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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 . . .

A step backwards

by Glyn Townson

At the recent Pacific AIDS Network forum in Cranbrook, Margaret Birrell of the BC Coalition of Persons with Disabilities announced information about new advance care directive legislation proposed by the provincial government.

Advance care directives are stand-alone written instructions that would override representation agreements (an estate-planning legal document that says who you give authority to if you need assistance managing your affairs). This proposed legislation would give authority for quality of life decisions to your care provider, who may know little about your particular circumstances. There is also the risk that patients may feel pressured into signing these agreements; patients may feel that signing is part of the procedure necessary to access care and may not fully understand the implications of these directives.

The potential for serious ethical conflicts exists: the service providers promoting these advance care directives are also the ones who decide the level of care you should receive. There's a potential for misuse, as people are often at their most vulnerable when accessing care and may feel pressured into life-changing decisions.

The advance care directive is a step backwards from our current safeguards and laws. British Columbia currently has the best system in the country with its ***Representation Agreement Act***, and doesn't need this new legislation.

The proposed legislation, if it becomes law, could seriously jeopardize the ***Representation Agreement Act*** that so many seniors and disability organizations, as well as individuals, have fought hard to create and maintain for the past 16 years.

The Community Coalition for the Implementation of Adult Guardianship Legislation has created a petition for groups and individuals opposed to this new legislation. The BCPWA Society has signed the petition, because we feel the ***Representation Agreement Act*** should be the only legal tool for advance care planning.

You can find further information on advanced care directives and the petition at www.bccpd.bc.ca. ⊕

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

REALITYBITES

News from home & around the world

BCPWA receives broadcast award

BCPWA Society has been named the recipient of the BC Association of Broadcasters' 2006 Humanitarian Award.

Beginning in July 2006 and running for a full year, television and radio broadcasters across BC will air, free of charge, two 30-second advertisements as part of an anti-discrimination campaign supplied by the BCPWA Society. Radio stations will broadcast a minimum of 520 airings; televisions stations will air between seven and 25 announcements per week. At current advertising rates, the broadcast value of the campaign is roughly $3 million.

The anti-discrimination campaign will focus on how ill-informed prejudices can make life terribly hard for HIV-positive persons.

The Cossette Communications Group has agreed to handle and finance the creative and the production of the television and radio spots, valued at more than $50,000. Circle Productions has graciously agreed to fund the production of the TV commercials.

Health records sold at public auction

The BC government has auctioned off computer tapes containing thousands of highly sensitive records, including information about people's medical conditions, their social insurance numbers, and their dates of birth.

Sold for $300 along with various other pieces of equipment, the 41 high-capacity data tapes were auctioned in mid-2005 at a site in Surrey that routinely sells government surplus items to the public.

Included among the files were records showing certain people's medical status—including whether they have a mental illness, HIV, or a substance-abuse problem—details of applications for social assistance, and whether or not people are fit to work. There were also hundreds of what appeared to be case-worker entries divulging extremely intimate details of people's lives.

Among the other files there was also a document containing more than 65,000 names along with corresponding social insurance numbers, birthdays, and what appeared to be amounts paid to each person for social support and shelter.

Source: Vancouver Sun

Lopinavir/ritonavir tablet filing in South Africa

On April 4, Abbott Laboratories announced that it had filed for registration of the new tablet formulation of lopinavir/ritonavir in South Africa. The South African government has granted fast-track review of the tablet formulation filing. This filing is a key milestone in Abbott's effort to pursue registration of the new tablet formulation in Africa and the least developed countries.

Abbott plans to maintain its current lopinavir/ritonavir price of $500 per patient per year in Africa and other developing countries for the new formulation. By maintaining this price, lopinavir/ritonavir will be one of the lowest-priced protease inhibitors in Africa and other undeveloped countries.

New coalition of handyDART users

The Coalition of HandyDART Users (CHU) is a group of seniors and people with disabilities working to find ways to improve handyDART service in the Greater Vancouver Regional District (GVRD). In late 2005, the group made a proposal to TransLink to put all handyDART services in the GVRD under one roof-as a wholly owned TransLink subsidiary

CHU feels the system isn't serving them as well as it could. They argue that most of the problems are due to multiple service providers across the GVRD, poor coordination, and a lack of long-term commitment to an ever-improving custom transit service.

If you would like to be added to CHU's mailing list or receive a copy of their report, contact Margaret Birrell, 604.875.0188 or Jane Dyson: 604.872.1278 or jwd@bccpd.bc.ca at the BC Coalition of People with Disabilities. Or visit the CHU Web site at www.bccpd.bc.ca/s/CurrentCampaigns.asp.

Doctor says HIV among addicts may double

A Victoria doctor at the Cool Aid Community Health Centre in Victoria, who has practiced inner-city medicine in Vancouver's Downtown Eastside and Victoria for the past 10 years, says that without new strategies and services to help intravenous drug users, the rate of HIV infection will double in that population.

Dr. Chris Fraser says HIV/AIDS In Victoria is a bigger problem than one would suspect. When injection drug use took off in the mid-1990s, so did the

REALITYBITES

News from home & around the world

spread of hepatitis C and HIV. Today, an estimated 20 per cent of the city's roughly 3,000 intravenous drug users has HIV or AIDS. "So there's about 600 injection drug users with HIV, and about one-third either don't know they're infected or are not engaged in regular care," he says.

Fraser worries that the percentage of injection drug users who are HIV positive could increase to 30 or even 40 per cent if those infected with the virus don't get proper care.

Source: Victoria Times Colonist

Study on PI use during pregnancy

An observational study from the University of Miami has found that the use of protease inhibitor-based antiretroviral therapy during pregnancy is associated with an increased risk of premature delivery. The study's findings were published in the May 1 edition of ***The Journal of Infectious Diseases***.

A number of observational studies have examined the effects of anti-HIV treatment on the outcomes of pregnancy, with diverging conclusions. For example, a large European cohort of 2,300 women found that exposure to antiretroviral therapy containing a protease inhibitor more than doubled the risk of pre-term delivery. In contrast, a recent study of 2,120 women from the US found no link between combination antiretroviral therapy and either pre-term delivery or low birth weight.

Investigators from Miami carried out an analysis of their data on outcomes in 1,337 HIV-positive women. They found that use of a combination including a protease inhibitor led to an elevated risk of delivery before 37 weeks' gestation, compared to combination therapy without a protease inhibitor.

Source: Aidsmap

Interaction between heroin substitute and atazanavir/ritonavir

Atazanavir (Reyataz) boosted by low dose ritonavir (Norvir) appears to interact with the opiate substitute, buprenorphine. In the March 21 edition of ***AIDS***, doctors from Connecticut report a series of cases demonstrating the interaction and recommend "the use of buprenorphine in combination with ritonavir and atazanavir should be undertaken cautiously."

The investigators report three cases of an interaction between atazanavir/ritonavir and buprenorphine. In all three cases the patients were also taking drugs from the nucleoside/nucleotide reverse transcriptase inhibitor class, but existing pharmacokinetic knowledge did not provide any reason for the doctors to expect an interaction between any of these antiretrovirals and buprenorphine.

A small test tube study had previously shown an increase in buprenorphine levels due to the blocking of its metabolism when used with ritonavir. Both drugs use the CYP3A4 pathway. The investigators speculate that atazanavir also inhibited a secondary pathway used to metabolize buprenorphine.

Source: Aidsmap

AIDS article in Harper's ignites controversy

A 15-page article in the March issue of ***Harper's Magazine***, titled "Out of Control: AIDS and the Corruption of Medical Science," has ignited controversy.

The article, by Celia Farber—who frequently writes about the position of AIDS dissidents, who argue that HIV does not cause AIDS—centres on a clinical trial in Uganda for the drug nevirapine that was later criticized for poor methodology and treatment of some test subjects.

However the final third of the article focuses on Dr. Peter Duesberg, a professor of molecular and cell biology at the University of California, Berkeley, and a leading AIDS dissident.

Rebuttals to Dr. Duesberg's theories and to other aspects of Ms. Farber's article have been posted on various Web sites. A 37-page document, written by eight prominent AIDS researchers, was posted on the Treatment Action Campaign Web site.

Source: New York Times ⊕

At the Stellar Celebration on Thursday, April 27, BCPWA Society treasurer Wayne Campbell (l) accepted a cheque for $10,000 from Shooting Stars Foundation chair Ryan Resch. The money will go toward BCPWA's Prison Outreach Program (POP).

THE THORNY TREE

Untested testing

by Paula Braitstein

Increasingly, the phrases "diagnostic testing and counselling" (DTC) and "routine testing and counselling" (RTC) are bandied about. You might think, given how often acronyms change in the world of HIV, that DTC and RTC are just new terms for voluntary counselling and testing (VCT). Well, they're not. DTC and RTC are new approaches to HIV testing that are being widely discussed and implemented in resource-constrained settings.

VCT has become a type of mantra throughout the AIDS world: HIV testing must be voluntary, there must be both pre-test and post-test counselling, and—in spite of decisions by various Canadian public health authorities—testing should be non-nominal. Why? Because the stigma against people living with HIV/AIDS has been, and still is, a huge barrier to getting tested, and to coming forward for treatment. HIV stigma is certainly no less of an issue in Africa, Latin America, and Asia—in fact, it may be worse.

With DTC, people come to a clinic or hospital because they're sick. The doctor or medical provider needs to diagnose the person's health issue if they're going to treat it, and more often than not, the problem is HIV related. The medical provider simply tests the person for HIV without asking their consent, and then tells them that they were tested, what the result was, and what their health issue is. The assumption is that by coming forward for care, a person is ***de facto*** consenting to the necessary diagnostic procedures.

With RTC, every person who walks through the door of a health care facility is tested: it's routine, like screening for tuberculosis or vaccinating children.

Clearly, this is a thorny issue, with upsides and downsides. For example, by testing everyone, in RTC or as DTC, the stigma of testing is removed: it doesn't matter who you are or what your risks may or may not be, you will be tested. HIV/AIDS is normalized as a result.

Testing people in this way is more likely to diagnose their infection earlier on in their course of disease. Early diagnosis increases the chance that people will access treatment sooner, and generally improves their health and long-term prospects. It removes the burden from healthcare workers of having to broach such a sensitive subject, and removes the burden from patients of having to ask for an HIV test. It also removes the risk that people will refuse to be tested, which is important because the people who refuse to be tested tend to be those at highest risk, both for acquisition of HIV and for the transmission of it onwards. Many healthcare workers are burnt out from watching so many people die of AIDS while refusing to be tested that they say they find DTC and RTC a relief.

On the other hand, DTC or RTC may cause people to receive their HIV diagnosis before they're psychologically ready for it; but, then, is a person ever ready? There have been reports of people who get their results and then never return to the healthcare centre, or who upon discovering their serostatus, leave their families, or abandon their children, especially if the child tests HIV-positive.

What about a person's right to choose ignorance? To what extent is testing people without their consent—even if it's "for their own good"—a breach of their privacy and rights?

And what about a person's right to choose ignorance? To what extent is testing people without their consent—even if it's "for their own good and the good of their community"—a breach of their privacy, human rights, and personal choice? Does it matter, and should it matter, that AIDS is such a public health emergency that extraordinary measures are required to try to curb the pandemic? How much of DTC and RTC is about the healthcare services and healthcare workers, and how much is about the patients?

Complex questions about a complex topic. One thing I've learned from this issue: not to leap too quickly to hard and fast conclusions. ⊕

***Paula Braitstein** is the epidemiologist and project manager of the ART-LINC Collaboration (Antiretroviral Treatment in Lower Income Countries Collaboration). She is the former BCPWA Society senior policy advisor on health promotion.*

ACCOLAIDS 2006

Honouring our heroes

On May 7, the BCPWA Society, in partnership with GlaxoSmithKline and Shire BioChem, held the fifth annual AccolAIDS awards gala at the Pan Pacific Hotel in Vancouver. This fundraising event honours community achievements of individuals and organizations in the BC AIDS movement.

ABOVE AND BEYOND
Karen Muirhead

Karen served as executive director for ANKORS (AIDS Network, Outreach, Resource Support) for ten years. Under her direction, ANKORS grew to provide support, prevention, and education services throughout the East and West Kootenays, an area of over 200,000 square kilometres. Karen worked tirelessly to develop an organization that is truly responsive to those living with HIV/AIDS and those working in support of PWAs. She worked with staff to develop policies and approaches that respect and centre around those affected by HIV/AIDS. She provided a phenomenal amount of love and support to PWAs living in the region and worked to bring the issues of living with AIDS in rural communities to the table. Karen served on national and regional organizations, including the Pacific AIDS Network and the Canadian AIDS Society. She continues to inspire, motivate, and set the standard for the work done at ANKORS.

HEALTH PROMOTION & HARM REDUCTION
Dr. David Burdge

David's non-judgmental and respectful approach ensures all women receive medical treatment in a safe, confidential, and women-centred environment. David is medical co-director of the Oak Tree Clinic and director of its adult service and research program. He takes a consultative approach in health care, education, health promotion, and access to clinical research for women and HIV/AIDS. Through his association with the BC Women's Health Centre, he works with family doctors across BC who treat HIV-positive women. David sits on the BC Centre for Excellence in HIV/AIDS' Therapeutic Guidelines Committee, and co-authored provincial and national guidelines for the care of HIV-positive women and pregnant women. He is principal investigator on several research projects related to women and HIV. In part due to his efforts, no HIV-positive baby has been born in the past ten years to any BC women who have accessed care and took anti-retrovirals during pregnancy.

INNOVATIVE PROGRAMS
Lucy Barney

As program manager of Chee Mamuk, the BC Centre for Disease Control's Aboriginal HIV/AIDS education program for seven years, Lucy is at the forefront of developing innovative and successful programming. She oversees such projects as: the "Chako Project," a health promotion project for youth based on traditional coming-of-age teachings; the "Gathering Tree," a beautiful children's book that deals with HIV and stigma in the family and community, which has been distributed to schools, health centres, and organizations throughout BC; and the "Around the Kitchen Table," a prevention and health promotion project that builds on the strength of Aboriginal women, returning to their traditional roles as nurturers, teachers, and givers of life. Lucy Barney's own life experience as a First Nation woman, mother, and traditional dancer brings enormous commitment, dedication, and creativity to her work. Her voice as a leader is crucial. She is a model of strong, innovative leadership in the Aboriginal community.

KEVIN BROWN PWA HERO
John Cameron

In 1995, John Cameron transferred his workaholism from paid employment to HIV/AIDS community activism. He stands out because he is 100 percent upfront about his personal journey with HIV. His example encourages multiple-diagnosed PWAs to take charge of their lives. John founded and facilitates the crucial Carnegie AIDS Support Group and the huge Carnegie

AIDS Day educational event. He co-founded and continues as a board director on the Downtown Eastside HIV/IDU Consumers' Board and was involved with establishing its needle exchange. John brings together community partners and PWAs to focus on important issues. He is a member of the Mayor's Coalition on Drugs (Four Pillars). He served on the HIV Advisory Committee to the Minister of Health and with the Heart of Richmond AIDS Society, AIDS Vancouver, the AIDS Candlelight Memorial and Vigil Committee, and continues as a director on the Working Group of the Pacific AIDS Network.

PHILANTHROPY
Fillmore Family Foundation

Each November, the Fillmore Family Foundation, led by sisters Linda and Doreen Fillmore, serves up a huge turkey dinner, along with big helpings of tongue-in-cheek entertainment at its annual Prairie Fairies Fowl Supper. Sponsors, participants, and volunteers contribute to the Fowl Supper's success. Hundreds of hours go to creating, coordinating, and producing the event. The Foundation's mission is to provide funding to non-profit agencies that deliver programs and services in the areas of nutrition, housing and health. In 2005, they broadened their scope with the creation of the Fillmore Family Seniors Services Fund, providing funding to lessen the physical, emotional and social isolation of ageing lesbian, gay, bisexual, and transgendered persons. The Fillmore Family Foundation's generosity, commitment, and imagination has raised over $70,000 for A Loving Spoonful, the McLaren Housing Society, and the Dr. Peter Centre.

SCIENCE/RESEARCH/TECHNOLOGY AWARD
Dr. Thomas Kerr

Dr. Thomas Kerr is one of Canada's most outstanding, talented, and productive HIV/AIDS researchers. Thomas began his work in HIV/AIDS in Montreal —as a music therapist in Montreal, then worked at the Dr. Peter Centre in Vancouver. He is now a research scientist at the BC Centre for Excellence in HIV/AIDS and an assistant professor in the Department of Medicine at the University of British Columbia. As a project manager at the Harm Reduction Action Society, Thomas authored Canada's first supervised injection site proposal. He has also volunteered with VANDU (the Vancouver Area Network of Drug Users), the Thai Drug Users Network, the Canadian HIV/AIDS Legal Network, and many other community-based HIV/AIDS organizations. Thomas has made a major local and international contribution as a principal investigator of VIDUS (the Vancouver Injection Drug Users Study) and SEOSI, the Scientific Evaluation of Supervised Injection. Since completing his doctorate in 2003, he has published an astonishing 80 peer-reviewed articles.

SERVICE DELIVERY
Dr. Paula Braitstein

For over a decade at the BCPWA Society, Paula distinguished herself as a passionate, dogged, and brilliant advocate of the empowerment of HIV-positive persons. Under her leadership, BCPWA became a nationally-trusted source of treatment information, publishing brochures and a magazine, and producing travelling "ABCs of HIV" workshops. She advocated for organ transplantation for PWAs and for better care and new drugs for PWAs co-infected with hepatitis C. Paula co-chaired several BC AIDS conferences, sat on the province's HIV/AIDS Advisory Committee, and chaired the Community Advisory Committee of the Canadian HIV Trials Network. She was also community representative to the Canadian Institutes of Health Research HIV/AIDS Advisory Committee and the Canadian Association of HIV Research. As an honorary member of the Canadian Treatment Action Council, she successfully lobbied for improvements in the drug approval and pricing process. Paula is now at the University of Berne in Switzerland as epidemiologist and project manager for the Antiretroviral Therapy in Lower-Income Countries Program.

SOCIAL/POLITICAL/COMMUNITY ACTION
Tarel Quandt

Tarel served the BCPWA Society from 1998 until her recent death, directing the original Individual Advocacy Department and establishing and leading the Treatment Information and Advocacy Department. Tarel argued fearlessly for social justice issues. She was an intelligent, energetic, vital member of our community who worked tirelessly to make things better, even when dealing with her own illness. The step-by-step Action Kits created under Tarel's direction help PWAs navigate complicated issues associated with accessing income assistance benefits. She also contributed to ***HIV/AIDS Policy and Law Review***, and chaired the Social Planning and Research Council of BC. Tarel elaborated and refined a legal basis for more nutritional and other health supports for PWAs on income assistance. Her enormously successful training of volunteer advocates led to 500 PWAs obtaining funding for food, bottled water, vitamins, and minerals. She also helped establish BC's Monthly Nutritional Supplement Benefit for most PWAs on income assistance. ⊕

British Columbia Persons With AIDS Society

Notice of ANNUAL GENERAL MEETING

DATE
Saturday, August 26, 2006
11:00 am (sharp)

LOCATION
The Training Room, 1107 Seymour Street, Vancouver

REGISTRATION
10:00 – 11:00 AM

LOOK FOR YOUR AGM PACKAGE IN THE MAIL FROM MID TO LATE JULY 2006.

The membership will meet to receive the Annual Report of the Directors, consider amendments to the by-laws of the Society, if any, elect the Board of Directors of the Society for 2006/2007, and conduct other such business as is deemed necessary in accordance with the constitution and by-laws of the Society.

Members wishing to have business placed on the agenda for the Annual General Meeting should submit it prior to June 19, 2006. A letter to the Secretary of the Society containing:

(1) a brief paragraph describing the specific intent of the business, and

(2) a properly worded motion pertaining to the business should be sent to the Society's registered office at:
1107 Seymour Street, Vancouver, BC V6B 5S8

IMPORTANT DATES TO REMEMBER

Resolutions from the Members to be submitted to the Secretary of BCPWA	by June 19, 2006
Mail out of AGM Packages	not later than July 31, 2006
For individuals who do not receive mail, AGM Packages will be ready for pick up from Member Services (Reception) Desk	on August 8, 2006
Last day Proxies are mailed	August 11, 2006
Last Day Proxies may be requested for Pick up	August 18, 2006

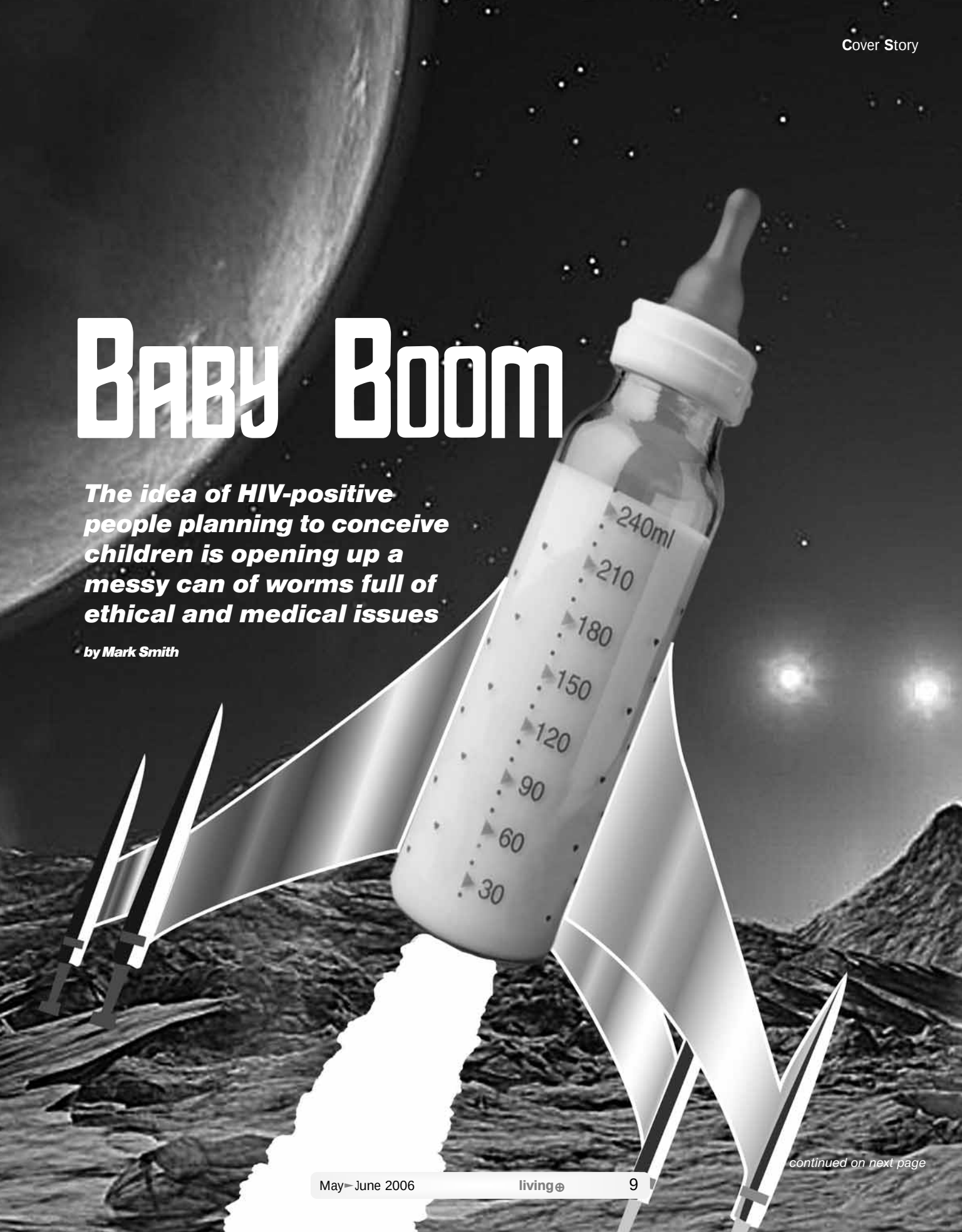
If you have any questions or would like to receive a copy of the Society's Annual Report, please call Derek Bell, Secretary, at 604.646.5317 and leave a confidential message. To ensure accuracy, please spell your last name slowly and leave a contact phone number.

ASL **Interpretation for the deaf will be available**

Baby Boom

The idea of HIV-positive people planning to conceive children is opening up a messy can of worms full of ethical and medical issues

by Mark Smith



continued on next page

One of the major taboos that polite society is uncomfortable talking about is people living with HIV/AIDS who deliberately conceived or are planning to conceive children. The mainstream population probably assumes that letting HIV-positive people have children is akin to attempted murder, because the child will be born with the virus or more mildly, that it's like conceiving an orphan, because the parent will die. It doesn't matter whether we're gay, bisexual, or straight, HIV-positive or -negative, celibate or sexually active—we just don't talk about it. Can you recall the number of times over the past year that you and your friends met for lunch or coffee and discussed HIV-positive people making babies?

Anecdotal evidence indicates that even casual mention of this taboo subject can cause an increased occurrence of sudden projectile spewing of beverage or food by unsuspecting tablemates!

Today, the life expectancy for people living with HIV is decades, and with the prospect of living a long life comes the desire to put your life goals back on track. For a many of us, having children has been a life-long desire. But the issue does raise a number of medical and, for many, ethical issues. Approaching this subject with an open mind and sifting through the variables can help you best view this complicated can of worms.

Reducing the chances of transmission

Current HIV pregnancy research by the World Health Organization shows that mother-to-child transmission, where an HIV-positive woman passes the virus to her baby, can occur during pregnancy, labour, delivery, or breastfeeding. Without treatment, around 15 to 30 percent of babies born to HIV-positive women will become infected with HIV during pregnancy and delivery. A further 10 to 20 percent will become infected through breastfeeding.

Antiretroviral drugs are highly effective at preventing HIV transmission during pregnancy, labour, and delivery. When combined with other interventions, including formula feeding, a complete course of treatment can cut the risk of transmission to below two percent. Even where resources are limited, a single dose of medicine given to mother and baby can cut the risk in half.

Pregnancy has not been shown to expedite the progression of HIV/AIDS in women.

When only the father-to-be has HIV, a procedure called sperm washing can be highly effective. (See the article on sperm washing on page 20.) This involves separating the sperm cells from the seminal fluid and checking them for HIV before artificial insemination or in-vitro fertilization. While sperm washing is a highly effective way to protect both the mother and her baby, it unfortunately is only available at a few clinics and can be difficult to access, even in well-resourced countries.

Special delivery

Early studies showed that elective and planned caesarean sections, or C-sections—which are performed before labour begins and before the mother's water (the membranes that surround the baby) breaks—lower transmission rates. That's because it reduces the baby's contact with the mother's blood. By contrast, emergency C-sections, which are done after the membranes break, do not reduce HIV transmission.

But today, HIV-positive women who are on effective HIV therapy and have undetectable viral loads have low transmission rates for vaginal births. Since C-sections require surgery, they carry some risks. Women who have C-sections are more likely to get infections than those who give birth vaginally.

If you're on HIV therapy with a low viral load (less than 1,000), a C-section is not likely to further reduce your already low risk of transmitting HIV. But if you have a viral load over 1,000 or you're not already receiving treatment at the time of delivery, a C-section may reduce the chances of transmission.

Antiretroviral drugs and birth defects

It still isn't clear whether antiretroviral drugs can cause birth defects in babies whose mothers took these drugs during pregnancy. It's still too early in the tracking process to tell how antiretrovirals might affect a baby as he or she grows up.

Today, HIV-positive women who are on effective HIV therapy and have undetectable viral loads have low transmission rates for vaginal births.

If you're a pregnant HIV-positive woman and you haven't needed to start antiretrovirals for your own health, you have choices about when in your pregnancy you start. The current recommendation is to start antiretrovirals after your first trimester. In circumstances where you haven't had any antiretroviral treatment during your pregnancy, it is recommended that you take the drugs at the start of labour, along with a C-section, to reduce the chances of mother-to-child transmission. See "Positively Pregnant," ***living*** ⊕, Issue 36, May/June 2005 for more information.

Over the past decade, I've met numerous PWAs who have had or are planning to have children: HIV-positive women in relationship with HIV-positive men, HIV-negative women in relationships with HIV-positive men, HIV-positive women and men who were unattached, and HIV-positive women and men who were in same-

sex relationships. All of these people are determined that, come hell or high water, they are going to be the best new parent a child could want. Here are a few of their stories.

Positive and pregnant in the 1980s

Angela (not her real name) is an African American woman, in her mid-forties, whose smallish build belies a giant presence of strength, courage, and dignity. She is a mother of two and has lived with AIDS for almost 20 years. It was after a lengthy illness that Angela learned from a doctor that she had the virus. In shock, she returned home that night to inform her husband of the devastating news. Instead of displaying disbelief, he sneered at her and told her, "Now you got it too, bitch!"

With nowhere else to turn, her fundamentalist upbringing, and the times being what they were in 1985, Angela felt she had no choice but to stay in that relationship and be the best wife she could be. In 1987, she gave birth to a girl. Two years later she gave birth to another daughter.

Today, Angela feels grateful that only one of her daughters was born HIV-positive, her abusive marriage is over, and she's rebuilt her life on new terms. Her biggest regret is that in 2001 her first grandchild was born HIV-positive. In some dark corner of her mind, it's not her daughter she blames for this child, but herself. She feels that if she had been a stronger woman when her daughters were growing up, she might have taught them how to make better choices in their lives.

It's never too late

Tom (not his real name) is in his forties and has been living with the virus for 12 years. After years of trying relationships with various people, Tom met the woman of his dreams in 2000. She was an HIV-negative single mother with a young daughter. With her family's full knowledge and consent, Tom married her and adopted her daughter. He now works and lives in a small city with his wife, daughter, and their new HIV-negative infant.

Tom had always hoped to become a biological father. His wife was also very interested in giving birth to another child. They spent months researching medical journals on-line and asking doctors on how an HIV-positive man and HIV-negative woman could conceive a child safely. They looked into sperm washing, which turned out to be too cost-prohibitive for them. They instead went with the medical opinion that when a HIV-positive man's viral load is undetectable, there is very little risk of transmitting the virus in his semen.

Throughout the pregnancy, his wife was regularly tested for the virus. No complications were found and their beautiful new daughter arrived safely.

This event has brought Tom the greatest joy he has ever known. If they could afford it, they would jump at the chance to have another child together.

Wake up and start dreaming

Barbara has lived with HIV for six years. She is quickly approaching her mid-30s and plans to have at least one child before she hits forty. Barbara has always felt she was destined to be a great mother.

When she got hit with her diagnosis in 2000, Barbara went through the so-called five stages of grief: denial, anger, bargaining, depression, and acceptance. Somewhere along this journey, her dream of motherhood died along with her hopes for a real future—until something shifted.

Barbara believes it was the support she received from family, friends, counselling, and doctors that encouraged her to start dismantling many of the limitations she had imposed upon herself. She feels that she's back on track with the direction of her life. She has a new career that she really enjoys and is staying abreast of the newest findings on HIV pregnancy. All of life's possibilities are back on the table.

While Barbara currently doesn't have a man in her life to father a child with her, she isn't certain that she wants an actual husband. She just wants to have that beautiful, healthy baby she's always dreamed of. She hopes for a girl.

Should any of these people be judged by society for what they've done or are planning to do? Are they just a part of a growing trend among HIV-positive people? Should we be worried about the future repercussions for their children? And at which point does community concern cross over into just being nosy?

Break this taboo and discuss the subject with a friend over lunch or coffee. But make sure you're wearing something washable. ⊕

***Mark Smith** is a member of the BCPWA Society and a community volunteer.*

Additional reading

More details and options can be found at *www.avert.org/pregnancy.htm* or at *www.pwn-wave.ca/index.cfm?group_ID=1174.*

Read more personal stories about HIV and pregnancy at *www.thebody.com/asp/may99/pregnancy.html*.

A twinkle in her father's eye

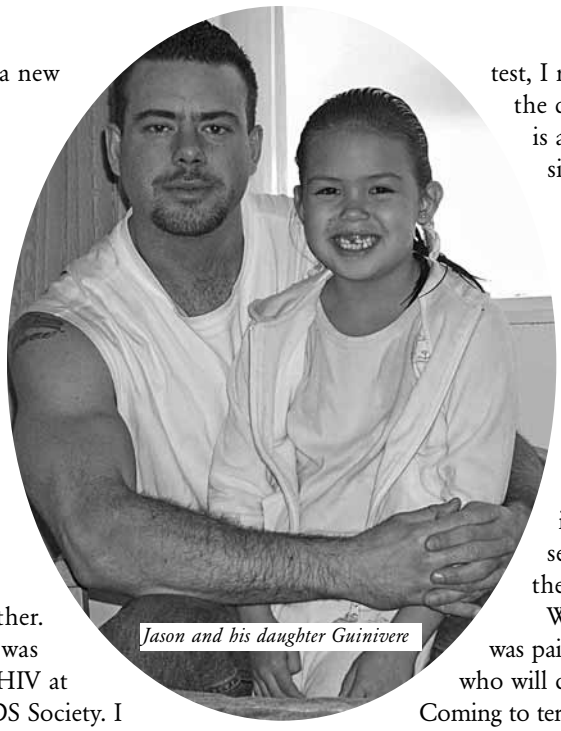
The joys—and challenges—of becoming an HIV-positive father

by Jason Wilcox

I've been a dad for seven years. For a new parent, a first child brings joy, fear, uncertainty, and raw emotion. Disquieting questions rush in like a storm. Will my child be born HIV-positive? How will my family react? What damage might come from the antiretroviral therapies administered to my unborn child through her mother? Other parenting concerns become complicated: who will care for my child when I am gone? How will I protect my child from the stigma that plagues me as an HIV-positive person? At what age will I inform her of my HIV?

These questions heighten the challenges of becoming a nurturing father.

When I found out that my partner was pregnant, I researched pregnancy and HIV at the BCPWA Society and YouthCO AIDS Society. I investigated HIV parenting services such as the Smile Program (a parenting resource facility in Burnaby where I took prenatal classes) and the Hummingbird Kids Society. Grateful for and humbled by their assistance, which combined research and advice, I felt supported and sufficiently informed to plan and comprehend the complexities of pregnancy and HIV.



Jason and his daughter Guinivere

My daughter attended a now-standard series of doctor visits and blood tests. I frantically awaited results during each appointment.

My then-partner, also HIV-positive, delivered our daughter uneventfully by Caesaran section. Treatment included administration of nelfinavir (Viracept), 3TC (Epivir), and D4T (Zerit) throughout the pregnancy, followed by six weeks of AZT (Retrovir) treatment, post-partum, via oral injection.

My daughter attended a now-standard series of doctor visits and blood tests. I frantically awaited results during each appointment, and the fear I felt was ten times worse than it had been while waiting for my own results in 1994. In contrast to my one test, I relived every test for 18 months until the doctors cleared her as HIV-negative. She is a normal, healthy, passionate, and polite six-year-old girl.

But the challenges aren't over. As an HIV-positive parent (and a single parent with full custody), I sometimes face hostility. I have faced stigma at pharmacies, government agencies, and blood clinics. Mostly, though, people are compassionate and understanding. This has helped me become a stronger parent and person. Oak Tree Clinic in Vancouver has been an important resource; while they primarily serve HIV-positive women and youth, they also help affected families.

Writing my living will was distressing. It was painful to plan for such contingencies as who will care for my daughter once I'm gone. Coming to terms with possibly leaving my daughter prematurely launched me into temporary grief and sorrow. Writing a living will with a "do not resuscitate" clause—and deciding whether or not my daughter should be in the room when I pass away—brings ongoing distress. This is one of countless quandaries I face as I plan the best future for my daughter.

Children are greatly affected by their parents' HIV status. The epidemic is devastating millions of children and their families who are permanently altered by the intrusion of AIDS. Assisting children to articulate their knowledge, feelings, or reactions to HIV/AIDS without leading their responses requires delicacy and methods tailored to their individual needs.

Comprehensive programs for families living with HIV/AIDS would assist this. Such programs could help everyone to better understand the impact of HIV on children, their families, and their communities.

We need to work toward eliminating stigma and discrimination against HIV-positive parents. Those of us who are HIV-positive parents also need support to ensure we remain a family unit with our children as long as possible. But we also need reassurance that our children and caregivers will receive support if we're no longer able to care for our children. ⊕

***Jason Wilcox** is a member of the BCPWA Society and a PWA peer advocate living in Victoria.*

It takes a Global Village

A taste of what's to come at the International AIDS Conference in Toronto

by Ron Rosenes

AIDS 2006
Time to Deliver • Passons aux actes

Organizers of the XVI International AIDS Conference in Toronto this August have high hopes for the success of the Global Village (GV). The GV will be the "town centre" for an estimated 20,000 or more delegates. They'll be joined by some 2,500 journalists and members of the Canadian public who will be able to experience the conference through free access to this dynamic and exciting space.

The XV AIDS Conference in Bangkok in 2004 held the first GV. Open to the public and delegates, it was conceived as a free networking space where people from various affected groups could gather to exchange ideas freely and safely, to share experience and knowledge, and to strengthen their commitment to work together on issues of shared importance. It was also a space filled with the rhythms of music, dance, the colours of PWA-made crafts, the wonderful aromas of Thai cuisine, and the medicinal offerings of local health practitioners.

For Toronto, the GV committee of volunteers and staff is working to give pride of place to the GV in the Metro Toronto Convention Centre. The Global Village will occupy 75,000 square feet in the Conference's point of entry, in the main exhibit hall.

The co-ordinator of the GV, Chris Lau, and his team are working with an advisory committee of volunteers to create a community-led space that is international in perspective, and highly interactive and participatory. The vision of the Global Village is:

- to engage the marginalized communities which have faced barriers to making their voices heard at previous International AIDS Conferences
- to challenge people by creating a platform for the critical analysis of key HIV issues and provoking discussion to identify new and emerging challenges in the pandemic
- to inspire where there is complacency and to rejuvenate where there is burnout by acting as a catalyst for change.

The GV committee is working with the Community Programme Committee to link the voices and perspectives that are expressed throughout conference sessions, community activities, and associated symposia. The goal is to add opportunities within the GV to pursue ideas or issues—including dissenting ones—that arise from the regular conference sessions.

Activities planned for the Global Village include:

- forums, panels, and debate sessions
- networking zones
- "meet the plenary speaker" sessions
- on-site community radio
- rooms for private meetings
- a main stage for cultural presentations, public discourse, and debates
- a youth pavilion
- virtual village, a website linked from the main conference site to broaden the conference's reach globally,
- an interactive video lounge
- NGO and marketplace booths.

Conference organizers are working hard to create an atmosphere of equality in which all voices and issues can be heard.

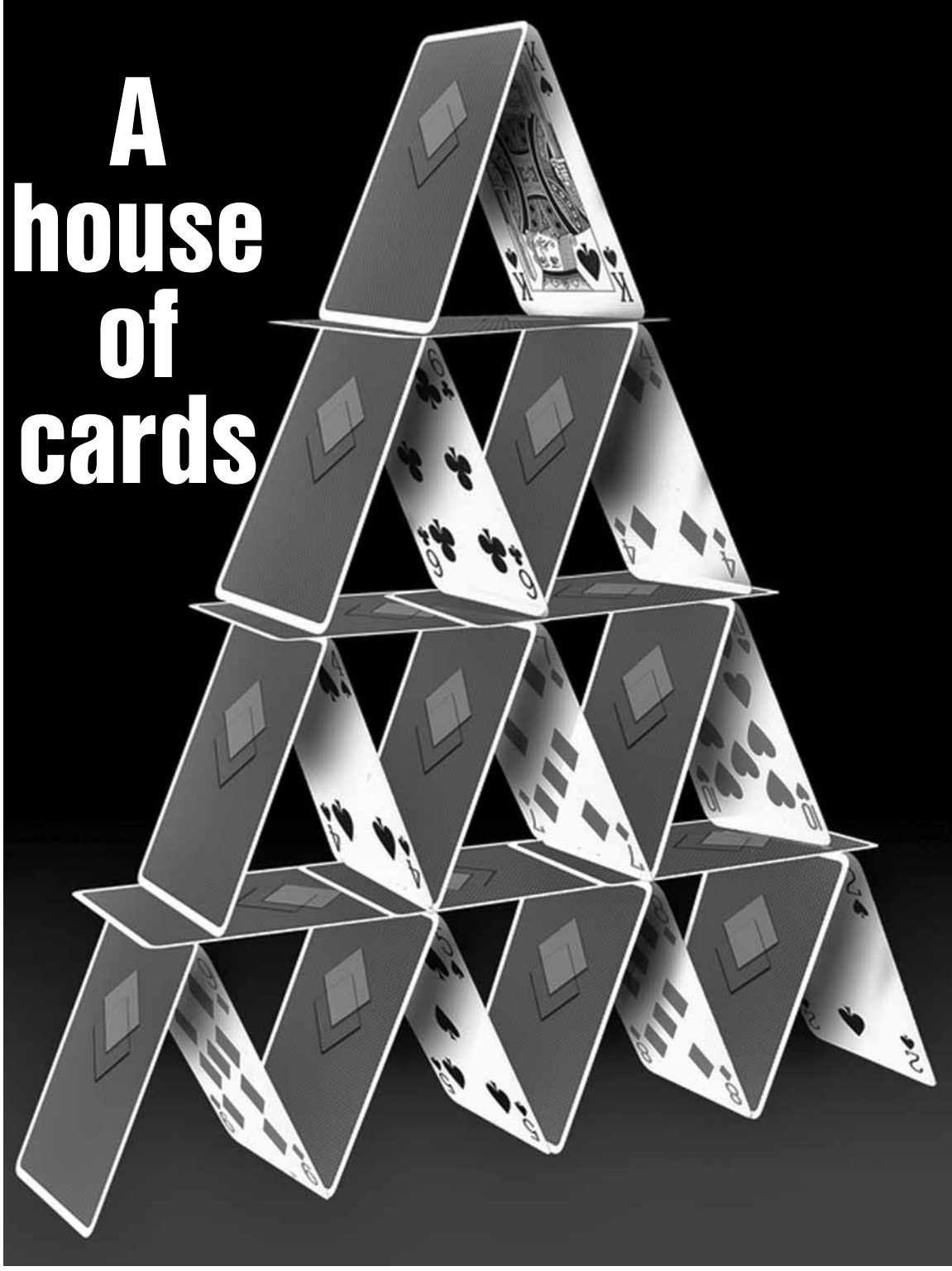
The Global Village seeks to support marginalized communities to better organize themselves, share lessons learned, understand the science, advocate more effectively for policy change, and deliver care, support, and prevention programs. The public will gain a better understanding of critical HIV issues in the context of human rights and social justice at home and abroad. The GV will strengthen ties between researchers and community to enable research to move forward. Organizers aim to build new and stronger coalitions, for example in the area of treatment preparedness and literacy, in Canada and abroad.

Conference organizers are working hard to create an atmosphere of equality in which all voices and issues can be heard. These program activities are intended to strengthen community engagement with the scientific and leadership streams of the conference in a way that will create a lasting legacy for future conferences.

For more information, please visit www.aids2006.org. ⊕

***Ron Rosenes** is on the boards of the Toronto Local Host, AIDS 2006 and the Canadian Treatment Action Council*

A house of cards



The overall housing situation in Vancouver is reaching desperate levels

by Damien Callicott and Neil Self

In the last issue of living ⊕ ***we talked about the long wait lists for subsidized housing and the results of the freeze in disability payments. In this issue, we explore the overall affordable housing situation in BC.***

There is almost unanimous agreement among HIV/AIDS service and healthcare providers that housing is a cornerstone for increased health and quality of life for people living with HIV. Access to affordable and stable housing contributes to increased mental health (less anxiety and depression), increased adherence to treatment protocols, and a general increase in the quality of life for people with HIV.

Currently, there are some dedicated housing programs and services for PWAs in Vancouver, primarily through three organizations: the Dr. Peter Centre, Wings Housing Society, and McLaren Housing Society. But that only adds up to 248 HIV-dedicated subsidized housing units. Clearly, that isn't enough.

Low vacancy rates, long wait lists

Finding affordable housing in BC and Vancouver is becoming an increasing challenge. In BC, 35 percent of all households are rentals and in Vancouver that jumps to 37 percent—which translates to a lot of people in the province who are tenants. Yet, according to the Canada Mortgage and Housing Corporation (CHMC), in October 2005, the vacancy rate in Vancouver was only 1.4 percent. (By comparison, the vacancy rate was 4.5 percent in Edmonton and 3.7 percent in Toronto). The average rent for a one-bedroom apartment in Vancouver in 2005 was $788.00.

This situation is not restricted to Vancouver. In Kelowna, the October 2005 vacancy rate was 0.5 percent—a 13-year low—and the average rent for a one-bedroom apartment will reach $638.00 by the end of 2006.

These low vacancy rates puts a premium on available rental units, making it even more difficult for low-income earners and people on employment and income assistance (including disability benefits) to secure affordable housing.

As of November 2005, there were 13,822 households on the BC housing application list; of these, 11,488 were seeking housing in the Lower Mainland. Currently there are approximately 43,000 people in subsidized housing in the Lower Mainland, 13,000 in the Interior, 4,300 in the North, and 14,000 on Vancouver Island. By the end of 2007, it's estimated that government-assisted programs will help more than 83,900 households, or almost 6 percent of the total households in British Columbia.

What our governments are—and aren't—doing

But that isn't enough. According to former Vancouver City councillor Jim Green, we need an aggressive way to advocate for sound housing because the current state of low-income housing in Vancouver is "a desperate situation." Green notes that the federal Liberals promised $2 billion for housing throughout Canada over the next two years and that Prime Minister Harper agreed to honour those commitments. That remains to be seen. The uncertainty of the federal housing funding is compounded by the provincial Liberals' plan to transition away from direct housing provisions to rental supplements. Moreover, Vancouver City Council recently backed away from commitments to low-income housing in the development of the south east end of False Creek.

The previous COPE Vancouver City Council found creative ways to provide low-income housing in Vancouver. For example, the Shangri-La, a luxury residential tower in downtown Vancouver, received extra height allowance for donations to social needs, such as one million dollars for social housing.

Green introduced legislation giving the City of Vancouver the right to refuse any applications to rezone single-room occupancy units. Green says the new NPA Mayor, Sam Sullivan, is on record as stating he wants to get rid of that bylaw.

The housing situation is only going to get worse, with mounting housing pressures in BC and Vancouver (in particular due to the upcoming 2010 Olympics), high real estate values, the increasing cost of construction, and the few new low-income residential housing units under construction. We desperately need creative government interventions and strategies to address this growing problem. ⊕

Damien Callicott *(l) is a board member of the BCPWA Society and sits on several Society committees.*
Neil Self *(r) is a social worker and a board member with the BCPWA Society.*

Condomizing in the Caribbean

The S-Concept is just one example of what's being done to address HIV in Trinidad and Tobago

by Moira Denman

Trinidad and Tobago (T&T) is a tropical, lush, two-island republic located in the Caribbean, just 11 kilometres off the coast of Venezuela. Anyone fortunate enough to visit T&T knows that the highlight of the year is Carnival. Residents and visitors alike look forward to this massive celebration at the end of February. People start to celebrate just after New Year's Eve in anticipation of Carnival: the music, the costumes, and two days of dancing, parading, and partying. But with all these festivities, and with thousands of visitors in attendance, it creates an environment conducive to high-risk behaviour. And that means an increased risk of HIV transmission.

The Caribbean, best known for its beaches and tropical beauty, is the second most HIV-affected region in the world, after sub-Saharan Africa. With a prevalence of 1.6 percent, there are approximately 300,000 people infected. In 2005, the AIDS epidemic claimed an estimated 24,000 lives in the Caribbean, making it the leading cause of death among adults aged 15-44 years. The HIV prevalence rate varies greatly among the Caribbean islands: Haiti has the highest rate, Cuba has the lowest, and T&T is in the middle.

Volunteers at the Condom Booth at an MSM party during Carnival

Since HIV/AIDS was first diagnosed in T&T in 1983, over 15,600 cases of HIV have been reported to the National Surveillance Unit of the Ministry of Health. Almost three-quarters of new infections occur within the age range of 15 to 49; within the 15 to 19 age group, HIV infection levels are six times higher among females. Like other countries, there are higher prevalence rates of HIV among such high-risk groups as men who have sex with men, commercial sex workers, and drug users.

The country has a National AIDS Coordinating Committee (NACC) that works out of the office of the Prime Minister and is charged with coordinating the expanded national response to the HIV/AIDS epidemic. Throughout the year, the NACC supports a national ABC program: abstinence, being faithful, and condom use.

Every year when Carnival rolls around, the emphasis is on condom use, or "condomizing." Different organizations from various sectors take part in this campaign. One example of the NACC's steps to scale up prevention programs is S-Concept, an intervention that focuses on the provision of condoms and accurate information surrounding condom use. Formally known as the Condom Krew, the group is comprised of volunteers. The Condom Krew distributed over 480,000 condoms over a four-year period; in a country of just over one million people, that's a lot of condoms. Condoms are distributed mainly at carnival parties, which are considered high-risk environments.

The information provided about accurate condom use and HIV prevention is especially important considering there are no standardized sexual education classes within the school system. The only program provided through the Ministry of Education is an abstinence program. If you grew up in a country with extensive sexual education programs in schools, you may be surprised to hear radio advertisements in T&T that encourage people to educate themselves about HIV and advise them that home remedies such as bleach will not prevent the transmission of HIV. High levels of stigma and discrimination surrounding HIV throughout the Caribbean, as well as strong religious influences, are also ongoing challenges to prevention efforts.

If you do get the chance to experience Carnival in Trinidad and Tobago, go! Just be safe. ⊕

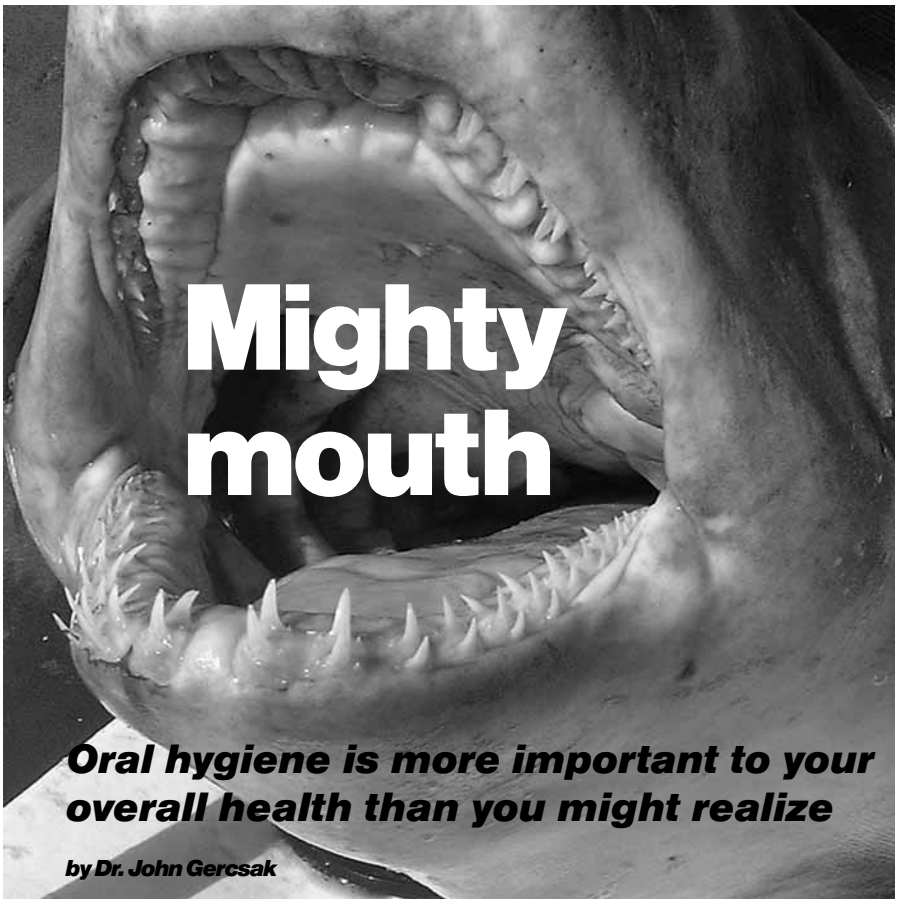
***Moira Denman** is a Canadian junior professional consultant working with UNAIDS in Trinidad and Tobago, and a volunteer for S-Concept.*

treatment. information

TREATMENT INFORMATION PROGRAM MANDATE & DISCLAIMER

In accordance with our mandate to provide support activities and facilities for members for the purpose of self-help and self-care, the BCPWA Society operates a Treatment Information Program to make available to members up-to-date research and information on treatments, therapies, tests, clinical trials, and medical models associated with AIDS and HIV-related conditions. The intent of this project is to make available to members information they can access as they choose to become knowledgeable partners with their physicians and medical care team in making decisions to promote their health.

The Treatment Information Program endeavours to provide all research and information to members without judgment or prejudice. The program does not recommend, advocate, or endorse the use of any particular treatment or therapy provided as information. The Board, staff, and volunteers of the BCPWA Society do not accept the risk of, or the responsibliity for, damages, costs, or consequences of any kind which may arise or result from the use of information disseminated through this program. Persons using the information provided do so by their own decisions and hold the Society's Board, staff, and volunteers harmless. Accepting information from this program is deemed to be accepting the terms of this disclaimer.



Mighty mouth

Oral hygiene is more important to your overall health than you might realize

by Dr. John Gercsak

If you're HIV-positive, it's extremely important to maintain excellent oral health. Gum diseases, fungal infections, dry mouth, and trench mouth are common problems in people with HIV. These often indicate immune suppression and disease progression.

Gum diseases, or periodontal diseases, attack the tissues that protect the tooth. This includes the bones that hold your teeth in place and the gums that cover the bone. Periodontal disease may progress at a faster rate in HIV patients. You may need a quick diagnosis and comprehensive treatment. This often requires a referral to a periodontist, or gum specialist.

Fungal infection, or oral candidiasis—also known as thrush or moniliasis—affects a large percentage of HIV patients. It often goes undiagnosed. It most commonly manifests itself as white patches on the hard and soft palate as well as the tongue. It can also appear as deep red sores. Angular cheilitis is a candida infection that appears as small cracks and fissures at the corners of the mouth. If you use asthma inhalers, rinse well with water immediately after inhaling the medication to prevent fungal infections.

Dry mouth, or xerostomia, is one of the common symptoms of HIV. Your mouth is an area highly affected by a lack of water. Without the water component of saliva, food and bacteria can build up on teeth, leading to rampant decay. It also makes chewing, swallowing, and digesting food very difficult. In addition, dry mouth leads

Table 1. Specific oral conditions and recommended treatments

Condition >	Fungal infections	Angular cheilitis	Dry mouth	Trench mouth
Treatment	• Topical therapy, nystatin oral suspension 100,000IU/ml: swish 5 ml in mouth then swallow, 4 times a day for 2 weeks. • Systemic therapy such as fluconazole: 100mg once a day for two weeks. • With either therapy, symptoms usually disappear within 2 to 3 days. • Because candida filaments grow into the surface of tissue, prolonged therapy is necessary to prevent recurrence.	• Antifungal cream such as nystatin cream: 100,000 IU/gm three times a day for two weeks. Nystatin cream can also be used under a denture.	• Restrict intake of diuretics such as caffeine and alcohol. Sources of caffeine include coffee, black tea, cocoa, and many colas. • Drink at least 1/2 your weight in ounces of water per day. • Use Biotene products (tooth paste, mouthwash, chewing gum, oral balance moisturizing gel).	• Immediate treatment with antibiotics, amosan mouth rinses, and scaling or root planing of teeth with local anaesthetic. • Vitamin supplements are also recommended.

to gum problems, bad breath, and a sore, burning sensation in your mouth.

Trench mouth, or necrotizing ulcerative gingivitis, is a bacterial infection of sudden onset and is usually associated with poor oral care at home and lowered body resistance. It is characterized by bad breath, and "punched out" gingival papillae with yellow-greyish ulcers. Your teeth and tissues become very sensitive, making it very difficult to chew food and brush your teeth.

Take oral hygiene into your own hands

Table 1 provides some recommended treatments for specific oral conditions. But there are also general things you can do yourself to maintain good oral hygiene. For starters, floss at least twice a day and use mechanical brushes such as Sonicare and Braun.

If you have an oral infection, change your toothbrush at the beginning of the infection, and then again when the infection ends; this will lessen the chance of the toothbrush reinfecting you. Your toothbrush should be stored in a covered and dry environment. Don't leave it open and exposed in the bathroom! If you do store your toothbrush and dental floss in the bathroom, put them in a drawer, away from the toilet, shower, and bathtub. Do not share a tube of toothpaste with your partner or a family member.

If you have a full denture or a partial denture, it could be contaminated with a bacteria or fungi. These germs are a detriment to your oral health. It may be necessary to replace or reline your old dentures.

Soak your dentures in an effervescent denture solution such as Polydent at least once a week. When a patient comes in to our office for dental examinations and treatment, we put their dentures in a special ultrasonic cleaner. If you take your denture out at night, store it in a baking soda solution of one teaspoon of baking soda to four ounces of water.

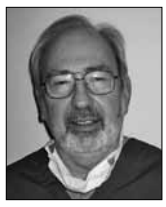
Oral rinses are good for treating specific problems—for example, fluoride rinses for decay or root sensitivities, and chlorohexidene rinses for periodontal infections. I don't recommend over-the-counter mouthwashes because most of them contain alcohol, which can be painful on open lesions. One teaspoon of salt in a glass of warm water is a useful mouthwash for bacterial lesions.

See your dentist regularly

Preventative dentistry is especially important. I recommend a minimum of two dental examinations and periodontal treatments a year for my HIV-positive patients. If you have specific problems, you may need three or four examinations a year and comprehensive periodontal treatment to avoid periodontal disease.

Please give your dentist an updated medical history and medication report at every visit, whether he or she asks for it or not, because changes in your medical condition may occur rapidly and can necessitate a change in your dental treatment.

Don't wait! Early diagnosis and treatment is always important to your health and well being. ⊕



***Dr. John Gercsak** has practiced dentistry in Vancouver's West End for over 35 years.*

British Columbia Persons With AIDS Society

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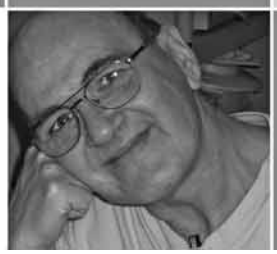


Pregnant with possibilities

Assisted reproductive technologies such as sperm washing can help PWAs conceive healthy babies

by Michael Connidis

In recent years, having children has become more of a reality for people with HIV. Thanks to effective antiretroviral therapy and enhanced awareness of the importance of adherence, people infected with HIV have longer life expectancies. Moreover, for HIV-positive people in their reproductive years, it's possible to have a family with minimal risk of infecting an HIV-negative partner or the infant. While assisted reproductive technologies (ARV) are usually used to help couples with infertility problems, they can also be used as a form of harm reduction to lower the risk of HIV transmission.

For most people with HIV, the barrier to conceiving is the risk of HIV transmission. Where one partner is HIV-positive and the other partner is HIV-negative, conception through unprotected intercourse poses great risks. Even in cases where both partners have HIV, there are still concerns about transmitting a different strain of the virus, especially one that has mutated and is drug resistant.

That said, women living with HIV are delivering healthy, HIV-negative babies, through the timely use of ARV during their pregnancy and delivery. Women with HIV-positive partners are also conceiving and delivering healthy, HIV-negative babies without becoming infected themselves. This is a new scenario, achieved primarily at fertility clinics. Of the two fertility clinics in British Columbia, only the University of British Columbia's Centre for Reproductive Health has assisted couples that live with HIV. The other clinic, Genesis Fertility Clinic, does not provide services for people with HIV, claiming they lack adequate lab space.

Assessment and counselling are the first steps

When a couple goes to a clinic, they undergo physical and psychological assessments. Doctors evaluate the fertility of both partners and conduct tests to ensure that there are no other infections or health factors that may reduce the chances of successfully conceiving. As well, both parties receive counselling to understand the risks of HIV transmission, however low. Prospective parents are also told that conception may fail for a number of reasons.

There are different reproductive technology options for each partner, depending upon who has HIV. When the woman is HIV-positive, self-insemination or assisted reproduction are recommended. When the man has HIV, assisted reproduction with washed sperm is the way to go. In either case, it is the woman who must undergo the invasive procedures and drug-induced changes to her normal ovulation cycle to optimize their chance of conception.

For self-insemination, the male provides the semen, which is then transferred into the woman's vagina using one of several techniques that can be done in the privacy of your home. The semen can be injected using a syringe without a needle or an eye-dropper. It's best to inject the semen as close to the cervical opening as possible. Another method uses a cervical cap, which holds the semen. The cap is inserted into the vagina and placed up against the cervix, somewhat like a diaphragm. You may need a doctor's assistance to place the cap initially.

Assisted reproductive technologies have been utilized for many years, but only in the past decade have they been used to help HIV-discordant couples conceive with a low risk of HIV transmission. These technologies include sperm washing (when the male has HIV), intrauterine insemination, in vitro fertilization, and intracytoplasmic sperm injection.

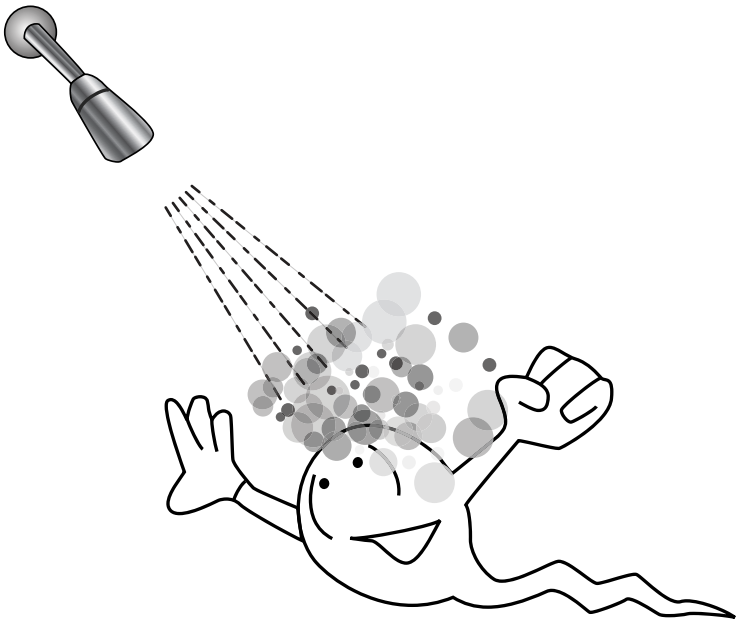
Extracting the best sperm

Sperm washing reduces HIV by 100,000 fold, with a five percent chance of HIV being present in the washed sperm. The process selects the strongest and most active sperm. Semen or ejaculate contains not only the sperm, but also white blood cells and seminal fluid. The sperm are separated by mixing the semen with a dense fluid and then centrifuging the solution. The different components of the semen settle into distinct layers. The layer of sperm is extracted and suspended in a salt solution, in which the most active sperm swim to the top and are then collected. This procedure costs about $150.

Following the washing procedure, some clinics test the separate components for HIV using a polymerase chain reaction (PCR), which is a similar test to the one used to check your viral load. The sperm are divided in half: one half is frozen for later use, the other half is tested for HIV. Since the possibility exists that HIV is still present in the stored sperm, the aim of reproductive technologies is to achieve conception with the least number of attempts when inserting washed sperm directly into the uterus. Each attempt or cycle may expose the women to HIV.

For the intrauterine insemination (IUI) technique, women must follow their menstrual cycle and know when they're ovulating. At the time of ovulation, the washed sperm is inserted directly into the uterus via the vagina, using a soft, flexible catheter.

In some cases, doctors may use ovarian stimulation (see below) to ensure ovulation occurs in a timely manner, optimizing the potential



Sperm washing reduces HIV by 100,000 fold, with a five percent chance of HIV being present in the washed sperm.

for conceiving. Depending upon the drugs used, each cycle of IUI can cost from $200 to over $2,000. There may be additional clinic charges of $300 or more.

The process of egg harvesting

The other methods of assisted reproduction—in vitro fertilization (IVF) and intracytoplasmic sperm injection (ICSI)—require egg harvesting. Women first undergo ovarian stimulation and monitoring. Then they receive daily injections of follicle stimulating hormone (FSH), which initiates the growth of multiple eggs in the ovaries. FSH is normally produced in the pituitary, but another drug is administered to shut down this function, allowing for better control and timing of egg growth and release.

Doctors will perform an ultrasound to look for developing follicles on the ovaries. The levels of estrogen and estradiol are also checked by taking regular blood samples. When the follicles mature, the woman receives a subcutaneous injection of human chorionic gonadotropin, which stimulates the release of the mature eggs from the follicles. The drug costs alone for this procedure are from $1,500 to $2,500.

Under local anesthetic and mild sedation, doctors harvest the eggs using a syringe that is inserted into the abdominal cavity. They use ultrasound to locate the eggs, which are drawn into the syringe. The harvested eggs are checked and then stored in a controlled environment prior to fertilization.

These procedures aren't cheap

With IVF, the eggs are mixed with the washed sperm and allowed to incubate for 24 hours. Fifty to 75 percent of the eggs are fertilized and incubated for a further 48 hours. The embryos are checked again prior to transferring them to the woman's uterus. Usually only the best three or four embryos are selected for transfer. Other healthy embryos may be frozen, sparing the woman from going through another cycle of ovarian stimulation and egg harvesting if the procedure is not successful.

Another way of fertilizing the egg is by injecting one of the washed sperm directly into the egg: intracytoplasmic sperm injection, or ICSI. The end result is a developing embryo that has been exposed to only one sperm, rather than a large number of them as in IVF. This is seen as further reducing the chance of HIV transmission.

In both IVF and ICSI, the embryos are transferred to the woman via her vagina into her uterus using a flexible tube or catheter. Costs for these procedures have a hefty price tag: between $5,000 to $7,000, plus the costs for ovarian stimulation and egg harvesting. Success rates per cycle range from 25 to 44 percent in the non-HIV population.

The success of these procedures depends on several key factors: the age of the woman, the response of her ovaries to stimulation, and the vigor of the sperm. The success rate for couples living with HIV who have used assisted reproductive technologies is not known. But if you're HIV-positive and you dream of having a family, it is possible to realize your dream. ⊕

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

Resources and further reading

- UBC Centre for Reproductive Health, www.ubcfertility.com
- Genesis Fertility Clinic, www.genesis-fertility.com
- Southern Ontario Fertility Technologies, www.soft-infertility.com
- "Baby Boom", *living ⊕ magazine*, Issue 28, January/February 2004
- "*Planning a Positive Pregnancy*," Positive Living Manual, BCPWA Society, 3rd Edition

Pregnant pauses

Recent updates in preventing mother-to-child transmission

by Shari Margolese

Two thousand and five babies were born to HIV-positive Canadian women between 1984 and 2004. Each year, the number has grown steadily, from 87 babies in 1993 to 163 in 2004.

What's behind the baby boom? According to a study by investigators at the California Epidemiologic Investigation Service, HIV has little effect on the desire to have children. Highly active antiretroviral therapy (HAART) has significantly reduced the rate of mother-to-child transmission (MTCT) and has improved prognoses of people with HIV. Coupled with advances in reproductive therapy, these breakthroughs have led to more planned families among PWAs. In addition, increased efforts to provide HIV counselling and testing to pregnant women have identified more HIV-positive moms.

Transmission news

Researchers have discovered that tiny amounts of HIV-infected blood leak from the placenta to the infant when contractions occur. This important study confirms the need to begin treatment before the onset of labour. Treating co-infections caused by viruses, bacteria, and parasites may further reduce the rate of MTCT. One recent study, by scientists at the Center for Global Health and Diseases and the Center for AIDS Research at Case Western Reserve University in Cleveland, showed that women who are co-infected with a parasitic worm called helminth were seven times more likely to transmit HIV to their infants. Malaria and herpes are also known to increase MTCT.

Treatment during pregnancy

Treatment decisions during pregnancy should always consider the health of the mother. Although many resource-poor settings use monotherapy (one drug) to prevent MTCT, it is internationally accepted that this is sub-optimal treatment, and that combination drug treatments are the standard of care. In Canada, it's recommended that all HIV-positive pregnant women, regardless of viral load and CD4 count, use HAART. When you should start and what you should take depends on your individual needs; discuss it with your doctor.

Nevirapine

Women can develop resistance to single-dose nevirapine when it is used as monotherapy or in a sub-optimal regimen. According to McMaster University's Dr. Fiona Smail, a member of the working group responsible for developing Canadian consensus guidelines for HIV-positive pregnant women, Canadian women are not typically given single-dose nevirapine.

Research presented at the 2006 Conference on Retroviruses and Opportunistic Infections showed that although single-dose nevirapine use during pregnancies usually leads to resistance, it is still effective in preventing mother-to-child transmission in subsequent pregnancies. This is good news in the prevention of MTCT where access to treatment is limited; however, the research, according to Dr. Smail, probably has little relevance in Canada, where treatment aims for complete viral suppression in the late stages of pregnancy rather than single-dose nevirapine.

Women are three times more likely to experience liver toxicity from nevirapine than men. A CD4 count over 250 increases the risk 12-fold. In fact, there have been reports of nevirapine-related deaths due to liver toxicity, including among HIV-positive pregnant women. Women with CD4 counts over 250 and/or who are co-infected with hepatitis should take particular care when considering nevirapine as part of their HAART combination. So far, serious and fatal liver toxicity has not been reported after single doses of nevirapine. ⊕

***Shari Margolese** is an HIV-positive activist and writer living in Ontario.*

Resources on HIV and pregnancy

- Canadian consensus guidelines for the management of pregnancy, labour and delivery and for postpartum care in HIV-positive pregnant women and their offspring, *Canadian Medical Association Journal,* June 24, 2003
- www.cmaj.ca/cgi/content/full/168/13/1671
- Fertility, Conception, and HIV, by Shari Margolese
- www.sfaf.org//treatment/beta/b55/b55_fertility.pdf

Tap into TIP

BCPWA's peer-driven Treatment Information Program can answer your questions about HIV-related conditions and treatments

by Zoran Stjepanovic

The Treatment Information Program (TIP) at the BCPWA Society is a provincial program serving all of BC. When it began in the early 1990s—before the advent of highly active antiretroviral therapy (HAART)—the program was run exclusively by volunteers. They collected any information they could find on treating HIV, creating hundreds of treatment files on complementary therapies.

When HAART became available in the mid-1990s, TIP was extremely busy serving HIV-positive members who wanted information about HIV medications and related side effects. In 1996, the volunteers advocated for the creation of a full-time staff position to provide support, program administration, and volunteer coordination. Today, the Treatment Information Program has two staff positions and approximately 20 volunteers providing ongoing support. The pivotal role of TIP is to provide information to BCPWA Society members, HIV-positive individuals, and any others needing information on treatments for HIV and related conditions.

Talk to your peers

People living with HIV go to their physicians and healthcare providers for information about HIV treatments and side effect management. But often these healthcare providers don't have enough time to adequately address the many issues that PWAs face. Sometimes people don't know how to get what they need from their physicians. They may also want to talk to someone who's going through similar issues.

That's why TIP exists. TIP provides a confidential, comfortable, and safe space to discuss any condition affecting your health. The treatment information volunteers have access to a wide variety of information on HIV-related conditions and treatments. Our volunteers receive extensive training on HIV and are very knowledgeable and willing to share information. Some of the most common inquiries we get are about antiretrovirals, switching medications, drug resistance, drug interactions, new drugs, side effect management, use of complementary and alternative medicine, HIV and hepatitis C co-infection, and requests for information on doctors.

These days, you can find lots of information about these drugs on various websites such as aidsmeds and aidsmap. There are still, however, many individuals who don't have access to the Internet and for whom traditional methods of information provision may not work. TIP is exploring new ways to contact harder to reach populations such as street entrenched people, ethnic communities, and new immigrants.

It would be great to hear from you! ⊕

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

CONTACT US
IF YOU NEED TREATMENT INFORMATION

If you have a question about HIV and related health issues, contact us!

Visit us

Come visit the BCPWA Treatment Information Program (TIP) office at 1107 Seymour Street and talk to a treatment information volunteer.

Call us

You can call us at 604.893.2243, or toll-free at 1.800.994.2437 if you live outside of Vancouver.

E-mail us

We can answer your questions by e-mail. Send us an e-mail at treatment@bcpwa.org.

Volunteer for us

We're always looking for more volunteers for the Treatment Information Program, especially peer treatment providers. You don't have to be an expert on HIV treatment, since you'll get plenty of training and support. All volunteers in the program have said that they find it extremely rewarding to provide information to other HIV-positive individuals, and at the same time gain personal knowledge about their own health.

New data and new controversies

Highlights from the 2006 Conference on Retroviruses and Opportunistic Infections

by Sean Hosein

The 13th Conference on Retroviruses and Opportunistic Infections (CROI) took place in Denver in February 2006. CROI is probably the leading scientific conference on HIV/AIDS. CROI acquired this status in the mid-1990s when scientists presented the first reports about the beneficial effects of highly active antiretroviral therapy (HAART) at the conference. So it is not surprising that CROI continues to attract leading researchers from around the world.

In the past several years, CROI has begun to extend coverage of care and treatment issues to those of low-income countries that are slowly gaining access to HIV medicines.

Every year brings new data and controversy at CROI and this year was no exception. HAART is usually a regimen of three or more drugs from four available classes. Unfortunately, over time, HIV can develop the ability to resist the effects of therapy. So new and more effective medications are needed, particularly for treatment-experienced people with HIV/AIDS. Encouraging signs from this year's CROI indicate that a new class of HIV medications is on the way: integrase inhibitors.

New therapies

Integrase is an enzyme needed by HIV to insert its genetic material into a cell's DNA, ultimately turning the infected cell into a potential virus factory. Integrase inhibitors interfere with HIV's ability to do this. Drug companies such as Merck have been developing integrase inhibitors for many years. Problems have occurred along the way because of toxicity and other issues.

At CROI, two companies—Gilead Sciences and Merck—gave presentations about their development of integrase inhibitors. What excited members of the audience is that the integrase inhibitors from both companies show anti-HIV activity in people and at least in the short term appear to be safe. The Merck integrase inhibitor appears to be furthest along in clinical development: they are testing it as part of combination therapy and it is significantly reducing viral load during four months of use.

Although these developments are promising, cautious optimism should always greet new classes and combinations of HIV medications. Until 10 years ago, changes in body shape and increased levels of lipids, glucose, and insulin in the blood were largely unknown among people with HIV/AIDS who were taking therapy. This is because therapy was generally simpler then—one or two nucleoside analogues in combination were the standard of care. Integrase inhibitors bring promise of hope and more treatment choices, but no one is yet certain about what kinds of side effects they might have or how long such side effects will take to appear in PWAs who use these new drugs.

Controversy over treatment interruption

In every chronic health condition, pill-taking becomes part of life. However, from time to time, it may be necessary to interrupt therapy, perhaps because of side effects, drug interactions, or for other reasons. But what is the best way to engage in treatment interruptions?

To answer this question, researchers in Canada and many other countries have been conducting clinical trials. In some of these trials, researchers select PWAs who have relatively high CD4 cell counts and suppressed viral loads. The PWAS have their treatment interrupted and the researchers monitor them regularly. Therapy is restarted when CD4 cells fall to a certain pre-set limit, such as 350 or 250 CD4 cells, and so on.

Results from one study of treatment interruption called Strategies for Management of ART (SMART) were presented at CROI. (See page 35 of the March/April issue of *living* ⊕.) It showed that participants who were assigned to receive treatment interruptions had at least twice the risk of developing a life-threatening infection or dying.

At CROI, two companies gave presentations about their development of integrase inhibitors, which show anti-HIV activity in people and at least in the short term appear to be safe.

Other studies of treatment interruption presented at the conference did not have such dismal results. This may be because the SMART study used a relatively low threshold for restarting therapy—250 CD4 cells. This is beginning to enter the range when life-threatening infections and other complications can develop. Thresholds for restarting therapy were stricter in other studies, which is perhaps why their results were less lethal.

The story on treatment interruption is not yet over. Researchers are still studying the results of the different clinical trials presented at CROI and trying to make sense of the various results. But what all researchers do agree on about treatment interruptions are the following: they can have serious and sometimes fatal complications. Also, improperly implemented, a treatment interruption can lead to drug resistance and fewer treatment options in the future. Therefore, treatment interruptions are best done in the setting of a clinical trial where close and regular monitoring is available.

Hepatitis C and sex between men

The hepatitis C virus is usually transmitted through sharing of drug-using equipment—including needles, syringes, and filters—or through the unsafe reuse of tattooing needles. Hepatitis C is rarely transmitted during sex between men and women. However, among HIV-positive men, unprotected anal sex appears to help transmit this infection (along with other strains of HIV and other sexually transmitted infections), according to researchers in the United Kingdom.

Being co-infected with hepatitis C and HIV makes both conditions harder to treat. Indeed, although therapy for hepatitis C is available, recovery rates from this infection are lower in co-infected people than in people who only have hepatitis C.

Bones in women

In the past several years, there have been reports of thinning bones in groups of mostly men with HIV/AIDS. But thinning bones are a concern for another group of people: women who are undergoing menopause, with or without the complication of HIV infection.

In HIV infection, there may be several reasons for bone loss. For instance, the virus damages the intestines, leading to malabsorption of nutrients. During the years between the acquisition of HIV infection and the initiation of treatment, the body may rob the bones of calcium to meet its needs. HIV may also adversely affect bone health in ways that are not well understood. For these and other reasons, researchers are studying factors that affect bone health, particularly in women going through menopause, who are at risk for thinning bones.

According to researchers in New York, HIV appears to reduce levels of the hormone estrogen in women, which in turn contributes to reduced bone density. The use of street drugs, particularly opiates such as heroin, morphine, and codeine, may also make bone thinning worse. Using HAART helps to reverse bone loss in HIV-positive women. However, long-term monitoring of these women is needed to assess changes in bone density over many years of HAART exposure. In addition, trials of bone-building drugs, calcium and vitamin D3 supplementation are needed in HIV-positive women, particularly those undergoing menopause.

Will other cancers occur?

HIV/AIDS has always been associated with an increased risk of certain cancers, including: cancers affecting lymph nodes and tissues (lymphoma); cancers of the cervix, vulva, and anus; and Kaposi's sarcoma, where tumours form on the skin but also near vital organs deep inside the body. What all of these cancers have in common is that they are caused by viruses that take advantage of the weakened immunity from HIV/AIDS.

As PWAs live longer thanks to HAART, there is concern that other cancers not normally associated with HIV/AIDS may become more prominent. One small and controversial American study at CROI suggested that PWAs, even those who do not smoke tobacco, might be at increased risk of lung cancer. Whether or not this is true will require confirmation by researchers elsewhere.⊕

A detailed CROI report will be available at www.catie.ca.

***Sean Hosein** is the science and medicine editor at the Canadian AIDS Treatment Information Exchange in Toronto.*

Beyond belief

If you're non-religious, transpersonal psychotherapy may be just the answer to your spiritual questions

by Jari Dvorak

In addition to the medical and emotional rollercoaster, HIV/AIDS can often bring about a spiritual crisis. In dealing with limitation and mortality, we confront life's Big Questions: Why am I here? Why go on living? And in the face of infection, why this? Why me? Why anything? The culmination of such intense searching, combined with a feeling of losing ground, can sometimes lead to extraordinary and unsettling experiences: spiritual visions, near-death experiences, or tunnels of light.

How do you process an inner experience that feels like a life's defining moment? It might feel too weird to share with friends, doctors, or even a psychiatrist.

Traditionally, we seek help with such spiritual questions from the clergy in the religious community. But what are the alternatives if you don't feel comfortable with organized religion? Is a psychiatrist the only option?

Enter the transpersonal psychotherapist.

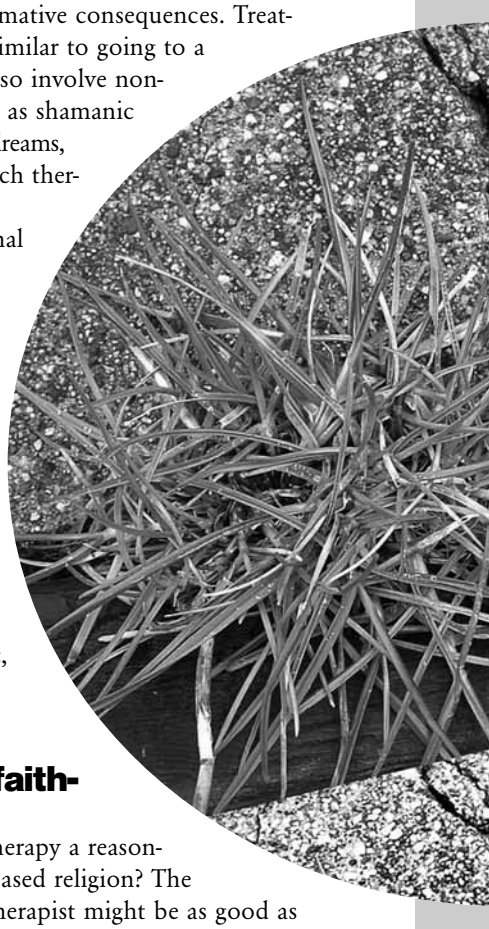
Transpersonal psychotherapists are part of a relatively new branch of psychology dealing with the spiritual dimension. The term "transpersonal" means "beyond the personal." Transpersonal experiences involve a different mode of consciousness in which the ordinary mental self is temporarily surpassed.

Combining Western psychology and mystical traditions

Transpersonal psychotherapists are trained to combine the insights of Western developmental and depth psychology with the insights of mystical traditions. The discussion focuses on your spiritual journey. The psychologist offers a map of commonly recognized markers of these "inner landscapes." The validation of the realness of mystical experience can itself be a big part of the healing. And going deeper, the experienced practitioner could help you open up to non-rational modes of knowing, such as intuition and integrative awareness.

The therapy might go beyond the prevailing Western view of the five stages of dying by considering mystical experiences as even more significant and transforming stages of surrender than death itself. These stages involve the qualities of grace, letting go, radiance, focusing inward, a sense of the sacred, wisdom, and, in the end, oneness or merging with the Spirit. This can open an entirely new, and richer, way of looking at life.

Transpersonal psychotherapy has very little, if anything, to do with New Age trappings such as crystals, alien abduction, fairies, levitation, or fire-walking—except to the extent that these phenomena, practices, or experiences may be investigated in terms of their transformative consequences. Treatment sessions might be similar to going to a shrink, but they might also involve non-traditional methods such as shamanic rituals, interpretation of dreams, meditation, yoga, and touch therapies such as Reiki.



Individual transpersonal psychotherapists may or may not have their own religious or spiritual beliefs. Although there is currently a predominance of Buddhist-inspired transpersonal psychotherapists, other traditions are also well represented. These include Christian, Jewish, Sufi, Hindu, Shamanic, Taoist, Tantric, Gurdjieffian, and Agnostic.

A substitute for faith-based religions

Is transpersonal psychotherapy a reasonable substitute for faith-based religion? The help of an experienced therapist might be as good as or better than what you could expect from a cleric. What could be missing is the support that people of faith receive from their faith-based communities. However, that might be partially offset by participation in ongoing therapy groups or healing circles.

Many private insurance plans will reimburse the cost of transpersonal psychotherapy, provided that the therapist has valid qualifications. That leaves one problem: how to find a qualified practitioner in your area. You could try doing a Google search. You could also check out the psychotherapy listings in the Yellow Pages or make enquiries in your local health food store.

THE PERILS OF MYSTICAL EXPERIENCE

Jack, a young baby boomer with AIDS, had a heart attack and was taken to the hospital. While on the operating table, he had a near-death experience.

Seeing God he asked, "Is my time up?"

God said, "No, you have another 23 years, two months, and eight days to live."

Upon recovery, Jack decided to upgrade his appearance. He took steroids, worked out with weights, had facial surgery, coloured his hair, and upgraded his wardrobe. Since he had so much more time to live, he figured he might as well make the most of it.

One day, while crossing the street on his way from the gym, he was killed by an ambulance. Arriving in front of God, he demanded, "I thought you said I had another 23 years. Why didn't you pull me from out of the path of the ambulance?"

God replied, "I didn't recognize you."

Book review

Meditation Without Myth, by Daniel A. Helminiak. Crossroad Publishing Co.

The value of this book is perhaps best summed up as follows: What I wish they'd taught me in church about prayer, meditation, and the quest for peace.

This book by renowned psychologist Daniel Helminiak is about practical ways of understanding spirituality without the heavy baggage of abstract theology. It is a masterful book! It gave me new insights, even though I have read others books on meditation and I meditate regularly.

What is so great, from my point of view, is that Helminiak keeps the focus on us, the non-religious folks. And he just might be the only one who explicitly targets non-religious people. I think he is up to something really important when, for example, he talks about God as the Santa Claus for adults.

Helminiak has a great gift of fresh thinking about the spiritual. I was really taken by the last part of the book ("God, Religion, and Spirituality"). For example, his thoughts on the two emerging visions of the global community. The first vision is that one society and its religion will dominate the globe and impose its ways on everyone. Having it put this way, the integrity of the alternative spiritual vision—in which societies and religions find the space in which to co-exist—becomes self-evident. Much of what the book says is something that I feel deeply, yet am unable to articulate as clearly as Helminiak does.

Also, I really like the way Helminiak goes through the reasons for a non-theological approach: "We are at a particular moment in history. Whereas religion was what gave many of us inspiration and vision, at this point religion might be more the problem than the solution."

Could a deeply religious person be part of the solution? Helminiak says it's not likely. I agree with him. But this is not the way we usually think about it. Most religious people think they are the key to the solution!

The part that goes to the core of my discomfort in discussing spirituality with religious people is stated very starkly by Helminiak: "I feel bad to be writing such [negative] things [about religious beliefs.] I wonder if I am not pulling the rug out from under people. I fear I am destroying the religious faith that gets most of us through life. Yet I do not think it is I who am doing this terrible deed. World events and personal growth have brought us to this point."

Another idea that sticks in my mind is the way Helminiak delineates spirituality from religion. "Spirituality is one facet of religion (love, compassion, concern for the common good), minus the dogmas and doctrines." Could this be the best definition of spirituality yet? He then proceeds to outline his non-religious vision of personal growth, closely approximating the path utilized by sages and wisdom seekers throughout ages.

The only part of the book I found weak was Helminiak's four laws of universal ethics to support personal growth. The precepts seem kind of true, yet there is something incomplete about them.

Overall, I found the book very helpful. It has the potential to stir the current spiritual discussions into a refreshingly new territory. The book's title does not do justice to the content. ⊕

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

Elevated mortality among female injection drug users

by Anne Drummond

The social and economic conditions in which people live have a powerful influence on their health. Safe housing, job security and satisfaction, adequate income, education, positive early childhood experiences, access to health and social services, and a circle of supportive friends and family—all these factors contribute to the health of individuals and communities. The absence of all or some of these factors creates distress and insecurity for people, which not only has a negative effect on their health but also predisposes them for unhealthy or risky behaviour.

Research, both qualitative and quantitative, continues to highlight the links between HIV and drug and alcohol use in the developed world. Furthermore, it is also clear that HIV infection exacerbates poverty, both material and psychological, and thus perpetuates and intensifies the epidemic. The mechanism underlying these links is probably that poverty and other social determinants such as poor education, childhood sexual abuse, and racial or social marginalization limit the choices available to people. Consequently, they are more vulnerable to risky behaviours in order to survive or to attempt to escape the misery of their situation.

The health and social conditions of women living in Vancouver's Downtown Eastside (DTES) have recently attracted considerable media attention. The health and social crisis among addicted women in the DTES is extensive, with Aboriginal women in particular at high risk of HIV infection.

Mortality among injection drug users (IDUs) has also been investigated; however, there are no studies focusing on mortality and causes of death specifically among addicted women. Dr. Patti Spittal and her colleagues at the BC Centre for Excellence in HIV/AIDS Research (BCCfE) at St Paul's Hospital in Vancouver thus took on the task.

Researchers at the BCCfE have been following a cohort of 1,400 female IDUs in Vancouver since 1996. From this group, 520 addicted women were recruited into Dr. Spittal's study and investigators followed them from May 1996 until May 2002.

Participants completed an interviewer-guided questionnaire at baseline and then every six months during the study. These questionnaires solicited information about housing, addiction treatment history, hospital or emergency department admissions, injection and non-injection drug use, injection practices, sexual risk behaviours, and HIV status. Based on information gathered at baseline, researchers grouped the cohort of addicted women according to whether or not they were involved in the sex trade.

Between May 1996 and May 2002 there were 68 deaths among women in the cohort. Estimates of mortality rates showed increased mortality among women who were HIV-positive at baseline, were involved in the sex trade, and who had unstable housing arrangements. The causes of death among the addicted women were primarily related to overdose, violence, and HIV/AIDS.

The overall death rate among women using injection drugs was 50 times higher than the death rate in the general British Columbia female population. These elevated rates of avoidable mortality are highly suggestive that the current addiction and HIV treatment strategies are failing addicted women in the DTES. Recent provincial and federal cutbacks and closing of services for women in BC have also contributed to increasing the vulnerability of these women.

The results of Dr. Spittal's study highlight the urgent need for innovative approaches to removing the barriers that addicted women experience in accessing HIV and addiction treatment. ⊕

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

Closing the gender gap in clinical trials

by Julie Schneiderman

Now that women represent more than 50 percent of the HIV/AIDS pandemic, one would expect a shift towards better representation in clinical research. So why is there still a gender gap? Historically, women have been excluded from a broad range of clinical trials across many disease areas, and researchers have overlooked the opportunity to better understand gender-specific outcomes.

As the keynote speaker at the Positive Women's Network Springboard event, Canadian HIV Trials (CTN) investigator Dr. Sharon Walmsley, from Toronto General Hospital's Immunodeficiency Clinic, addressed the gender imbalances in HIV/AIDS treatment and research. Speaking to a room of women in downtown Vancouver in honour of International Women's Day, Dr. Walmsley explained that barriers to participation in clinical trials for women exist at many levels.

Studies can be inaccessible because of demands on time due distance from the clinic site, lack of transportation, and inconvenient appointment hours. "We have husbands and children and duties in the home. We have to take care of much more than ourselves," said Walmsley, pointing to the fact that women tend to have more familial responsibilities.

Other factors such as the exclusion or inclusion criteria for entering a study can also serve as deterrents for women. Walmsley noted that many studies do not allow pregnant women to enroll and insist that women promise to use two methods of contraception. Women are often disqualified because they have a lower viral load and higher CD4 count than men, or because of set parameters, like those for hemoglobin, which is lower in women than men.

Dr. Walmsley recognizes recruitment strategies are not the only barrier. She believes that studies need to be designed with women in mind. Researchers should consider a gender lens, from development of the informed consent to the determination of the theory or drug(s) under investigation. "We know that women respond differently than men to HIV infection, the effectiveness of antiretroviral therapies (ART), and to adverse effects caused by treatments and dosages. I see this everyday in my clinic."

The challenges are complex, admits Walmsley, who showed the incredibly large sample sizes required in order to detect twofold differences in toxicity rates between women and men. Nevertheless, she acknowledges that by participating in clinical research, women can take the first step to help identify why HIV and some ART act differently in women's bodies than in men's.

To counteract their underrepresentation, the CTN continues to facilitate women's participation in clinical trials. Recent changes to policy by the CTN's Community Advisory Committee have provided for daycare and travel costs in all CTN trials. ⊕

***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 (DIDC) and St. Paul's Hospital, Vancouver; Medical Arts Health Research Group, Kelowna General Hospital

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

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

CTN 213 — Dose finding and proof of concept study of Leukotriene B4 (LTB4) as ART
BC site: St. Paul's Hospital, 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.

Reading the fine print

Here's a primer in demystifying nutrition labels when you're grocery shopping

by Treena Hansen

If you've visited a dietitian recently, you've probably heard plenty of nutrition recommendations for heart disease, diabetes, or weight gain or loss. If your cholesterol/triglycerides are high, you were likely advised to reduce fat, especially saturated and trans fat, and increase fibre and omega 3 fatty acids. If you have diabetes or insulin resistance, you probably were told to eat regular meals and snacks, reduce sugar, and aim for a certain amount of carbohydrate, protein, and fat per meal.

That's all great advice, but how do you put this into practice when you go grocery shopping? Reading labels on packaged foods can help you make informed, healthy choices. It can also help you to meet your dietary goals.

As of December 12, 2005, the regulations for the new nutrition labels became mandatory for large companies, with smaller companies given an extension of another two years.

Nutrition labels appear on most packaged food in a standard format: white background with black lettering. If t he package is small, the food label will appear on the inside of the package or on a tag. If a package is too small to put a label on the outside or the inside, then there must be a toll-free number or a postal address for consumers to contact for nutrition information.

Three parts to a packaged food label

There are three parts to a label: nutrition facts, ingredient list, and nutrition claims. The nutrition facts table provides specific nutrition information based on a particular serving size of the food; it must include calories plus 13 nutrients that have been identified as important to the health of Canadians. Some labels may list more than the 13 nutrients. The fat, carbohydrate, protein, cholesterol, and sodium are represented in grams or milligrams, whereas the vitamins and minerals are expressed only as percent daily value. The percent daily value is based on a 2,000-calorie diet; this figure indicates whether there is a little or a lot of a specific nutrient in that serving of food.

Table 1.
Nutrition facts table for canned cooked kidney beans

Nutrition Facts

Serving Size 1 cup 256g (256g)

Amount Per Serving	
Calories 218	Calories from Fat 7
	% Daily Value*
Total Fat 1g	1%
Saturated Fat 0g	1%
Trans Fat	
Cholesterol 0mg	0%
Sodium 873mg	36%
Total Carbohydrate 40g	13%
Dietary Fiber 16g	66%
Sugars 1g	
Protein 13g	

Vitamin A	0%	• Vitamin C	5%
Calcium	6%	• Iron	18%

*Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

For example, Table 1 shows a typical nutrition facts table for canned cooked kidney beans. A one cup serving provides a total of 40 grams of carbohydrate, in which 16 grams come from fibre and 1 gram from sugar; the remaining grams, which are not mentioned, come from starch. The protein content is 13 grams, comparable to eating 2 ounces of meat by weight. The same one cup serving also contains one gram of fat none of it in the form of saturated and trans fats.

According to the percent daily value in Table 1, the canned kidney beans contain a lot of salt. As for other vitamins and minerals, the serving of beans contains a moderate amount of iron and a small amount of calcium and vitamin C. A helpful hint to reduce the salt in canned foods is to strain the contents under cold water; this removes most of the salt.

The second part to a label is the ingredient list. Nearly all pre-packaged foods will list ingredients by weight, from the most to the least. This list is a source of information on what nutrients are contained in the package. The information is especially important for people with food allergies or those who want to avoid certain ingredients based on religious beliefs. For example, the can of kidney beans might list the ingredients as "red kidney beans, salt, and water." Because salt

is listed second, it is the largest ingredient in the can after kidney beans, indicating the product has a high salt content.

Check out the nutrition claims

The third part to the nutrition label is the nutrition claims. Nutrition claims are not mandatory on labels; providing the information is at the discretion of the manufacturer. Some nutrition claims describe a specific nutritional feature of interest. The canned red kidney beans, for example, might claim to be "very high in fibre." Other key words used in nutrient content claims are listed in Table 2. To help you decide whether a product is a good choice, review labels for such nutrition content as sodium, cholesterol, fat, fibre, and calcium.

Nutrition claims also include diet-related health claims that highlight a relationship between diet and a disease or condition; these claims must be supported by scientific research. Health claims may be printed on packaged foods that reduce the risk of high blood pressure, heart disease, cancer, or osteoporosis. An example: "A healthy diet rich in a variety of vegetables and fruit may help reduce the risk of some types of cancer, and a healthy diet low in saturated and trans fats may reduce the risk of heart disease. [Food contained in the package] is low in saturated and trans fats."

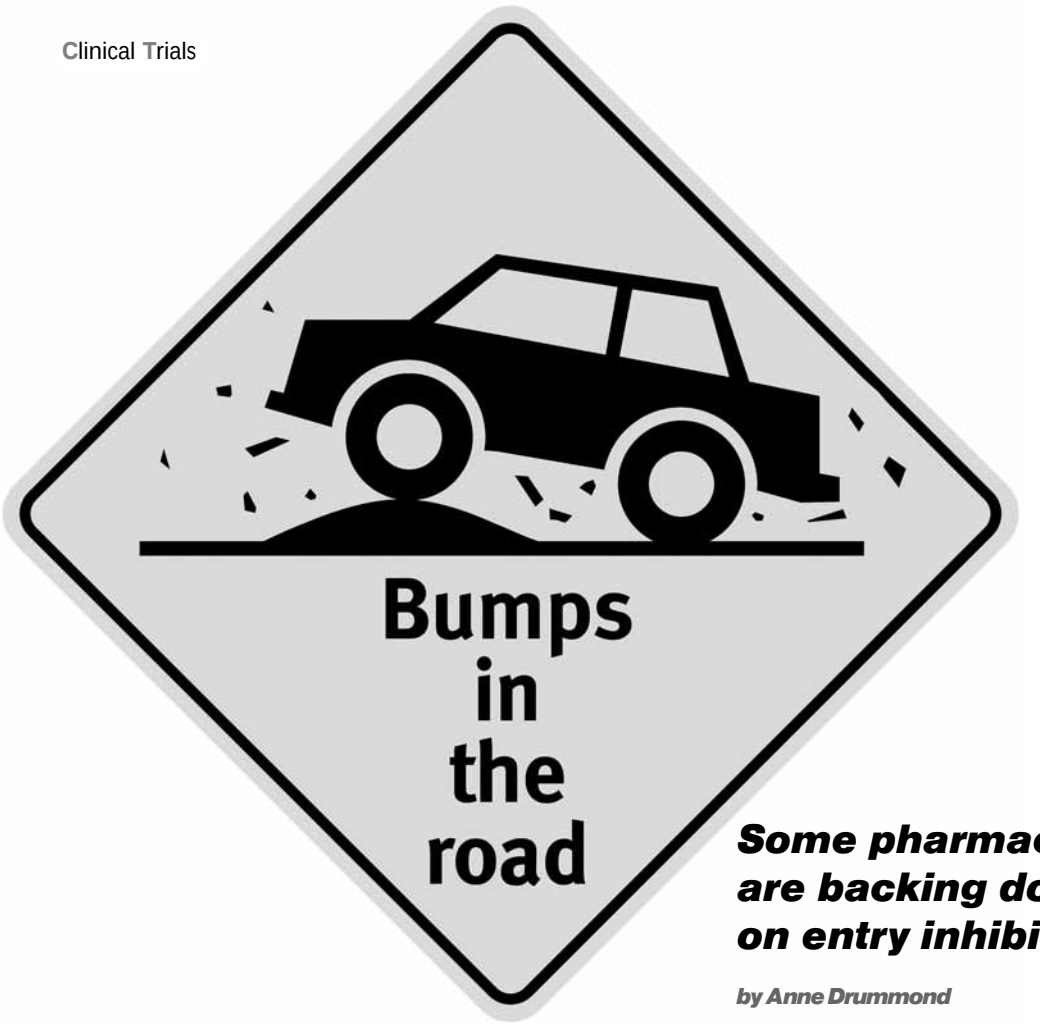
Health and nutrition information is becoming widely available to consumers. Understanding how to interpret the data on food labels is a valuable resource for product-specific nutrition information at the point of purchase. Next time you're at the grocery store, pick up a package and inform yourself about the food you're about to purchase. Enjoy—and bon appetit! ⊕

Table 2. **Key words used in nutrient content claims**

Key words	What they mean	Nutrition recommendations
Free	**An amount of nutrient so small, it is considered nutritionally insignificant**	
Sodium free	Less than 5 mg of sodium*	Less than 2400 mg/day
Cholesterol free	Less than 2 mg cholesterol, and low in saturated fat (includes a restriction on trans fat)*	Less than 200 mg/day
Sugar free	Less than 0.5 g sugar	No recommendation
Low	**Very small amount of nutrient**	
Low fat	3 grams or less*	Based on an 2000 calorie diet; aim for less than 30% or 65 g/day (1 tsp fat equals 5 g of fat)
Low in saturated fat	2 grams or less of saturated and trans fats combined*	Less than 10% of total fat
Reduced	**At least 25% less of a nutrient compared with a similar product**	
Reduced in Calories	At least 25% less energy than the food to which it compared	
Source	**Always associated with a "significant amount"**	
Source of fibre	4 grams or more*	Aim for 25-35 g/day
Good source of Calcium	165mg or more*	Calcium (age in years): 9 – 19: 1,300mg/day 20 – 50: 1,000mg/day >50: 1,200mg/day
Light	**When referring to a nutritional characteristic, "light" is allowed only on foods that are either "reduced in fat" or "reduced in energy" (calories)**	
	Explanation on the label of what makes the food "light";this is also true if "light" refers to sensory characteristics, such as "light in colour."	

**Per reference amount and per serving of stated size (specific amount of foods listed in nutrition facts)*

Treena Hansen *is a registered dietitian and a certified diabetes educator who works at the Diabetes Centre at St. Paul's Hospital in Vancouver. She is a member of Vancouver Dietitians in AIDS Care.*



Some pharmaceutical companies are backing down from research on entry inhibitors

by Anne Drummond

With drug resistance an increasing problem in the fight against HIV/AIDS, the new class of drugs called entry inhibitors show promise in addressing the issue. However, there have been bumps along the way in developing these drugs.

High rates of viral replication and mutation enable the HIV virus to develop resistance to antiretroviral drugs. To counter this resistance, HIV clinicians use a regimen of drugs with different mechanisms of action. But, due to less-than-perfect adherence to complex regimens and to the reduced efficacy of older drugs, many PWAs have developed multi-class resistance, particularly people who have been on antiretroviral medication for an extended time. Multi-class resistance reduces the treatment options for these people, which has created an urgent need for a new class of antiretroviral drugs.

That's where the entry inhibitors come in. This class of drugs focuses on preventing entry of HIV into CD4 cells, unlike the protease inhibitors, nucleoside reverse transcriptase inhibitors, and non-nucleoside reverse transcriptase inhibitors which derail viral activity once the virus is inside the cell. For HIV to enter a CD4 cell, molecules on the viral envelope must attach to a receptor on the CD4 cell membrane and then insert a glycoprotein into the CD4 cell. This action allows the virus to fuse with the host cell and release its contents into the CD4 cell.

Entry inhibitors have been developed either to target the process of attachment or fusion by blocking receptor proteins, or to target co-receptors on the surface of the CD4 cell, thus inhibiting the viral fusion sequence. T-20 (enfuvirtide, or Fuzeon) was the first drug in this new class to be licensed, and it is used regularly for patients who have developed multi-class resistance. Fuzeon is a fusion inhibitor and acts by preventing the insertion and attachment of the viral glycoprotein.

GlaxoSmithKline pulls the plug on aplaviroc trials

Three other very promising entry inhibitors began advanced clinical trials in 2004. Aplaviroc, maraviroc, and vicriviroc are all attachment inhibitors and act by blocking the attachment of HIV gp120 to the co-receptor CCR5 on the CD4 cell membrane. The efficacy of these three CCR5 antagonists during the pre-clinical phase of their development suggested that they would significantly enhance and complement the current highly active antiretroviral therapy (HAART) regimens.

This was not to be. In October 2005, GlaxoSmithKline (GSK) announced that they were ending all clinical trials involving aplaviroc after they found potentially serious liver toxicity in several patients. This initiated concern that liver toxicity would prove to be a CCR5 antagonist class effect. No

one in the GSK trials died, only four of 308 trial patients developed liver toxicity, and the toxicity always resolved when they stopped taking aplaviroc.

Later that month, Schering-Plough stopped the low-dose vicriviroc arm in their trials because of viral rebound. There was no evidence of hepatotoxicity or any other safety concerns in these trials.

In October 2005, GlaxoSmithKline announced that they were ending all clinical trials involving aplaviroc after they found potentially serious liver toxicity in several patients.

Holding out hope for maraviroc

Maraviroc, which Pfizer is developing, is still undergoing advanced Phase 3 clinical testing in both naïve patients and those with more advanced disease. To date, this drug has proved to be safe and well tolerated, and trial patients have shown sustained decreases in viral load.

In November 2005, Pfizer reported one case of hepatotoxicity while the patient was on maraviroc, resurrecting concerns that hepatotoxicity may, after all, be a class effect for these drugs. However, the patient was also on two other drugs that may have caused hepatotoxicity, and this was only one case among many hundreds who had tolerated maraviroc without developing liver toxicity. Clearly, these fears were unfounded. The HIV/AIDS community now awaits results from Phase 3 trials of maraviroc in order to clarify the potential role of CCR5 entry inhibitors in the anti-HIV arsenal.

It's cause for concern that GSK would so readily abandon its investment in aplaviroc on the basis of a problem affecting barely one percent of the trial patients; particularly in the light of research from Spain and Italy suggesting that liver toxicity of unknown origin is associated with HIV infection. The alternative to abandoning trials would be to pre-empt problems through early detection, and then closely monitor and manage any problems that occur; better, still, would be to take the opportunity to investigate the mechanisms whereby this toxicity arises.

It is probable that the recent flurry of publicity and lawsuits associated with other non-HIV drugs has generated a policy of extreme caution among pharmaceutical companies. However, this caution may prove to be inhibitory and has the potential to severely limit the progress of new drug research and development. ⊕

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

Not just for bodybuilders

Natural sources of testosterone can strengthen your immune system—whether you're male or female

by Kenn Blais

Testosterone is a misunderstood steroid hormone. Few people realize the positive effect it has, like any hormone, on all levels of our being. Most hormones are either peptides, made from amino acids, or steroids, made from cholesterol. We need testosterone for proper protein absorption and utilization. It also plays a significant role in the Krebs cycle, which is how the mitochondria produce energy in cells. Low testosterone slows the Krebs cycle, leading to low energy and fatigue. Decreased testosterone levels cause decreased quality of life, decreased muscle strength, and decreased bone density.

In men, symptoms of low testosterone include decreased sexual function, lowered libido, and erectile dysfunction (impotence). As devastating as these symptoms are, they are not the first signs of hypogonadism (reduced or absent secretion of hormones from the sex glands). Fatigue, depression, loss of strength, poor self image, and weight loss usually appear first, and doctors often misdiagnose them as symptoms of depression or chronic illness. Low testosterone influences fat distribution and deposition. Boosting low testosterone improves lipid profiles and reduces cardiovascular risk. Testosterone works with vasodilators such as nitric oxide to improve erectile function.

But most people don't realize that women need testosterone, too. Although women need one-tenth the level of testosterone that men do, the correct ratio of testosterone completes the gonadal function in women, in conjunction with estrogen and progesterone. Hormone replacement therapies (HRT)—traditionally estrogen/progesterone based—are being improved by the addition of testosterone. Low levels of testosterone cause decreased sexual desire and libido disorders in women, and can also affect the severity of depression and mood disorders. The high rate of amenorrhea (absence of menstruation) and weight and muscle loss among HIV-positive women is also directly related to low testosterone.

Testosterone and HIV disease progression

Hormone dysfunction starts early in HIV disease but usually isn't detected until symptoms are noticeable. This could take ten years or longer. It is estimated that 50 percent of men and women with HIV have low testosterone levels, and the percentage rises with disease progression. Since hormone levels are rarely monitored with HIV, this is probably a conservative estimate. Everyone should have his or her blood hormone levels taken when diagnosed with HIV in order to establish a baseline. Total and bioavailable testosterone and dehydroepiandrosterone (DHEA) levels should then be checked on a regular basis.

Every hormone requires "messengers" in order to perform properly—including enzymes, neurotransmitters, the liver, as well as the pituitary and hypothalamus in the brain. The key to hormone therapy is to re-establish the intricate balance of all these components. Natural remedies contain active chemicals and nutrients that gently influence the entire system.

One of those messengers is a molecule called cyclic adenosine monophosphate (cAMP), which boosts hormonal activity by making sure that the right hormones get through to the right cells at the right time. Studies have observed decreased cAMP ratios and activity in AIDS patients, causing lowered hormone function and cellular miscommunication. The herb coleus forskohlii increases cAMP by activating the enzyme adenylate cyclase that makes cAMP. Maintaining adequate cAMP increases the hormonal signals needed to make testosterone.

Hormone dysfunction starts early in HIV disease but usually isn't detected until symptoms are noticeable. This could take ten years or longer.

Three key alternative therapies

Traditional Chinese Medicine: In Traditional Chinese Medicine (TMC), low testosterone is categorized as kidney deficiency, which manifests as low sex drive, lassitude, and a weak chi (energy) pulse. Treatment targets sexual potency, bone marrow function, and chi regulation.

One of the main herbs used in kidney formulas is epimedium. It's known for its aphrodisiac effects, and it promotes sexual function and desire in both men and women. Epimedium increases sperm count and blood flow to the genitals. It also increases testosterone through stimulation of cAMP, enhances fertility, and relieves menstrual problems. Astragalus, one of the most important herbs used in TMC to treat HIV, increases cAMP levels.

Homeopathy: Homeopathic remedies are highly effective in reviving hormonal dysfunction. Groups of homeopathics called cell signal enhancers are used to restore the intercellular communication at the root of low hormone levels. Both cAMP and insulin-like growth factor-1 (IGF-1) are cell signal enhancers and in homeopathic form have been used effectively along with homeopathic testosterone to normalize low serum levels and function. IGF-1, a hormone released from the liver, is responsible for the stimulation of muscle mass formation. An increase in muscle mass requires testosterone, growth hormone, and IGF-1, all of which are diminished with HIV.

Ayurvedic medicine: Ayurvedic medicine offers many formulas and preparations to improve hormonal and sexual function. The herbal remedies used to treat HIV also increase hormone function since both involve decreased ***ojas***. Roughly translated, ojas refers to primary energy function and is the key to a strong immune system.

Decreased gonadal function is a symptom of lowered immunity. Ayurvedic medicine has identified the importance of correcting gonadal dysfunction when treating immune system disorders. Two Ayurvedic herbs well known to increase sexual function are especially indicated in HIV for their immune boosting properties. ***Ashwagandha*** is used for men and has aphrodisiac, rejuvenating and tonic benefits. It is used for sexual debility, muscle energy loss, and fatigue. ***Shatavari***, the main Ayurvedic female rejuvenative herb, is used for infertility, menopause, sexual debility, and female organ debility. It increases breast milk and female hormones, and nourishes the ovum. Both of these Ayurvedic herbs are taken with warm milk (preferably boiled and cooled organic milk), raw sugar, and ground almonds for the synergetic effect.

Herbal remedies can help, too

Maca root

Many herbs are known to increase testosterone. Maca grows in the high altitudes of the Andean Mountains in Peru where other cultivated plants cannot survive. Among its benefits, it balances adrenal and gonadal hormones, increases dehydroepiandrosterone (DHEA) and testosterone levels, and improves libido, fertility, and erectile dysfunction. It also has aphrodisiac effects. Maca relieves depression, stress, and insomnia.

For women, it also relieves PMS, hot flashes, and menopausal symptoms. As well, it is used to increase stamina, endurance, and to improve athletic performance. Maca is full of nutrients including amino acids, alkaloids, sterols, vitamins, and minerals. It is non-toxic and can be taken in large doses.

A native evergreen from Africa, pygeum is used for its beneficial action on the prostate. It relieves symptoms of benign prostatic hyperplasia, prostatitis, infertility, and impotence.

Saw palmetto

Tribulus Terrestris

Saw palmetto is recognized by modern medicine as an effective treatment for prostatitis, enlarged prostate, and for increasing urine flow. Long known as an aphrodisiac, it increases reproductive health in men and women. It has also been studied to treat hirsuitism (abnormal hair growth) and ovarian disease in women.

Traditionally used by Bulgarian athletes, tribulus terrestris, or puncture vine, is known as an aphrodisiac and tonic. It is used to increase testosterone and sperm production; it treats genitourinary conditions, impotence, and infertility.

Remember that many things will influence hormonal health. Proper nutrition and adequate rest are important with HIV to keep stress-induced cortisol levels from rising. Cortisol eats away at testosterone. Yoga postures, meditation, and moderate exercise are key things that you can include with your herbal regime to keep yourself vibrant to the core. ⊕

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

Watch your herb dosages!

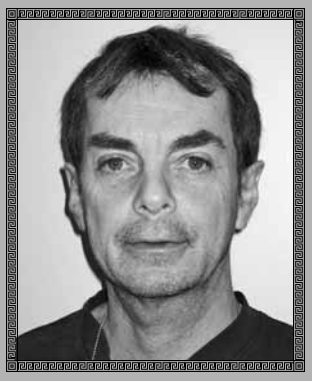
Even though herbal remedies aren't drugs, this designation doesn't diminish their potency: they do contain chemicals that influence body functions. Herbal medicines can cause unwanted side effects and interfere with some medications.

When beginning a new herbal therapy, start at the lowest dose and work up to the full dose to allow the body to adapt. More is not better; herbs work subtly, so be patient.

Some herbs that increase sexual function may cause increased blood pressure and heart rate, dizziness, and headaches. It's always best to be well informed from as many sources as possible, including both self-education and professional therapists.

Volunteering at BCPWA

Profile of a volunteer: Keith Morris



Keith is not only a committed Internet Cafe leader, but a great team player! He is organised, thoughtful, and a pleasure to work with. Keith has proven to be a highly dedicated, reliable, and skilled volunteer.

Ruth Marzetti
Manager of
Information Technology

Volunteer history

I first started volunteering at the Vancouver Food Bank. I still volunteer there once a week. Primarily I handle new registrations.

Started at BCPWA

Fall of 2004 in the mailroom. I'm also a counsellor and presenter for the Treatment Information Program, the leader for the Internet Café program, and I do data entry for Fund Development.

Why pick BCPWA?

First, for my partner of 14 years who passed away in 1990. I also wanted to contribute to the organization that had helped so many of my other friends who, sadly, are no longer here. It's also a great opportunity to learn new skills and to interact with people dealing with problems similar to mine.

Why have you stayed?

It was hard to adjust to an early retirement. Volunteering at BCPWA keeps me motivated and keeps my mind active. I go home at the end of the day feeling good, knowing I have made a contribution.

Rating BCPWA

I think it would be pretty hard to match this place. The unconditional love and support from other volunteers and staff is always on tap.

Strongest point

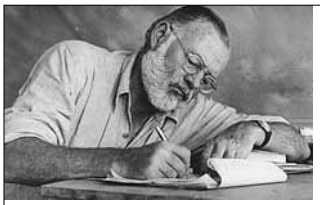
Knowing that my contribution is needed and valued.

Favourite memory

Protesting in front of Ujjal Dosanjh's office last Christmas for the release of the HIV drugs TMC 114 and 125. I also really enjoyed being a first aid volunteer at last year's Walk For Life.

Future vision of BCPWA

Hopefully there will come a time when it is no longer needed.



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
May 10, 2006	1:00	Board Room	Written Executive Director Report / Financial Statements — March
May 24, 2006	1:00	Board Room	Executive Committee
June 7, 2006	1:00	Board Room	Written Executive Director Report / Standing Committees Financial Statements — April / Director of Development
June 21, 2006	1:00	Board Room	Director of TIAD
July 5, 2006	1:00	Board Room	Written Executive Director Report / Executive Committee Financial Statements — May

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: Melissa Davis
t 604.893.2209 e melissad@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: Jane Talbot
t 604.893.2284 e janet@bcpwa.org

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** Annual subscription includes 6 issues*

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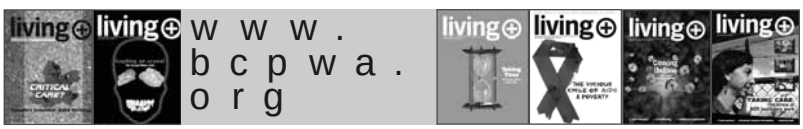
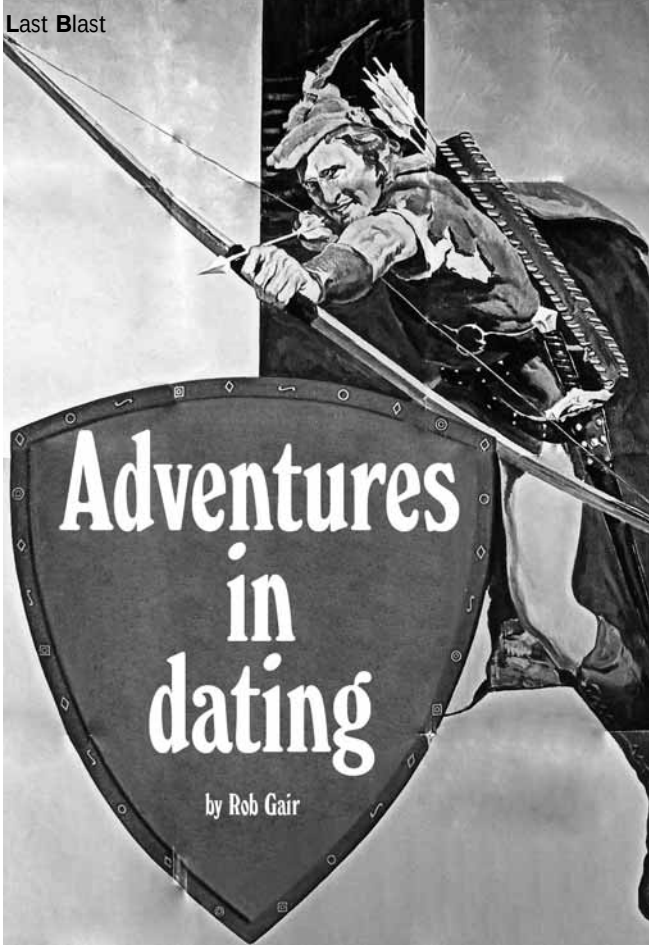


living⊕

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



A bit of good marketing can do wonders when you're hunting for guys on the Internet

"The Internet is where it's at, man." This is what my friend says about finding guys for sex or other stuff. Be that as it may, I resisted on-line dating for a long time.

The reason, I suppose, was a bad taste in my mouth from eons ago when I belonged to that funny Rainbow chat line (does anybody remember it?). That was back when the only thing you had to rate potential mates was his words on the computer screen. Maybe it was just me, but after months of bad dates and one particularly bizarre incident with a cute 20-something blond, I couldn't take it anymore.

I traded my Rainbow membership for an F212 membership and I never looked back. I figured at least at the bathhouse you can see what you're getting up front—an instant sizing-up of prospects so you know right away whether to hook up or hike out. None of this waiting for him to arrive, wondering what he looks like in 3D. No travelling across town in a torrential downpour only to find a tweaked out party boy with a serious case of verbal diarrhea.

But lately the bathhouse nooks and crannies haven't been cutting it for me. Maybe it's my imagination, but in the last few years there seem to be fewer guys, even on the "busy" nights. Or maybe I'm losing my edge—I've noticed the development of varying degrees of resistance to my immutable charms. I tried the park with good results, but freezing my ass off in the dark for a quickie is not my idea of a fun time.

Still, I procrastinated going on-line. At first I didn't have a computer at home, then I didn't have a digital camera to take photos of myself, then I couldn't think of a good nickname. Stalling, I know, but finally I was asked to write an article that required doing some "research" on barebacking sites. I said to myself, "resistance is futile, dude, get yourself a nick and sign up."

Once I made the mental transition, the rest was easy. I thought up some cute nicknames, downloaded some decent pictures, and tweaked my profile until I had just the right combination of sexy and smart: HOT SCIENCE GEEK LOOKING FOR OTHER STEAMY POZ GUYS TO TURN MY CRANK. I was pleasantly surprised by the, um, enthusiastic response.

The best part is all the cute HIV-positive guys I've met. I decided early to be straightforward about my HIV status. I didn't want the hassle of awkward disclosures and I figured telling people up front would weed out the poz phobics. Indeed it did, and the bonus was all the hot pozzies that came out of the woodwork.

So where to now? Acknowledging that I'm relatively new to all of this, could it be that my early success is just a honeymoon phase? You know, guys taking advantage of fresh meat. If so, fine with me fellas. Love the attention!

But seriously, so far it's been a series of relatively brief encounters. I've asked myself a few times, do I want something more meaningful? I've always been ambivalent about relationships, which is probably why I'm single most of the time. Though I do like cuddling on the couch and I would like to share more than just sex. So maybe the next phase is to seek out guys who are more earnest about pursuing that elusive LTR—long-term relationship. You never know, maybe Mr. Right is actually out there.

If you're new to Internet dating, here are a few pointers:

- Don't take romantic pillow talk too seriously. If he's still amorous after you've shagged ***and*** if he shows up for a second date, then you're allowed to be optimistic.
- If you're a top, you'll be in high demand. Pace yourself.
- HIV isn't the only nasty bug out there.
- Give the guy the benefit of the doubt, but if he's being a complete asshole feel free to take the piss out of him.
- Be sure to get a face pic before you meet up. Saves the embarrassment of inviting your best friend's boyfriend over. It happens. ⊕

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