 subsequent studies cited it. Moreover, there were two systematic meta-analyses: one, a summary of 16 trials, was published in 1994, the other, a summary of 45 trials, was published in 1997. Both clearly showed that aprotinin was effective. Yet only two published clinical trials made reference to these meta-analyses.

Researchers are not doing their homework

The reason for the wasted effort appears to be the obvious one—that the later investigators simply didn't do their homework. Clinical trials begin with a literature search, a trawl through the existing published data, so the prospective study can be planned accordingly. In the case of aprotinin, it looks like some studies got singled out for reference early on, while others just fell by the wayside and stayed there. This is almost impossible to understand in the age of electronic publishing. As Fergusson writes, “all...publications were easily identifiable through Internet literature search....PubMed identified 58 of the 62 publications.”

The whole system of checks and balances seems to have failed. In an article published in ***Clinical Trials*** entitled “The scandalous failure of science to cumulate evidence scientifically,” author Iain Chalmers criticizes “the investigators doing those 52 [unnecessary] trials, but also ... the institutions that funded the research, the ethical bodies that permitted it, and the journals which continued to publish the results despite the fact that they contributed little or nothing to the scientific record.”

Some obvious questions emerge from Fergusson’s analysis. Was this just a fluke? Is this wasteful scenario the exception or the rule? For this article, we couldn’t conduct an in-depth analysis. However, researchers at the Canadian HIV Trials Network (CTN) were able to provide some insights. First of all, repeating a study is not necessarily a bad thing. Repeatability is a cornerstone of science—if you can do it over there, we should be able to do it here. Single studies are generally not deemed sufficient: findings become definitive only when they are duplicated by similar studies.

Less duplication in HIV research

The knack, obviously, lies in deciding what’s definitive enough, which, admittedly, is a grey area. CTN scientists believe that we generally don’t see this kind of wasteful duplication in HIV research—at least not to the absurd extent seen in the aprotinin example.

A lot hinges on scrutiny. There’s always the risk that published research will end up gathering dust on the shelf. HIV clinical research, however, is a relatively new and fast-paced field. (Although it may not seem so at times!) New results have many eyes upon them; findings tend to be eagerly awaited, pounced upon, dissected, and publicized. In this atmosphere, which is more like a stock exchange than a dusty library, lapses in research quality aren’t impossible, but they’re more likely to be spotted and critiqued.

Investigators found that no fewer than 64 separate clinical trials between 1987 and 2002 had addressed the single question: how effective is aprotinin?

Centralized resources such as the Canadian HIV Trials Network also serve to monitor and coordinate clinical research. The CTN points out that researchers, now more than ever, are actively encouraged to work within these systems. As of last summer, 12 leading medical journals made trial registration a requirement for results publication. In another example of self-policing, ***The Lancet*** has announced a new editorial policy: the journal will now require authors “to include a clear summary of previous research findings, and to explain how their trial’s findings affect this summary.”

The question of research self-policing leads directly into the infrastructure of medical research. This is a fascinating area in itself, which will be described more fully in part two of this article in the March/April 2006 issue of ***living*** **⊕**. To that end, comments and discussion of these issues are welcome, and can be sent to dt@readablewriting.ca. ⊕

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

Prophylaxis and treatment guidelines for shingles

by Sam Friedman

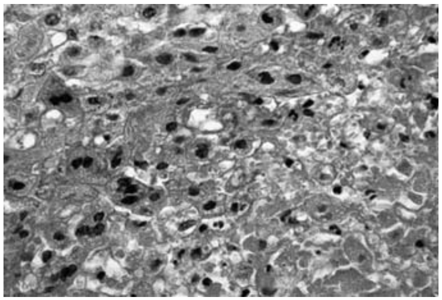
Knowing which pathogens (micro-organisms such as bacteria and viruses) you've acquired and which you've lost immunity to is a prudent part of managing your HIV disease. You can determine this through simple antibody/antigen tests, which can help your doctor determine what immunizations you may need, when to start or stop prophylaxis (preventative treatment) for specific opportunistic infections (OIs), and the best way to treat OIs if they occur.

Shingles is a common OI among people with HIV. It's a viral infection caused by a reactivated infection of the varicella-zoster virus (VZV), which is the chickenpox virus. Ninety-five percent of adults have been exposed to or vaccinated with VZV, usually in childhood, but if you are severely immunocompromised, you may have lost any immunity you once had.

Shingles is characterized by pain that feels like a burn or muscle injury, leading to sores that resemble chickenpox. In rare situations—but usually when CD4 count drops below 50—VZV can cause other complications:

- sores spreading over the body and affecting deeper tissues
- retinal necrosis, if the shingles affects your eye, which can lead to vision loss
- inflammation of the spinal cord, causing muscle weakness, loss of sensation, paralysis, and encephalitis (inflammation of the brain) and/or stroke

While there is no proven treatment for the prevention of shingles in people with advanced HIV, there are precautions you can take to reduce the chances of getting a VZV infection. First, avoid physical contact with anyone with chickenpox or shingles. Also, get tested for VZV antibodies or antigens, to know whether or not you have immunity to it. If you test negative for VZV and your CD4 count is over 200, consider getting the VZV vaccine. If your CD4 count is below 200, however, the vaccination can cause shingles or chickenpox.


Inclusion bodies typical of varicella-zoster virus infection (shingles).

If your CD4 count is below 200 and you've been in contact with someone with chickenpox or shingles, it's recommended that you take five 1.25ml vials of varicella zoster immune globulin by intramuscular injection less than 96 hours after exposure—though within 48 hours is better.

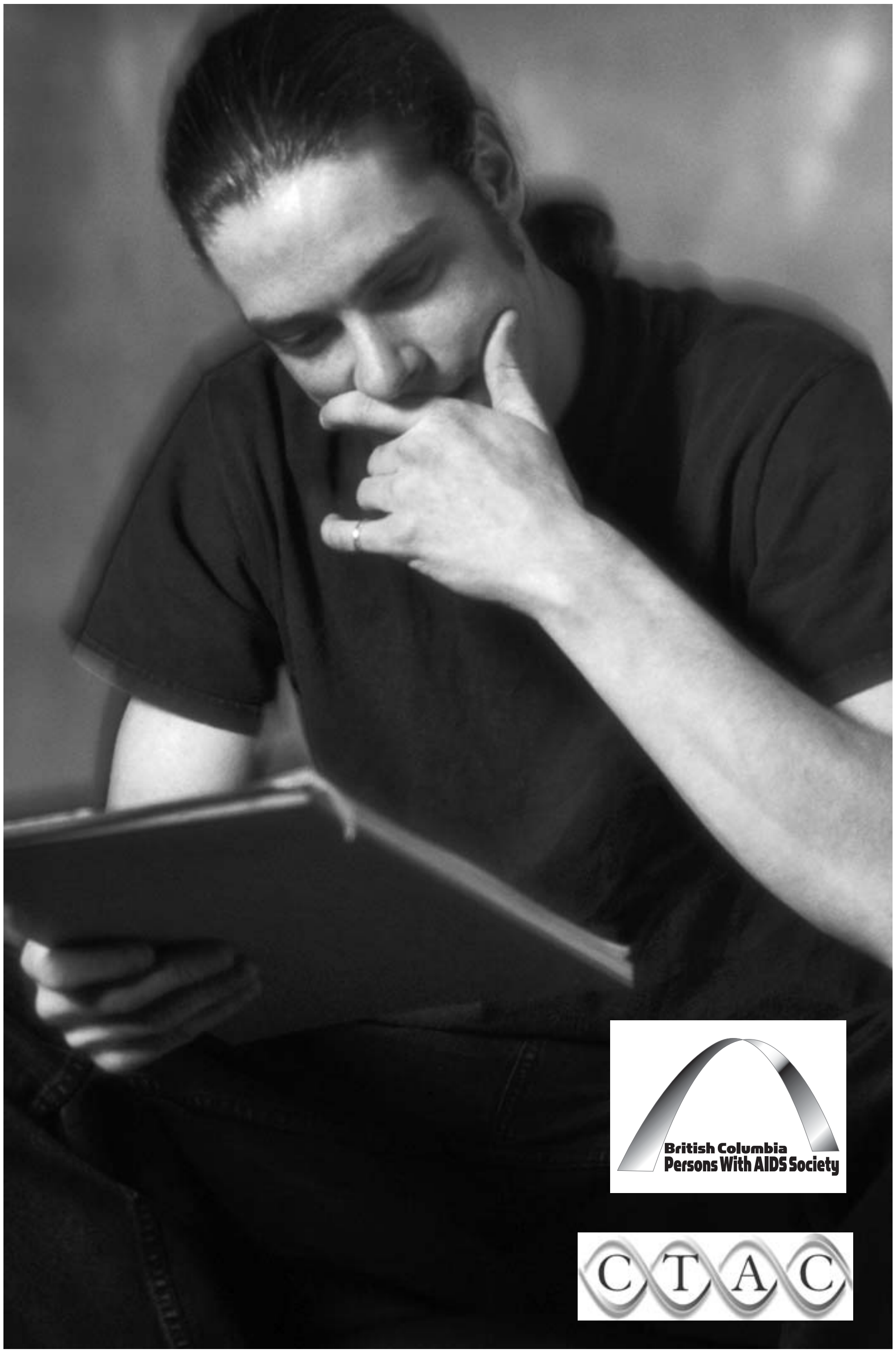
If you have shingles symptoms, take either 500mg of famciclovir (Famvir) or 1g of valacyclovir (Valtrex) orally three times a day for seven to 10 days. If the lesions are extensive or deeper in the tissue, initiate IV acyclovir (Zovirax) and continue it until the lesions begin to clear up. Progression of retinal necrosis is rapid when CD4 counts are under 50; the recommended treatment is high-dose IV acyclovir in combination with foscarnet (Foscavir) followed by oral valacyclovir.

An unfortunate lasting side effect of shingles is a constant pain, burning and/or itching where the outbreak occurred. ⊕

For more information, contact the BCPWA Society Treatment Information Program at 604.893.2243, toll-free at 1.800.994.2437, or e-mail treatment@bcpwa.org. Or visit the following Web sites:

- ***www.thebody.com***
- ***www.medscape.com***
- ***www.cdc.gov***
- ***www.cfenet.ubc.ca***

__Sam Friedman__ is a provincial and national AIDS activist and advocate and a Canadian Trials Network Community Advisory Committee member. He sits on several BCPWA Society Standing Committees and writes for living ⊕.



2005 PASS Study Results

The BC Persons With AIDS Society (BCPWA) and The Canadian Treatment Action Council (CTAC) invite you to a free presentation and dinner.

The presentation will report on results of the Post Approval Surveillance System (PASS) study that tested community-based ways of reporting side effects to HIV drugs. Participants will learn about the current side effect reporting system in Canada and exchange ideas about the key role that HIV-positive persons and AIDS organizations can play in improving it.

Date: Tuesday, February 7, 2006

Location: Hotel Château Granville,
1100 Granville Street (corner of Seymour St.)

Room: Château Room, Ground Floor

Time: 5PM – 8PM

Cost: Free

Please RSVP to 604.646.5338 and specify if you would like chicken or fish.

Face value

Lipoatrophy continues to be one of the most devastating conditions for PWAs

by Diana Johansen

Lipodystrophy was first noted soon after highly active antiretroviral therapy (HAART) became a standard of care in the Western world. Initially it was thought that all body fat changes and the metabolic complications were part of the same syndrome, but we now know that there are four distinct conditions—including lipoatrophy—that collectively make up lipodystrophy syndrome.

Lipoatrophy refers to fat (lipo) wasting (atrophy) with unique contributing factors and manifestations. For many people with HIV, it's the most difficult condition to deal with, even though the medical consequences may not be as severe as the metabolic complications of lipodystrophy.

The symptoms of lipoatrophy

Lipoatrophy in HIV infection refers to a loss of subcutaneous fat (just below the skin) in the face, arms, legs, buttocks, and sometimes the torso. The process somewhat resembles fat wasting due to starvation but is more pronounced in certain areas and the appearance is more dramatic.

In the limbs, it's typical to see bulging veins and preserved muscle mass, which is not the case in simple starvation. The face loses fat in an atypical pattern that includes cheeks, temples, and areas around the nose, mouth, and eyes. In severe cases, you can lose functional fat around the eyes and jaws as well. Loss of fat in these areas results in deep naso-labial (nose to mouth) folds, projections of zygoma (cheekbones), and a skeletal look around the eyes. People look emaciated but could actually be well nourished.

It's important to differentiate between lipoatrophy and general wasting, which includes the loss of muscle mass. While it can be disturbing to lose body fat, it's critical to preserve lean body mass. Sometimes a thinning of the limbs and buttocks is ascribed solely to fat wasting from lipodystrophy but there may be an underlying wasting process unfolding. The only way to determine the cause of thinning is to do body composition measurements such as a Bioelectrical Impedance Analysis (BIA) test or circumference and skin fold measurements with a measuring tape and calipers.

Facial wasting is assessed in terms of severity:

- Grade I describes mild localized atrophy that may not be noticeable
- Grade II indicates more visible hollowing with pronounced cheekbones
- Grade III is more advanced wasting that is definitely noticeable
- Grade IV is the most severe case where loss of fat has extended to all areas of the face, making it "the new face of AIDS," in the opinion of many

What causes it

Researchers have identified different mechanisms that contribute to fat wasting. Like everything that happens in the human body, the process is complex. Mitochondrial toxicity from HAART has widespread effects throughout the body's systems, including playing a role in fat wasting. Mitochondria, the energy-producing machines in cells, have their own mitochondrial DNA that can be depleted by drug toxicity.

The evidence that mitochondrial depletion has a role in lipoatrophy comes from studies that show lower levels of mitochondria in the fat cells of people with the disorder. Other studies have revealed a blockage in the biochemical pathway through which new fat cells usually differentiate into mature fat cells capable of storing fat. The enzymes responsible for this activity are present but appear to be dysfunctional. Also, high levels of TNF-α and other cytokines that cause the death of fat cells have been found in cells from lipoatrophic fat tissue. In other words, the fat cells die off and the body is unable to make new ones.

Understanding the underlying mechanism has not made it easier to predict who will develop lipoatrophy. The interaction between the person, the disease, and the medications is complex. There is no doubt that nucleoside reverse transcriptase inhibitors (NRTI) have a strong impact in the development of lipoatrophy. One type of NRTI, called thymidine analogues (D4T and AZT), appears to have the most powerful effect, with D4T being the worst offender. It has also been suggested that older age, longer duration of therapy, and protease inhibitor use in conjunction with NRTIs may increase the risk.

Some studies have shown that thinner individuals are more likely to lose their subcutaneous fat, however it's easier to see fat loss on a thin person. It may be that fatter people lose as much, or even more, fat but that the loss is less visible. To complicate matters, recent information from a conference on antiretroviral toxicity suggests that the most important contributing factor to developing lipoatrophy is the type of medication used in the treatment of the HIV infection.

Plastic surgery remains the most effective treatment for people with severe facial wasting, but it's expensive and not covered by most medical plans.

Reversing the effects

The "ounce of prevention" approach now influences treatment decisions so that drugs more likely to cause mitochondrial toxicity and lipodystrophy can be avoided as long as possible. People on a D4T-containing regimen may be offered a switch to a more tolerable regimen.

Studies have shown that some people are able to recover subcutaneous fat when they switch therapy to more favourable medications like tenofovir (Viread) and abacavir (Ziagen). The changes are not dramatic, however, and can take up to two years to be noticeable. There is no guarantee that everyone who changes therapy will experience fat recovery, but it's worth a try if the medication history and resistance profile allow for the switch.

Researchers are studying other medications to see if fat cells can be stimulated to function better. These medications include a class of drugs called glitazones: diabetes medications that seem to stimulate growth of subcutaneous fat. Currently, glitazones are used to treat lipodystrophy in a study setting only and the results have been mixed.

While there is good evidence that diet and exercise will benefit fat accumulation and metabolic complications, they have little effect on lipoatrophy. However, it's important to remember that any weight loss will worsen facial wasting.

Plastic surgery

Plastic surgery remains the most effective treatment for people with severe facial wasting, but it's expensive and not covered by most medical plans. (Although most people only consider facial filling, a few hardy individuals opt for buttocks reconstruction.) A number of different techniques use fillers to replace the lost fat. Facial fillers can be injected or surgically implanted using solid materials. They can be temporary, semi-permanent, or permanent.

There are a number of injectable fillers but the three main ones used in HIV are silicone oil, Bio-Alchamid, and NewFill (Sculptra). A newer product, Radiesse, has shown promising results. Silicone oil lasts the longest and is safe as long as you don't have too much injected. NewFill (polylactic acid) is more temporary and requires a series of injections. The end result varies from individual to individual. Bio-Alchamid has a more dramatic effect but requires a more technical and difficult surgical procedure. It can be injected in larger amounts so it can be used for larger areas, including buttocks reconstruction. Among other fillers, gortex is a solid implant that is surgically placed inside the cheek. It offers better results when used in conjunction with an injectable filler such as silicone oil.

Clearly, plastic surgery has dramatically helped address the devastating effects of facial wasting for many individuals. Bear in mind, however, that plastic surgery transforms your facial appearance rapidly and may lead to unwanted questions from friends and family.

Many studies have explored how lipodystrophy affects quality of life, but it may be impossible to get a really good understanding of its impact on a person's well-being. The condition raises issues like disclosure and confidentiality, loss of self image, and conflicting feelings about the advantages of taking HAART. Although antiretrovirals restore health, the ***appearance*** of health declines.

In ***AIDS and its Metaphors***, Susan Sontag wrote of how we place importance on facial appearance: "Our very notion of the person, of dignity, depend on the separation of face from body. And, however lethal, illnesses like heart attacks and influenza that do not damage or deform the face never arouse the deepest dread." ⊕

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

STRAIGHT
from the source

what's new in research

The ongoing debate on the effect of HCV on HIV

by Anne Drummond

Hepatitis C virus (HCV) infection is common in a number of HIV-positive populations, with the highest prevalence among the most marginalized people—injection drug users, Aboriginals, and women. HIV-HCV co-infection has been associated with rapid progression to HCV-related liver disease and with a greater risk of developing HCV-related cirrhosis of the liver. As highly active antiretroviral therapy (HAART) and prevention and treatment of opportunistic infections have increased the lifespan of HIV-HCV co-infected people, HCV-related liver disease has become a major cause of hospital admissions and death among people with HIV.

Despite numerous studies addressing the effect of HCV on HIV disease progression, there is little consensus in the results; the topic thus remains one of the most debated and contentious issues among researchers into HIV infection. The results of five studies published in 2005 are characteristic of this debate. Rockstroh and colleagues showed that HCV status did not influence the incidence of AIDS-defining illness or death in the EuroSIDA cohort of HIV-positive patients.

Three other studies, however, showed that HIV-HCV co-infection was associated with faster onset of AIDS-defining illness, lower CD4 cells counts, and increased risk of HIV-related death. All authors acknowledged the confounding effects of drug and alcohol abuse and psychiatric illness on clinical outcomes in these study populations.

In Vancouver, an epidemic of HIV and HCV infection among the city's drug users provided the impetus for Dr. Paula Braitstein and her colleagues at the BC Centre for Excellence in HIV/AIDS to investigate the effect of HCV on the risk of HIV-related death. They drew data for their analysis from clients accessing antiretroviral drugs from the HIV/AIDS Drug Treatment Program at St Paul's Hospital in Vancouver. They included in their analysis all program clients who had started an antiretroviral regimen consisting of two nucleoside reverse transcriptase inhibitors (NRTIs) plus either a protease inhibitor or a non-nucleoside reverse transcriptase inhibitor (NNRTI) between July 1996 and July 2000.

Of the 1,186 people monitored, 51 percent were HCV-positive and 49 percent were HCV-negative. Of the 163 deaths from natural causes that occurred during the study, 118 were among HCV-positive patients. Co-infected people were also significantly more likely to die of HIV-related causes than were people infected only with HIV. When investigators examined the statistical probability of survival of HIV-positive people, HCV seropositivity was strongly predictive of an untimely death, especially HIV-related death.

The results from this study are useful as they provide further evidence that HCV co-infection does have an adverse effect on HIV disease progression and HIV/AIDS-related mortality. In addition, because the investigators took the data for this study from an HIV population-based cohort, the results are more generally applicable than other similar studies. As such, the results allow for a more accurate characterization of this particular subset of the HIV-positive population.

Further research is needed to identify the actual mechanism that causes the hepatitis C virus to influence HIV disease progression. The hepatitis C virus does not directly kill liver cells; rather, liver damage results from the interaction between the virus and the host's immune system. Scientists have suggested that HCV and associated liver damage may accelerate HIV disease progression either by reducing the efficacy of HAART, thus completely precluding the use of some hepatotoxic antiretrovirals, or by suppressing the host's immune system. ⊕

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

Updates from the Canadian HIV Trials Network

Can valproic acid lure HIV out of hiding?

by Julie Schneiderman

New research suggests we might finally have the ability to tap into latent HIV reservoirs. Results from a proof-of-concept study published in August 2005 in the ***The Lancet*** led to a flurry of attention over the potential effects of valproic acid (Depakene). Valproic acid is presently on the market and approved for use as an anticonvulsant.

The team of Texas-based researchers set out to assess the efficacy of a standard clinical dose of valproic acid to deplete HIV from resting CD4 cells. Unlike highly active antiretroviral therapy (HAART), which attacks the virus but cannot access and block the latent reserves, their pilot study showed that in three out of the four participants the amount of resting cell infection was reduced by an average of 75 percent.

Researchers believe that once valproic acid has flushed out and isolated the virus, a combination of antiretroviral therapy, vaccines, and other interventions might be able to effectively purge the virus from the body. The methods used to treat HIV in the future, then, might not be much different from strategies currently used to treat certain types of cancers.

To further test these concepts, Canadian HIV Trials Network (CTN) investigators Drs. Jean-Pierre Routy, Cecile Tremblay, and Rafick-Pierre Sékaly and their team at McGill University have proposed a clinical trial using valproic acid to lure latent HIV reserves out of cells and then block their re-entry (CTN 205). Since reservoirs have continued to be one of the most complex elements of the disease, valproic acid could be the key to unlocking some of the mysteries. As Dr. Routy explained: “It used to be a mission impossible to play with reservoirs and now this is a first step.”

Routy and his colleagues had initially planned a single-site study with approximately 50 participants. However, following the CTN’s semi-annual meetings in Montreal, new sites have agreed to participate. In addition to Montreal Chest and Hôtel Dieu (CHUM), they include: Dr. Julio Montaner, St. Paul’s Hospital, Vancouver; Dr. Danielle Rouleau, Notre-Dame Hospital, Montreal; Dr. Benoît Trottier, Clinique Médicale l’Actuel, Montreal; Dr. Jonathan Angel, Ottawa General Hospital; Dr. Jean Guy Baril, Clinique Médicale du Quartier Latin, Montreal. These sites could increase participation to at least 75 people. The study expects to begin enrolling in early 2006.

Research on valproic acid is not without its critics who are hesitant to point to results until further research is done. Others caution that while resting CD4 T-cells remain an important hiding spot for HIV, it is still unclear whether reservoirs of the virus can stay latent elsewhere in the body. Despite the skepticism and words of warning, Dr. Routy is optimistic about the study and its long-term potential for furthering research: “It is amazing to see that something can even begin to crack the enormous wall of HIV.” ⊕

__Julie Schneiderman__ is the communications manager at the Canadian HIV Trials Network in Vancouver.

Trials enrolling in BC

CTN 147 —	Early Versus Delayed Pneumococcal Vaccination *BC sites*: Downtown Infectious Disease Clinic (IDC) and St. Paul’s Hospital, Providence Health Care, Vancouver
CTN 167 —	OPTIMA: Options with Antiretrovirals *BC sites*: Viron Health, Downtown IDC, and St. Paul’s Hospital, Vancouver, Cool Aid Community Health Centre, Victoria and Medical Arts Health Research Group, Kelowna
CTN 178 —	Effect of Rosiglitazone Maleate (Avandia) on Blood Vessels *BC site*: St. Paul’s Hospital, Vancouver
CTN 189 —	3TC or No 3TC for HIV with 3TC Resistance *BC sites:* St. Paul’s Hospital, Vancouve; and Cool Aid Community Health Centre, Victoriar
CTN 190 —	SMART: Strategies for Management of Antiretroviral Therapy *BC site:* Downtown IDC, Vancouver

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

Abandono al propio placer

Por Sergio Plata

Desde la época victoriana hasta entrado el siglo XX la masturbación ha sido vista como algo perverso, inmoral, sucio y malo para la salud. En algunos momentos incluso se llegó a relacionar el acto de la masturbación con enfermedades como la tuberculosis, la locura, la parálisis, la perdida de cabello y la ceguera. Para evitar la masturbación, las mujeres eran obligadas a utilizar guantes de material áspero, y los hombres debían usar correas de castidad que impedían la erección del pene.

En 1896 Sigmund Freud señalaba que el onanismo inmoderado era el causante de la neurastenia. La masturbación era considerada como el vicio secreto y la causa de todos los males: músculos fláccidos, espalda débil, ojos hundidos y sin brillos, manos húmedas, mirada huidiza, debilidad, fallas en la memoria y en la capacidad de pensar. También se pensaba que la masturbación era una manifestación de otras patologías.

Afortunadamente se han ido rompiendo mitos y tabúes entorno a la masturbación y es en 1972 cuando la American Medical Association declara que la masturbación es normal, después de haber sido considerada como una enfermedad durante casi doscientos años.

En la década de los ‘60 surgen movimientos feministas reivindicatorios de la sexualidad de la mujer y de sus derechos. La masturbación pasó a ocupar un lugar preponderante y a ser considerada como una forma de expresión sexual. En los años ’70, una representante de grupos feministas, Betty Dodson, comenzó a dirigir talleres de aprendizaje de masturbación para mujeres. En sus talleres las participantes se familiarizaban con el uso de vibradores, reconocían sus genitales a través del uso de espéculos, aprendían nuevas técnicas y realizaban tareas sexuales en sus casas que luego comentaban en el grupo.

Posteriormente la ciencia médica revalorizó la masturbación como herramienta terapéutica y se crearon terapias sexuales que actualmente se llevan a cabo para tratar la eyaculación precoz, la eyaculación retardada y la anorgasmia.

El autoerotismo nos enseña que somos totalmente activos sexualmente, es una manera de aprender a separar el amor del sexo, nos permite ser mejores compañeros sexuales, nos enseña la anatomía genital y también nos enseña a aceptar el resto de nuestro cuerpo. A las mujeres les permite mantener lubricada la vagina, ayuda con el dolor menstrual y la congestión pelviana y a los hombres ayuda a mantener el buen funcionamiento de reflejos de la erección y la eyaculación.

Los estudios demuestran que el 90 por ciento de los hombres y el 70 por ciento de las mujeres se masturban.La masturbación es parte de la sexualidad humana y es algo que se debe enseñar, es una actividad sexual saludable, es una manera de disfrutar el cuerpo y procurarse placer. En tiempos de VIH/SIDA la masturbación ha aumentado considerablemente, en algunos países se ha propuesto como una forma de sexo seguro.

La masturbación nos ayuda a relajarnos física, mental y emocionalmente. Es un acto de redescubrimiento que nos permite prepararnos para posteriores relaciones. “La masturbación es legal y es segura.” ⊕

BCPWA Treatment Information Program (TIP)

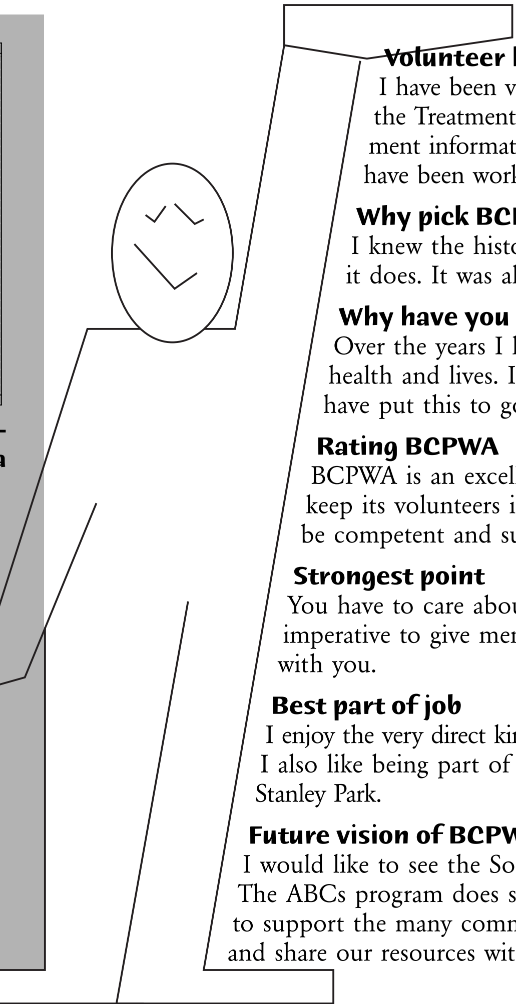
Ofrece información en español sobre tratamientos del VIH/SIDA.
Todos los miercoles 1:00PM a 5:00PM.
1107 Seymour Street, 2nd Floor,Vancouver, BC V6G 5S8
Llame a la línea directa: 604.893.2243
email: treatment@bcpwa.org

Volunteering at BCPWA

Profile of a volunteer: Wayne Moore

Wayne is more than a treatment volunteer. He is also a friend, and someone who cares deeply for those around him.

Zoran Stjepanovic
Coordinator of Treatment Information



Volunteer history

I have been volunteering at BCPWA for seven years. I started in the Treatment Information and Advocacy Department as a treatment information peer counsellor and as an ABCs presenter. I have been working there ever since.

Why pick BCPWA?

I knew the history of the organization and liked the work that it does. It was also a way to give back to my community.

Why have you stayed?

Over the years I have seen how much my work impacts people's health and lives. I have also learned a tremendous amount and have put this to good use in my own life.

Rating BCPWA

BCPWA is an excellent place to volunteer. The Society does a lot to keep its volunteers involved. It also provides them with the tools to be competent and successful volunteers.

Strongest point

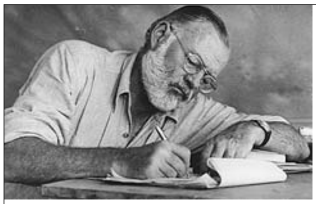
You have to care about people and be interested in their stories. It's imperative to give members the opportunity to share their experiences with you.

Best part of job

I enjoy the very direct kind of communication I have with our membership. I also like being part of a team, our meeting and socials, and picnics in Stanley Park.

Future vision of BCPWA

I would like to see the Society reach more people across the province. The ABCs program does some outreach, but we need to do more in order to support the many communities and organizations around the province and share our resources with them.



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 V6G 1J6
t 604.682.5992 ***f*** 604.682.3592
e info@friendsforlife.ca
www.friendsforlife.ca

Healing Our Spirit
3144 Dollarton Highway,
North Vancouver, BC V7H 1B3
t 604.879.8884 or 1 866.745.8884
e info@healingourspirit.org
www.healingourspirit.org

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

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

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

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

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

Positive Living North
1–1563 2nd Ave,
Prince George, BC V2L 3B8
t 250.562.1172 ***f*** 250.562.3317
e info@positivelivingnorth.ca
www.positivelivingnorth.ca

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

Positive Women's Network
614 – 1033 Davie St, Vancouver, BC V6E 1M7
t 604.692.3000 or 1.866.692.3001
e pwn@pwn.bc.ca ***www***.pwn.bc.ca

Purpose Society HIV/AIDS program
40 Begbie Street
New Westminster, BC V3M 3L9
t 604.526.2522 ***f*** 604.526.6546

Red Road HIV/AIDS Network Society
804 – 100 Park Royal South,
W. Vancouver, BC V7T 1A2
t 604.913.3332 or 1.800.336.9726
e info@red-road.org ***www***.red-road.org

Vancouver Native Health Society
441 East Hastings St, Vancouver, BC V6G 1B4
t 604.254.9949
e vnhs@shaw.ca

Victoria AIDS Resource & Community Service Society
1284 F Gladstone Ave, Victoria, BC V8T 1G6
t 250.388.6620 ***f*** 250.388.7011
e varcs@islandnet.com
www.varcs.org/varcs./varcs.nsf

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

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

YouthCO AIDS Society
205 – 1104 Hornby St. ,
Vancouver BC V6Z 1V8
t 604.688.1441 1.877.968.8426
e information@youthco.org
www.youthco.org

For more comprehensive listings of HIV/AIDS organizations and services please visit www.bcpwa.org.

Upcoming BCPWA Society Board Meetings:

Date	Time	Location	Reports to be presented
January 18, 2006	1:00	Board Room	Written Executive Director Report / Executive Committee
February 1, 2006	1:00	Board Room	Quarterly Department Reports / Standing Committees Financial Statements — December
February 15, 2006	1:00	Board Room	Written Executive Director Report / Director of TIAD
March 1, 2006	1:00	Board Room	Executive Committee / Financial Statements - January Director of Development

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

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

BCPWA Standing Committees and Subcommittees

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

Board & Volunteer Development
Contact: Teresa Stancioff
t 604.646.5377 e teresas@bcpwa.org

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

Education & Communications
Contact: Lisa Gallo
t 604.893.2209 e lisag@bcpwa.org

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

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

living ⊕ Magazine
Contact: Jeff Rotin
t 604.893.2206 e jeffr@bcpwa.org

Prevention
Contact: Ross Harvey
t 604.893.2252 e rossh@bcpwa.org

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

Treatment Information & Advocacy
Contact: Tarel Quandt
t 604.893.2284 e tarelq@bcpwa.org

Yes! I want to receive living⊕ magazine

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Address ______________________ City ________________

Province/State _____ Country______________ Postal/Zip Code________

Phone _______________ E-mail _________________________

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

○ $25 within Canada ○ $50 (Canadian $) International
please send ______ subscription(s)

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

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

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

* *Annual subscription includes 6 issues* ***Cheque payable to BCPWA***

www.bcpwa.org

living⊕

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

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

Brushes with greatness

Sometimes interactions with famous people can make you re-evaluate your criteria of stardom

by Denise Becker

I have probably had so many so-called brushes with greatness that I sometimes feel like an extra on my own stage of life. I've met Elton John, Jimmy Connors, Bjorn Borg, Colin James, Vicki Gabereau—even the Queen!

I met my heartthrob, David Cassidy, when I was 21. I asked him to sign my dinner theatre program. When he found out my name, he began to sing the Blondie song, "Denise, Denise, I'm so in love with you...." Can it get much better than that? Well, yes, if you're a Bryan Adams fan. Bryan was signing autographs in a Chapters bookstore. Hating to queue up for anything, I decided to catch him on his way in to the store. As he stepped out of the limo, I shouted, "Bryan, I need your autograph!"

"Sorry, you'll have to join the line-up inside," he replied.

Undaunted, I pleaded, "But, Bryan, my husband's waiting for his tea!"

"You cheeky devil," he laughed as he came over to sign my CD.

But as my world has changed, and as I've faced living with HIV I've gotten pickier about who I classify as a great person. I believe that true greatness is embodied in those who have made a difference to the world, often despite seemingly insurmountable odds. By that standard, my list of brushes with greatness gets very, very short.

Stephen Lewis, the UN Special Envoy for HIV/AIDS in Africa, definitely makes the cut. I met him in Vancouver last year. His love for his job despite his personal struggle with depression and grief makes him a true hero in my eyes. A humble man, he was embarrassed by all the attention he was receiving and gladly came to sit at our table to discuss HIV, women, and children. It was the thrill of a lifetime to meet him and he showed genuine interest in what was being done at a local level to help people with HIV. He made us feel like *we* were the celebrities.

I also met Dr. Jonathan Mann, AIDS activist and researcher, and the first director of the World Health Organization's Global Programme on AIDS. He was a philosopher who could see the future of AIDS and the terrible pandemic it was becoming. He saw how the AIDS movement was falling apart from divisiveness and infighting. His message was solidarity. While at a conference on children with HIV in England in November 1996, he and his then fiancée, Dr. Mary Lou Clements, came over to speak to me. They commended me for speaking out about women and children with HIV. Tragically, they were killed in the ill-fated Swiss Air Flight 111, which crashed off Peggy's Cove in Nova Scotia in 1998.

But my most cherished brush with greatness is with Nobel Peace Prize winner Elie Wiesel of Boston University. Wiesel was just 15 when he and his family went to Auschwitz. He wrote about his experience in his book, ***Night***, and went on to become the founding Chairman of the US Holocaust Memorial Council and the chairman of The Elie Wiesel Foundation for Humanity. Wiesel has used his fame to plead for justice for oppressed peoples in the Soviet Union, South Africa, Vietnam, Biafra, and Bangladesh.

I believe that true greatness is embodied in those who have made a difference to the world, often despite seemingly insurmountable odds.

I once wrote to Wiesel, and in his reply he wrote that my story was a sad one and added, "the strength and hope you display are inspiring." I was dumbfounded to discover that this man was inspired by my story. To receive such words from my hero gave me strength.

That letter from Wiesel made me realize that we all have the ability to be stars on the stages of our lives and that, quite possibly, the people we meet along the way are the extras who can help us make our own stories into great ones. And we all have that potential. As Lloyd Bridges said in the film ***Cousins***: "Sometimes you just have to make chicken soup out of chicken shit." ⊕

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