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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 4500 HIV+ members.

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Walking in solidarity and support

by Paul Lewand

What does September mean to you? For some, it means autumn leaves. For others, it means back to school. But around the BCPWA Society offices, September means WALK for LIFE.

The BCPWA Society has the distinction of having established the first ever AIDS WALK in Canada. In 1986, a group of less than a dozen people organized a fundraising walk-a-thon around the Stanley Park seawall and raised $7,000 for people living with HIV/AIDS in the community. More than 20 years later, this event has generated over $5 million. The WALK has grown into a high profile national event in numerous cities across Canada.

There's a familiar rhythm around the BCPWA Society office in the months leading up to the WALK. During the summer, many workplaces typically slow down. Not so for us. Throughout the summer, the WALK for LIFE offices are filled with a flurry of activity: confirming corporate sponsors; designing and printing promotional materials; supporting our community partners; and recruiting teams, individual walkers, and volunteers.

And that's just the beginning. There's also a mountain of on-site logistics to arrange—from tents, staging, and fencing, to merchandise, food, and entertainment.

But the WALK for LIFE is like a well-oiled machine. Each year, on the last Sunday in September, the sun shines, the crowds gather, and the energy swells as our community collectively raises hundreds of thousands of dollars to provide direct and essential services for people living with HIV and AIDS.

When I think back over the more than 15 years that I've been living with HIV, it's impressive to think that Vancouver's WALK pre-dates my own diagnosis. In those very early years, I remember my feelings of isolation. The social stigma was intense back then, and the journey to self-acceptance and community support was a long one for me and for many others. But I also recall the sense of reassurance in discovering the WALK—a community event where thousands gathered, in solidarity, to support people living with HIV and AIDS: people like me. And I recall my sense of gratitude in benefiting from the vital programs and services supported by revenue from the WALK.

I suppose that 20-plus years is a long time to be coordinating, fundraising, or volunteering for the same event—especially one as large as our WALK for LIFE. Some of you have been involved since the very beginning, others are newcomers. And still others, newly diagnosed with HIV, will attend the WALK or access services funded by the event for the very first time this year. I expect they will feel a similar sense of reassurance and gratitude that the WALK has stood the test of time—that people have not tired of giving, helping, and caring.

After more than two decades of AIDS, your support is needed more than ever. We hope you will strengthen your involvement in the 21st annual WALK for LIFE once again this year, in whatever ways you choose to participate: as a team captain, individual walker, pledged supporter, or volunteer. ⊕

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

REALITYBITES

News from home & around the world

BCPWA launches police complaint

BCPWA Society has filed a complaint with the Vancouver Police Department (VPD) for unnecessarily publicizing a man's HIV-positive status.

The man was charged in February with two counts of aggravated sexual assault for allegedly engaging in unprotected sex with two Vancouver men on different occasions after denying to them that he was HIV-positive.

Shortly after the accused was charged, the VPD issued a press release about him under the banner "wanted sex offender," asking for help in determining his whereabouts.

The BCPWA complaint alleges that the accused cooperated fully with police investigators and appeared in court on March 21. But on March 30, the VPD issued a second press release again revealing the man's HIV-positive status.

The BCPWA complaint urges the police board to establish a firm policy preventing the VPD from publishing any individual's HIV-positive status unless there is unambiguous evidence of ongoing reckless personal behaviour that endangers public safety.

Source: Xtra West

Aptivus safety warning

During a routine database review, Boehringer Ingelheim Canada Ltd. (BI) noted 14 case reports of intracranial hemorrhage (ICH) in 13 patients receiving Aptivus, also known as tipranavir, while participating in clinical trials. Many of the patients experiencing ICH in the Aptivus clinical development program had other medical conditions—including CNS lesions, head trauma, neurosurgery, coagulopathy, hypertension, or alcohol abuse—or were receiving concomitant medications, including anti-coagulants and anti-platelet agents, that may have caused or contributed to the hemorrhages.

These events have been reported to Health Canada. BI and Health Canada have agreed to issue a letter to HIV-treating physicians along with a public advisory.

None of these ICHs were in Canadian patients taking Aptivus. BI is continuing its surveillance of Aptivus clinical trial reports to gain a better understanding of this side effect.

Sculptra for facial lipoatrophy

A new implant containing poly-L-lactic acid (Sculptra) has shown promising results in clinical trials for treatment of HIV-associated facial fat wasting. A recent review examining four separate studies found "significant long-lasting increases" in skin thickness and facial appearance. In one study, the positive effects were observed for up to 96 weeks.

Sculptra is injected directly into the facial tissue. Side effects include bruising and bumps under the skin, which can be felt but not seen. These effects may decrease as clinicians develop more experience and better injection techniques. The manufacturer, Sanofi-Aventis, is currently seeking regulatory approval for Sculptra from Health Canada. The expected market date is not known.

Rob Gair

African circumcision study to continue

On June 27, officials at the US National Institute of Allergy and Infectious Diseases (NIAID) examined preliminary data examining the effects of adult male circumcision on HIV transmission in Africa. Researchers are studying circumcision as an AIDS prevention tool because lower HIV infection rates have been observed in African populations where male circumcision is routine. The NIAID has decided that more research is needed and the trial has been extended for another year.

A previous study sponsored by the World Health Organization found that circumcised men were 65 percent less likely to become infected with HIV. Evidence suggests that the uncircumcised men have a lack of protective keratin on the inner surface of the foreskin plus high concentrations of cells that may assist HIV entry.

Rob Gair

FDA approves TMC114

US health officials have approved the use of Prezista, a protease inhibitor designed to treat resistant strains of HIV in combination with related therapies.

Also known as TMC114, the drug is given with a low dose of an older protease inhibitor, ritonavir, which slows the clearance of Prezista and increases its concentration, the US Food and Drug Administration said. The drug will have a wholesale cost of $25 a day.

The FDA said it approved Prezista based on two six-month trials that found 70 percent of patients who had tried other therapies improved when they added

REALITYBITES
News from home & around the world

Prezista and ritonavir to their regimen compared with 21 percent of those who took ritonavir with other protease inhibitors.

Source: Medscape

Abbott picks and chooses patients

People living with HIV/AIDS in developing countries in urgent need of an improved version of the AIDS drug lopinavir/ritonavir continue to be denied access to it by its sole manufacturer, Abbott Laboratories, according to the international medical humanitarian organization Doctors Without Borders/Médecins Sans Frontières (MSF).

Abbott began shipping the new formulation to a limited number of MSF projects in Africa for $500 per patient per year. However, Abbott refuses to sell the drug to MSF for use in its programs in Thailand and Guatemala and has dragged its feet registering it in developing countries. The result is that the new formulation of lopinavir/ritonavir remains unavailable and unaffordable for the vast majority of patients who need it.

The new version of lopinavir/ritonavir has important advantages over the old version, including lower pill count, storage without refrigeration, and no dietary restrictions. But without registration, the drug is virtually impossible to obtain at any price.

Pentagon lists homosexuality as disorder

A US Pentagon document classifies homosexuality as a mental disorder, decades after mental health experts abandoned that position. The document outlines retirement or other discharge policies for service members with physical disabilities, and in a section on defects lists homosexuality alongside mental retardation and personality disorders.

Critics said the reference underscores the Pentagon's failing policies on gays, and adds to a culture that has created uncertainty and insecurity around the treatment of homosexual service members, leading to anti-gay harassment.

The Pentagon has a "don't ask, don't tell" policy that prohibits the military from inquiring about the sex lives of service members but requires discharges of those who openly acknowledge being gay.

Source: Associated Press

McGill to spend $4 million on AIDS Centre

The McGill AIDS Centre at Montreal's Jewish General Hospital plans to spend $4 million to upgrade its facilities.

The facility's director, Mark Wainberg, said the money will help renovate the existing laboratory and expand the centre, which co-ordinates, facilitates, and promotes research, treatment, and teaching activities relating to HIV/AIDS at McGill University and its affiliated hospitals.

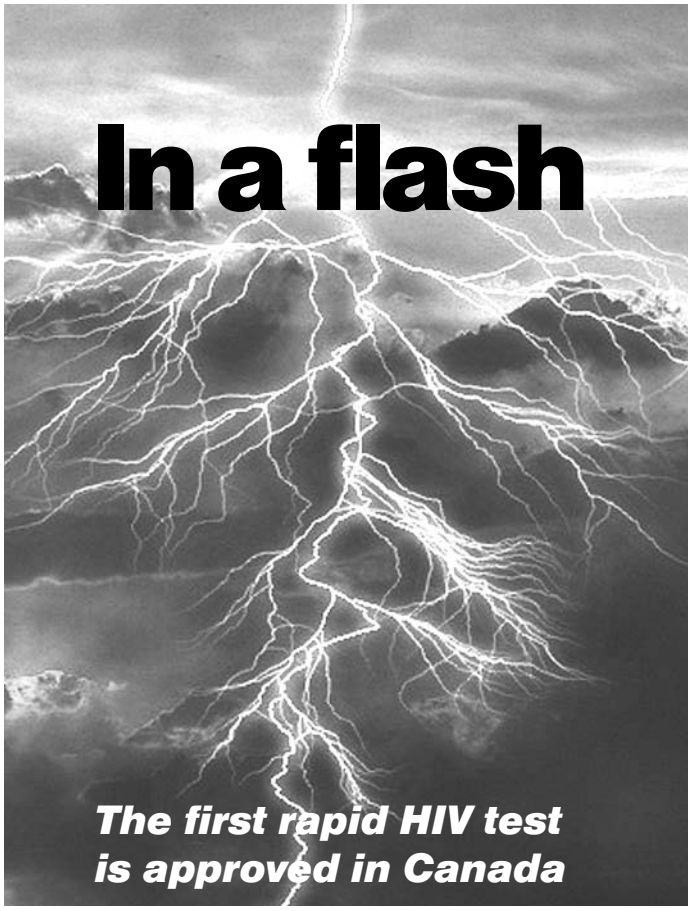
When it opened 20 years ago, the centre was at the cutting edge of HIV and AIDS research. But, Wainberg said, its facilities are now outdated.

"The objectives are always the same—to find better drugs and, if possible, vaccines and other prevention modalities that will stop the spread of this virus," he said, "and continue to do state-of-the-art work."

Source: CBC ⊕

BCPWA Society promoted the End HIV Stigma campaign during the Vancouver Pride Parade on August 6.

photos Gary Ferguson



In a flash

The first rapid HIV test is approved in Canada

by Carole Lunny

In 2000, Health Canada approved the first rapid HIV test for use in health facilities in Canada, although it was subsequently withdrawn from the market following concerns about accuracy. That same year, Canadian testing guidelines were published.

Since then, BioLytical Laboratories, based in Richmond, BC, has developed a rapid HIV test called the INSTI HIV-1 Antibody Test. It is a rapid, in vitro qualitative test for the detection of antibodies to Human Immunodeficiency Virus Type 1 in human whole blood, serum, or plasma. The test can be administered and confirmed in 60 seconds, however, the "presumptive" result of a positive rapid test would need to be confirmed by the usual laboratory procedures. If a patient's test yielded a negative result, no subsequent lab testing would be required.

The current procedure for testing for HIV is to first use the enzyme-linked immunosorbent assay, or ELISA test, and then confirm with an immunoblot blood test, also known as a Western Blot. The rapid test can save the healthcare system up to 30 percent by eliminating one laboratory test. The one caution is that the rapid test can cause false positive results when a person presents with multiple myelomas.

Approved for HIV-1 testing by Health Canada in October 2005, the INSTI HIV-1 Antibody Test has a 99.6 percent accuracy rate. (Health Canada and the US Food and Drug Administration's regulations say that an HIV test cannot fall below a 98 percent accuracy rate.) Currently, INSTI HIV-1 Antibody Test is being pilot tested by the Hassle Free Clinic, a Toronto-based anonymous clinic, and by the BC Centre for Disease Control. The test is still in trials for approval of rapid testing for HIV-2.

The test is approved for sale in Europe and is going through the approval process in the US. However, even if the FDA approves the rapid HIV test in the US, BioLytical would not be able to sell it there because Viread Inc. already owns the rights to testing of the HIV-2 virus in the US.

The test is approved for sale in point-of-care settings such as hospitals, clinics, or doctor's offices, and is designed to be administered by a healthcare professional. The test is not authorized for over-the-counter sale or use at home, although Health Canada hasn't regulated the distribution of its sales, so it could potentially make its way to Internet pharmacies or the black market.

The cost of the testing kit is $7.00 to $9.00 per test, if ordered through BioLytical. However, clinics may charge more. The test has a shelf life of 12 months but will remain stable for up to 18 months.

Pre- and post-test counselling for HIV has been considered best practice for healthcare providers. The reality, however, is that some healthcare providers often don't provide sufficient, if any, counselling when testing for HIV. With the approval of the rapid test, there is an even greater need to develop and train all healthcare providers in good communication and counselling skills. Informed consent is a central element of good HIV testing practices and of protection of human rights for those being tested. ⊕

***Carol Lunny** is the former ABCs outreach coordinator for the BCPWA Society.*

2006 WALK FOR LIFE

Where the money goes

Join us for the WALK for LIFE!

SIDA AIDS
WALK FOR LIFE
MARCHE POUR LA VIE

WHEN:
Sunday morning — September 24, 2006

WHERE:
Stanley Park — Vancouver

WHAT:
A 10K WALK around the Seawall or a 2K WALK around Lost Lagoon

Two easy ways to register!

ON-LINE: Go to ***www.bcpwa.org*** and click on the red ribbon WALK for LIFE logo.

BY PHONE: Call us at ***604.915.WALK***

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

A Loving Spoonful is a volunteer-driven, non-partisan organization that provides free, nutritious daily meals to people living with HIV/AIDS in the Greater Vancouver area. A Loving Spoonful believes that by meeting this fundamental need, it improves the health and well-being of its clients, enabling them to focus on life's other demands. Proceeds from the WALK will ensure a supply of fresh fruit is available to accompany the weekly delivery.

Asian Society for the Intervention of AIDS (ASIA) is committed to providing culturally appropriate and language-specific support, outreach, advocacy, education, and research on HIV/AIDS and related issues. ASIA also works to raise consciousness on discrimination issues related to HIV, and strives to embrace the diversity and complexity of Asian Canadian and Canadian communities. Proceeds from the WALK will directly benefit all ASIA programs.

Camp Moomba is about belonging. Established in 1997, it is a specialized summer camp program for kids between six and 17 who are impacted by HIV/AIDS. Many of the children who attend Camp Moomba face similar issues in their lives. By coming together each year, they are able to find the type of support that can only come from understanding. Funds from the WALK will go toward the 2007 Camp Moomba.

Healing Our Spirit BC Aboriginal HIV/AIDS Society's mandate is to prevent and reduce the spread of HIV/AIDS and provide care and support services to Aboriginal people infected and affected by HIV/AIDS. Money raised from the WALK will go towards emergency funds to help members pay for telephone, cable, hydro connection fees; for bus passes; and toward annual holiday dinners for members.

McLaren Housing Society uses the money it raises from the WALK for one thing only: housing! The Society provides stable, safe, and affordable housing to low-income people living with HIV/AIDS. The number of people in urgent need of housing assistance as they cope with their illness continues to grow rapidly: 265 people are currently on McLaren's wait list, all of whom qualify for, and desperately require, housing support.

Positive Women's Network is a partnership of women living with and affected by HIV/AIDS. The Network provides safe access to support and education/prevention for women in communities throughout BC; supports women in making informed choices about HIV and health; and provides leadership and advocacy around women's HIV/AIDS health and social issues. Proceeds from the WALK will go towards the PWN Housing Subsidy Program.

Surrey HIV/AIDS Centre Society assists the community and those living with HIV/AIDS in overcoming vulnerability, challenges, and stigma through education, advocacy, research, ongoing support, and empowerment. WALK monies will go toward such client services as supplies for weekly support group meetings, group recreational activities, additional food for the Djaeff Mahler Grocery food bank, and bus passes.

Vancouver Friends For Life Society serves to enhance the wellness of individuals living with life-threatening illness by providing complementary and alternative health and support services free of charge. The Society assists members in assuming responsibility for their own health and well-being. Funds raised from the WALK will support Friends For Life's mission and its members.

YouthCO AIDS Society is a non-profit organization building capacity with youth between the ages of 15-29 throughout BC to reduce vulnerability to HIV, AIDS and hepatitis C through peer support, peer education, and shared leadership. The money from the WALK will go toward its breakfast program, member dinners, member activities, and outreach supplies. ⊕

The Living Well Lab

Friends For Life and BCPWA win funding for new complementary therapy project

by J. Evin Jones and Andrea Mulkins

Do you use complementary or alternative medicine (CAM) as part of your self-care and wellness regimen? Do you find that CAM helps you cope with the symptoms of living with HIV/AIDS, or with the side effects of your medications? Then you may be interested in participating in an exciting community-based research project, the Living Well Lab, at the Vancouver Friends For Life Society. The goal is to set up a dynamic database that allows you to track your wellness and allows the team at Friends For Life to assess the overall impact of CAM on the wellness of a large number of members.

CAM encompasses a broad spectrum of health practices and includes modalities such as acupuncture, therapies such as naturopathy, and complementary lifestyles such as yoga. CAM has beneficial impacts on the health and wellness of people living with HIV/AIDS, including enhanced immune response, reduced symptoms and side effects from conventional therapies, reduced emotional stress, increased sense of control, and improved quality of life and daily well-being. In spite of the growing popularity and acceptance of CAM, there is still far too little evidence of how CAM programs impact the overall health of PWAs in the community.

The goal is to set up a dynamic database that allows you to track your wellness and allows the team at Friends For Life to assess the overall impact of CAM on the wellness of a large number of members.

Friends For Life (FFL) has been providing complementary health therapies free of charge to people living with a life-threatening illness such as HIV/AIDS and cancer since 1993. Services include clinics in naturopathic medicine and Traditional Chinese Medicine, massage and other forms of bodywork, yoga, and tai chi. Due to growing demand and limited space at FFL's West End Vancouver location in the Diamond Centre For Living, FFL and the BCPWA Society formed a partnership in 2005 to explore the creation of a new CAM clinic with a community-based research institute.

As a preliminary step, FFL and BCPWA conducted assessments in the summer of 2005 to explore how the community envisioned the proposed CAM clinic and research institute. Front-line workers, CAM practitioners, FFL and BCPWA board members, and CAM users participated in a series of focus groups and individual interviews which examined the impacts of CAM on PWAs and expectations about the proposed Living Well Lab concept.

In April 2006, FFL learned it had won a tough competition for a prestigious Canadian Institutes of Health Research award to fund the Living Well Lab. This is a significant achievement not only for FFL but also for community-based organizations like FFL and BCPWA, as the majority of organizations that are normally awarded this funding are large institutions like universities.

The Living Well Lab will assess the impact of CAM therapies on the quality of life and wellness of PWAs. The Lab will also evaluate FFL's wellness programs, thus allowing for the continual evidence-based evolution of CAM services offered at FFL. One of the key features of the Living Well Lab is a user-friendly database that will provide members with tools to self-monitor and track their wellness journey.

The official launch for the Living Well Lab is slated for the end of September. FFL is recruiting peer researchers to assist with all aspects of the project and is also looking for suitable candidates to act as members of the community advisory group. Members of the community advisory group must be living with HIV/AIDS and actively using CAM, but do not need to be members of FFL. If you are interested in joining the advisory group, or if you would like more information, please call 604.682.5992, ext. 3, to leave a voice mail for Andrea Mulkins, the Living Well Lab project coordinator. ⊕

***J. Evin Jones** (r) is the executive director of the Vancouver Friends For Life Society.*
***Andrea Mulkins** (l) is the project coordinator for the Living Well Lab Project.*

photos Glyn Townson

A time to deliver

Report from the XVI International AIDS conference, August 13 – 18, Toronto

by Glyn Townson

The XVI International AIDS conference, which took place last month in Toronto, flew by with amazing speed. Over 23,000 delegates and nearly 2,500 media representatives from all over the world attended the six-day event. The conference organizers should be commended for the number of delegates from Third World and vulnerable populations who received scholarships to attend the conference.

The conference opened with a First Nations' welcome from Chief Bryan Laforme. Also making opening remarks were conference co-chairs Mark Wainberg (who noted the absence of Prime Minister Stephen Harper) and Helene Gayle; Her Excellency the Right Honourable Michaëlle Jean, Governor General of Canada; Ontario Premiere Dalton McGuinty; Toronto Mayor David Miller; and Frika Chia Iskandar, a PWA speaker from Indonesia. The keynote speakers were Bill and Melinda Gates.

continued on next page

The evening was a star-studded event with live performances by Amanda Marshall, Chantal Kreviazuk, the Barenaked Ladies, Our Lady Peace, Alicia Keys, Thomas Mapfumo from Zimbabwe, the Red Spirit Singers and Dancers, Massari, Blue Man Group, and DJ Tiesto from the Netherlands. In addition, Richard Gere and Olympia Dukakis presented the Red Ribbon awards.

A tone of cautious optimism

Overall, the news from the conference was cautiously hopeful that scientific knowledge and now-proven programming and service delivery hold the potential to start working towards long-term solutions in managing HIV/AIDS. We know what to do and the ways to do it; the main problem continues to be political will and adequate resources to fund these activities. To meet growing needs, global spending will have to increase from $15 billion next year, to $22 billion annually by 2008. Confirmed funding from all the world partners is far below what is required.

The popular PLHA lounge.

One of the highlights of the conference for PWAs was the Persons Living with HIV/AIDS (PLHA) lounge, which provided a comfortable, inviting space with Internet stations, refreshments, a rest area, and practitioners available for massage appointments. The organizing committee did a wonderful job creating the space. The lounge had been designed to handle between 1,800 to 2,100 visitors per day, and wound up successfully managing upward of 2,900 visitors per day.

The session with Bill Gates and Bill Clinton was standing room only.

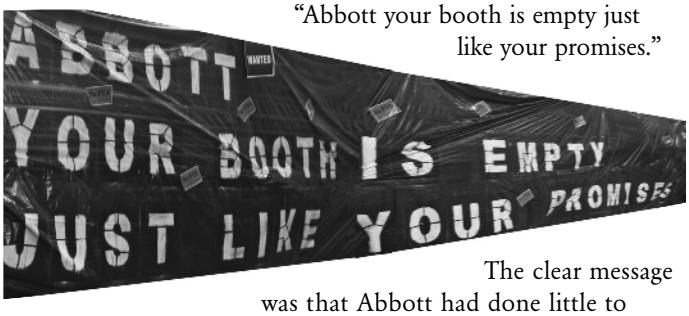
Another highlight of the conference was a session with former US president Bill Clinton, and Microsoft founder and chairman Bill Gates and his wife Melinda. They drew attention to the world's growing HIV/AIDS problem, and framed AIDS as the most devastating health crisis in the history of humanity. However, some people complained that there was too much stargazing and not enough emphasis on actual people's lived experiences with HIV/AIDS.

Protestors from around the world

Protestors were in full force. On Wednesday, there was a well orchestrated, large-scale protest in support of Canada's only legal supervised injection site, Insite, in Vancouver's Downtown Eastside, which faced closure on September 12. The demonstration blocked traffic on some of Toronto's busiest downtown streets for two minutes in the early afternoon, with protesters holding large banners to bring attention to the federal government's failure to extend the exemption to the Canada Health Act for the injection site.

The Insite demonstration outside the convention centre.

Other protests broke out regularly around the conference site. Activists from Act UP demanded funding for healthcare workers during the opening ceremonies. Demonstrators from Act UP Paris also occupied an area in the exhibition hall for a day, condemning Abbott Laboratories for not attending the conference. The Parisian protestors held placards with bold messages saying: "Abbott your booth is empty just like your promises."



The clear message was that Abbott had done little to make existing second-line treatment more accessible in Third World settings, as they have been slow to develop formulations of their products that don't require refrigeration.

Other demonstrations brought attention to the restrictive policies in funding proven prevention methods based on harm reduction rather than the current focus on abstinence, being faithful, and condoms (ABC).

Prevention as a key focus of the conference

In terms of the plenary sessions, the focus in prevention strategies was preventing mother-to-child transmission. There's enough evidence proving that with proper use of antiretroviral therapy, this mode of transmission could be almost eliminated, reducing

new HIV infections significantly. Unfortunately, most people living with HIV—in particular those in developing countries—aren't aware that they're infected and often don't seek help until they're very ill or their child becomes ill.

There was a lot of discussion about speeding up the development of microbicides to give women more control over their sexual health. From all accounts, a vaccine for HIV is still at least ten years away. Some microbicides trials may have products available for widespread use within the next five years; however, these products are primarily for vaginal use. On that note, the downside of these studies is the lack of research on microbicides for anal use.

Prevention workshop.

The second arm of the prevention presentations addressed the need to ramp up appropriate prevention strategies. At the current rate of new HIV infections, the increasingly huge number of people who will need treatment will overwhelm all the progress that has been made if the trend isn't reversed.

Another highlight was the plenary session "Advancing Treatment and Universal Access: A Report on State-of-the-Art and Progress," which included the studies from Dr. Julio Montaner's re-evaluation of the cost-effectiveness of highly active antiretroviral therapy (HAART). Montaner's case for expanding treatment access to curb the growth of the epidemic attracted a lot of media attention.

The Canadian Working Group on HIV and Rehabilitation partnered with the University of Toronto and three African groups to discuss the usually separate domains of HIV/AIDS, disability, and rehabilitation issues in the plenary session entitled "Bridging HIV, Disability and Rehabilitation." Many disability groups complained that conference organizers had overlooked disability issues, a complaint based on the general lack of services for persons with disabilities attending the conference, including access to sign language translators—in both English and French—for the deaf community, and services for visually impaired.

There was a vast amount of information on the effectiveness of antiretroviral therapies in the Third World; the overall message was that the drugs work, and access to treatment is hindered less by the cost of the medications than by the need to create support systems to deliver and monitor the use of medications. With the approval of several generic antiretroviral therapies, the cost for first-line regimens can be less than 50 cents a day. Most countries in Africa simply don't have the trained personnel, or access to cheap portable blood monitoring tests, to meet demand.

Stephen Lewis's last conference as special envoy

At the closing event on Friday, there was a video of highlights from the conference, as well as a moving call to action by BC First Nations activist and mother Kiesha Larkin, and a "time to deliver" message from Anders Nordstrom of Switzerland.

The keynote speaker was Stephen Lewis, who made no apologies for his statements against the South African government and announced that this would be his last International AIDS Conference as special envoy to the United Nations. He made it quite clear that his successor should be a woman from a Third World country, reaffirming that women must be taken seriously at the UN.

This was my first experience at a world conference, and my first time as a media representative for ***living⊕*** magazine. At times, it was a bit overwhelming, sifting through mountains of news releases, dodging hordes of delegates, and attending the frequent press conferences highlighting key events at the conference.

The Media Centre, with workstations, computers, faxes, phones, and press gallery.

BCPWA's Cheryl C. beside Advocacy poster for Action Kits, in the poster exhibition hall.

BCPWA Society was well represented, and our poster presentations and oral sessions were well received. Over 250 people attended our prevention workshop and over 200 people attended our prison panel discussion.

For further information on abstracts and webcasts from the conference, visit the conference Web site at www.aids2006.org. ⊕

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

FIGHTING WORDS

Not-so private records

by Dr. Jel Coward

What's left of medicine if we take away the privacy?

Sitting unobtrusively in an appendix of the recently signed agreement between the BC Medical Association (BCMA) and the BC Ministry of Health is the framework for the creation of a health information network. The format of this information network will have long term and far-reaching implications for everyone. Electronic medical records will now be held on servers outside of individual medical practices and a core data set—including diagnoses, patient identifiers (demographic information), etc.—will then be made available on another computer network. If physicians want to receive funding to incorporate information technology into their practices, they'll have to agree to this arrangement. Both the provincial government and the BCMA are promoting this plan.

I fully support the use of electronic medical records (EMR)—indeed, my patient charts are kept electronically within my office—but with the new agreement between physicians and government, the message the government is sending to doctors is: send your patients' information outside your office or we'll restrict your ability to provide care by not funding you to use information technology tools.

This requirement has dangerous implications for the confidentiality of the doctor-patient relationship, which has always been the cornerstone of good medical practice. For example, when it comes to matters of sexually transmitted infections or psychiatric problems, if patients feel that their clinical history might be widely available, they may not seek care or they may feel compelled to be dishonest with their physicians in order to protect their privacy. As a result, patients won't receive appropriate care.

The recent agreement between the BCMA and the BC Ministry of Health is the framework for the creation of a health information network that will have long term and far-reaching implications for everyone.

As a physician, I don't want to see this happen in BC.

This paradigm shift, from patients entrusting physicians to protect their personal information within their offices, to that information being sent through the Internet to different databases and made available to others, has been enacted through an appendix to a complicated pay negotiation. Physicians voted to accept the deal, but many of us contend that few physicians understood this technological aspect of the agreement.

No public consultation

Surely, we have to ask: Where were the voices of citizens and patients in the decisions that were just made on their behalf? This question was put to the Ministry of Health representative at the BCMA Annual General Meeting on several occasions, and the final response was "...not quite yet." The sad reality is that there do not appear to be any plans to consult with the public. The process is going ahead without the public having an opportunity to weigh in on the matter.

To give an example of what can happen to patient information, the Ministry of Health created toolkits for the management of chronic diseases that they would like doctors to use. These toolkits involve sending confidential patient data to government servers. Many doctors have resisted such schemes in order to protect their patients' confidentiality.

Of course, sharing information between identified healthcare providers can be very useful and can greatly facilitate care provision. We do this daily with referral letters and consultations and we accept that patients implicitly consent to this. These procedures are very different from moving patient information en masse outside doctors' offices and making it available to others.

Making private information available across the Internet should require explicit consent for every piece, every time; patients should be able to see what's available for others to access and have the right to instantly rescind consent for any piece, without a prolonged or complex application process. Such a consent process is possible using a model where the patient has the key to their information, which then allows the relevant information to be pulled from their chart, which remains housed in the physician's office. Unfortunately, this model is not being proposed.

Concerns about continuity of care

In addition to the direct privacy issues, there is a concern that runs even deeper into the practice of medicine. Some physicians fear that there may be a belief that having access to every bit of every patient's information, everywhere in the system, is a substitute for the continuity of care that comes in a long-term relationship of trust between a healthcare provider and a patient. Of course it isn't. Having all the information about a patient is not the same as knowing all the information, neither of which is the same as knowing the patient.

Technology is a valuable tool that, when used properly and for the purpose for which it is designed, can be of great benefit to users. It's time for physicians to start using EMR and other tools effectively. BC is behind the curve on this. However, using EMR shouldn't force physicians to send patient information outside their offices.

The BC government has quietly taken a critical step down a path that has serious ramifications for us all. This type of change in health policy should be discussed in the public arena rather than slipped into the back pages of a pay agreement. ⊕

***Dr. Jel Coward MD**, is a family physician in Pemberton, BC, and an information technology enthusiast.*

Speak up about how your patient records are kept

Learn more. Visit www.bcpwa.org and click on "Take action" under "Community Representation and Engagement" to read our background paper and letters of protest.

A positively positive experience

The 2006 Positive Gathering will bring together PWAs and their allies to share experiences

by Malsah

The second provincial Positive Gathering takes place in Vancouver, from October 20 – 22, 2006 at the Plaza 500 Hotel. This conference brings together HIV-positive individuals and our allies from across BC to network, share experiences, and to empower, support, and educate ourselves and each other. The event is about embracing diversity, building unity, and understanding the challenges that we face living with HIV. It's also about empowering ourselves, individually and collectively, so that we never lose hope or faith in the future.

This year's Positive Gathering is the result of program and logistical planning by representatives from ten community-based AIDS organizations serving diverse populations across BC. All AIDS organizations in the province were invited to serve on the conference planning committee, and those that have volunteered their time, resources, and expertise include: ANKORS, AIDS Vancouver, BCPWA Society, Friends For Life, Pacific AIDS Network, Positive Living North, Positive Women's Network, Vancouver Island PLWHA Society, Wings Housing, and YouthCO AIDS Society.

The event is about embracing diversity, building unity, and understanding the challenges that we face living with HIV.

Broad-based planning has been going on for some time now, with PWAs as the key decision makers; the direction and content for this event has been established largely through discussion and planning exercises coordinated through the Pacific AIDS Network (PAN) Forum over the past two years.

The 2006 conference is structured on the theme "From Decade to Decade: Living Life Well" and will include content for people living with HIV and AIDS at all stages of the life cycle. Recognizing the emerging HIV-positive seniors' population, sessions such as "HIV-Positive and Living for Decades" and "Life after 50: Aging Gracefully" are included in the event program. Workshops will also address issues of relevance to diverse communities impacted by HIV, including women, people of colour, and Aboriginal peoples, and their unique experiences.

Specific workshop topics for the Gathering were identified through focus group research and a subsequent survey of HIV-positive British Columbians of all ages. Sessions of more general interest to conference attendees will explore the physical ("Treatment Issues and Side Effects"), mental ("Shifting the Focus from Illness to Wellness"), and spiritual ("Benefits of Mindful Meditation") aspects of living with HIV. There are also workshops planned to address practical matters ("Tips for Improving Your Doctor-Patient Relationship") as well as more intimate issues ("Strengthening, Affirming and Enhancing Relationships in Sero-Divergent Couples").

More than 250 people are expected to attend the 2006 Positive Gathering. Registration is free for people living with HIV/AIDS and scholarships are available to provide transportation and accommodation for HIV-positive registrants. Promotional materials and conference information, including details and registration forms, are available from all AIDS organizations in BC.

The Positive Gathering is a unique opportunity, bringing HIV-positive British Columbians together in an environment where we feel comfortable and secure to exchange personal experiences, within a structure intended to maximize the sharing of practical information about healthful living. ⊕

Malsah is a member of the board of the BCPWA Society.

For more information

Visit the Positive Gathering Web site at www.positivegathering.ca for a complete conference program and to register on-line.

See you later

Why doctors tend to test women for HIV later than men

by Helenka Jedrzejowski

HIV tends to be stereotyped into three high-risk groups: gay men, injection drug users, and "working girls." If you fit into one of these groups, you're fairly certain to be tested for HIV and thus more likely to be diagnosed sooner after you've seroconverted.

In reality, we all fall into a risk group and each one of us faces visible and/or invisible barriers to HIV diagnosis. Women, in particular, face unique and multiple challenges in getting HIV care, testing, and/or diagnosis. Late diagnosis is especially a problem. The experiences of HIV-positive women and insights from long-time AIDS outreach and support workers can help us to understand the issue of late HIV diagnosis among women.

Women who are diagnosed late are typically—and inexplicably—categorized as being at low risk for infection. They are often perceived as middle class and non-drug users. They may be women who have sex with women, or in stable heterosexual relationships. While all these factors generally indicate a low risk of HIV, the rate of infection is rapidly increasing among women.

Finding out their HIV status when pregnant

Particularly misleading is the assumption that women in so-called stable heterosexual relationships are not at risk for HIV. "Married women in particular are the women who live for years with HIV without getting a diagnosis," says Sangam, a support worker at Positive Women's Network (PWN) in Vancouver, which serves exclusively women living with HIV. "It's about behaviour. These women presume themselves to be in a monogamous relationship and so don't see unprotected sex with their husband or partner as a risk behaviour. Unfortunately, they are impacted by the high-risk behaviours of their partner."

A fairly common story is that of Laura (not her real name), a 35-year-old mother of three who was diagnosed only when she became pregnant and received the standard gamut of tests. She was in a heterosexual relationship and had no idea her partner was injecting drugs—and no idea that she was at risk for HIV. "Now when I think about it," she says, "I must have been positive for years before getting diagnosed. If I hadn't gotten pregnant, I don't know when I would have come to know my status."

Aside from the fact that many women don't realize that their male sexual partners put them at risk for HIV, family doctors often fail to suspect HIV when symptoms surface, which influences the timing of diagnosis. "I had all kinds of symptoms," says Sue (not her real name), an HIV-positive woman from New Westminster. "Now I see the connection. But at the time, it was all up to my doctor. The thing is, I wasn't diagnosed because of my symptoms. It was only because I got pregnant."

It seems to be the case that many family practitioners just don't see certain types of women as being at risk for HIV. In addition, many doctors aren't sex friendly, so talking to women about their sexual health and sexually transmitted illnesses just doesn't happen as often and as early as it should.

High-risk women are diagnosed late, too

But what about women who do fall into pre-conceived high-risk categories? If their doctors know they're at risk for HIV, why doesn't diagnoses happen early?

In Vancouver, the most vulnerable and marginalized women tend to frequent the Downtown Eastside. They are women who manage a range of poverty issues on a daily basis: they may be homeless, dealing with addictions, or trying to cope with mental health issues.

"These women don't have access to regular health care," observes Stacie Migwans, an outreach worker at PWN. "At best, they get sporadic care. Lack of health care definitely contributes to late diagnosis for these women."

And a lot of women living in the Downtown Eastside simply don't want to find out that they're HIV-positive, because they've already got enough survival issues on their plate, according to Cara Moody, an outreach worker at PWN and Oak Tree Clinic, which serves HIV-positive women and children. That said, they do recognize the reality of their vulnerability to HIV infection, but many live in denial and fear of finding out the truth.

In addition, the stigma around HIV hasn't dwindled all that much. For many women, denial is considered a better option

than facing the judgment of others. Stigma and discrimination are particularly severe within the Aboriginal population. Women may avoid accessing services because the community is so small that they fear loss of confidentiality.

Particularly misleading is the assumption that women in so-called stable heterosexual relationships are not at risk for HIV.

Putting the needs of others first

Moody and Migwans both sense that for women who are high risk, late diagnosis often has to do with a missing sense of self-worth. "So many of these women have grown up with the belief that they're not worth taking care of," says Moody. "If you don't believe that you're worth it—if you were never told or if no one ever led you to believe it—you just won't make your health a priority."

Similarly, women may be diagnosed late because they tend to put others before themselves. "A lot of women don't want to burden anyone. They're the core of the family," says Migwans. "They often have others to care for—their children, their partners. That's where they put their energy. Their own health doesn't come first."

We're decades into the HIV pandemic and one thing is certain about HIV infection: we are all vulnerable. Rather than thinking in terms of high risk and low risk, it makes more sense to acknowledge that we are all at risk. Until economic inequity, gender inequity, racism, stigma, and discrimination are dismantled, women's vulnerability to HIV infection and disease progression, as well as late diagnosis, will continue. ⊕

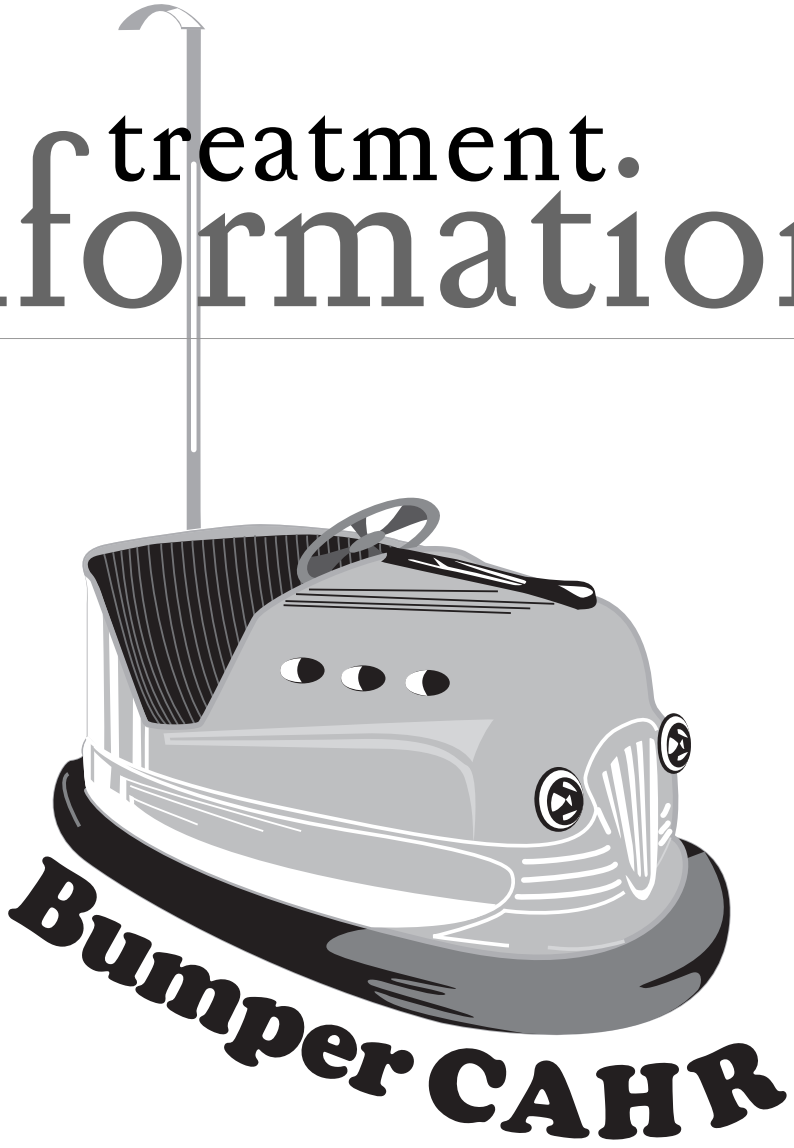
***Helenka Jedrzejowski** is a summer practicum student with the Positive Women's Network in Vancouver and currently studying health promotion at the University of Toronto.*

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.



Highlights from the 15th Annual Canadian Conference on HIV/AIDS Research

by Sam Friedman

The annual Canadian Association for HIV Research (CAHR) Conference, held in historic Quebec City from May 25 – 28, 2006, brought together many of Canada's best research investigators, clinicians, PWAs and community group representatives to share and highlight the important HIV work being conducted throughout Canada. The following are a few highlights of oral presentations and symposia from the Basic Sciences, Clinical Sciences, Social Sciences, and Epidemiology and Public Health Sciences tracks given by top Canadian researchers:

Sex trade workers

Of particular interest to marginalized woman living within disadvantaged circumstances was the research conducted by the BC Centre for Excellence's (BCCfE) MAKA Project. Researcher Kate Shannon presented a disturbing and informative description of the risks of HIV infection present in the context of violence, harassment, police presence, and lack of syringe access among survival sex trade workers who are also injection drug users (IDUs). By a direct interview process, Shannon was able to gather a more comprehensive picture of the realities faced by these women. This research brings a greater understanding of how to best reach, treat, and assist this group.

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DOT

BCCfE's Dr. Mark Tyndall's presentation indicates that comprehensive support programs that include directly observed antiretroviral therapy (DOT) correlate with strong adherence to highly active antiretroviral therapy (HAART) and improved quality of life for IDUs. IDUs are a marginalized group who are traditionally hard to reach and hard to treat. The provision of programs that are specifically tailored to this group, such as DOT, as well as addiction, nutrition, social, psychological, and medical support, in a one-stop clinical setting, is the new standard of care for this population living with HIV/AIDS.

Antiretrovirals

Jesse Raffa from the University of British Columbia gave an impressive presentation on the intermediate use of antiretrovirals and the development of resistance to antiviral therapy. Building on past knowledge, this research broadens our understanding of the very real risks of developing resistance from taking HIV medications in a less than optimal manner. It has been known for some time that taking antiretroviral medications 95 percent or more of the time is the best way to prevent the development of antiretroviral drug resistance. What is newly discovered is that a small window of 80 to 90 percent compliance is most risky in terms of developing resistance; in fact, it is considerably riskier than taking medications 80 percent of the time or less.

Co-infection

Dr. Marina Klein from McGill University gave an in-depth presentation on the challenges of co-infection. Dr. Klein has developed a large co-infected cohort who she will observe and treat over many years. As importantly, she has created an advisory committee, including two co-infected community representatives, to oversee her research. She should be applauded for including and listening to co-infected members of the community in her research efforts.

Facial lipoatrophy

Dr. Mona Loutfy from the University of Toronto, the Maple Leaf Medical Clinic, and the Face Forward Foundation, spoke about her research results and advocacy efforts for facial lipoatrophy (FLA). Dr. Loufty is spearheading some of the only FLA research in Canada. She is also working hard with colleagues and AIDS community groups from across Canada to support people devastated and deformed by FLA: by fighting for FLA reconstructive treatments to be covered on provincial drug formularies; and by advocating for accreditation of specialists in the use of FLA reconstructive procedures.

Red Ribbon award

The Red Ribbon award is presented annually to a member of CAHR who has made a significant contribution in advancing research in the field of HIV/AIDS in Canada and/or advancing the objectives of CAHR. This year's winner, James Kreppner, was presented with the award amidst a standing ovation for his long, ongoing, and significant role in encouraging research in the field of hepatitis C/ HIV co-infection. Kreppner is a brilliant and devoted man with a huge body of service and knowledge under his belt. He inspires, motivates, and mentors people without hesitation.

The CAHR 2006 Conference was a successful event that provided a huge learning, networking, and relationship-building opportunity. Scholarships for CAHR 2007 are available. Visit the CAHR website at www.cahr-acrv.ca for more information. ⊕

***Sam Friedman** is a proud and dedicated member of the BCPWA Society and several other groups involved in the Canadian AIDS movement. He has been living with HIV/AIDS for 21 years.*

NEW HOURS AT BCPWA

British Columbia Persons With AIDS Society

A major change is coming to BCPWA: more flexible hours to accommodate *YOUR SCHEDULE.*

The Board of Directors and Staff of BCPWA are responding to numerous requests from the membership:

The office will be open on Tuesday and Thursday evenings until 9:00PM, starting October 2, 2006.

A series of workshops, info sessions and trainings will be scheduled on Tuesday evenings.

Thursday evenings will be open for drop-ins to meet treatment counselors or advocates.

This will be a year-long pilot project to determine the need for these extended hours.

THE BCPWA LOUNGE WILL NOT BE OPEN FOR DROP-IN DURING THESE EXTENDED HOURS.

To provide feedback on our new hours and to suggest future programming ideas, contact Mike V. at 604.893.2253 or email newhours@bcpwa.org

A bold new idea

The BC Centre for Excellence unveils a theoretical model to dramatically slash the number of HIV cases worldwide

by Glen Edwards

What if medication that can save one HIV-positive individual's life could also protect others from being infected by the deadly virus?

The use of triple-drug therapy—the anti-HIV drug regimen formally known as highly active antiretroviral therapy (HAART)—has exclusively focused on improving a person's health outcome, not global infection rates. However, according to emerging evidence, a new strategic shift in the use of anti-HIV drugs could in theory reduce worldwide spread of the virus 70-fold in less than 50 years.

The BC Centre for Excellence in HIV/AIDS (BCCfE) at St. Paul's Hospital in Vancouver recently unveiled a bold new theoretical strategy that contends a massive expansion of the use of HIV drugs could slash the number of global HIV cases by more than 98 percent in just two generations.

The advent of simpler, less toxic drugs, the development of rapid HIV testing, and the potential for long-term cost-savings has made the BCCfE's new innovative framework extremely appealing for many veterans in the HIV/AIDS community who have had few opportunities for optimism.

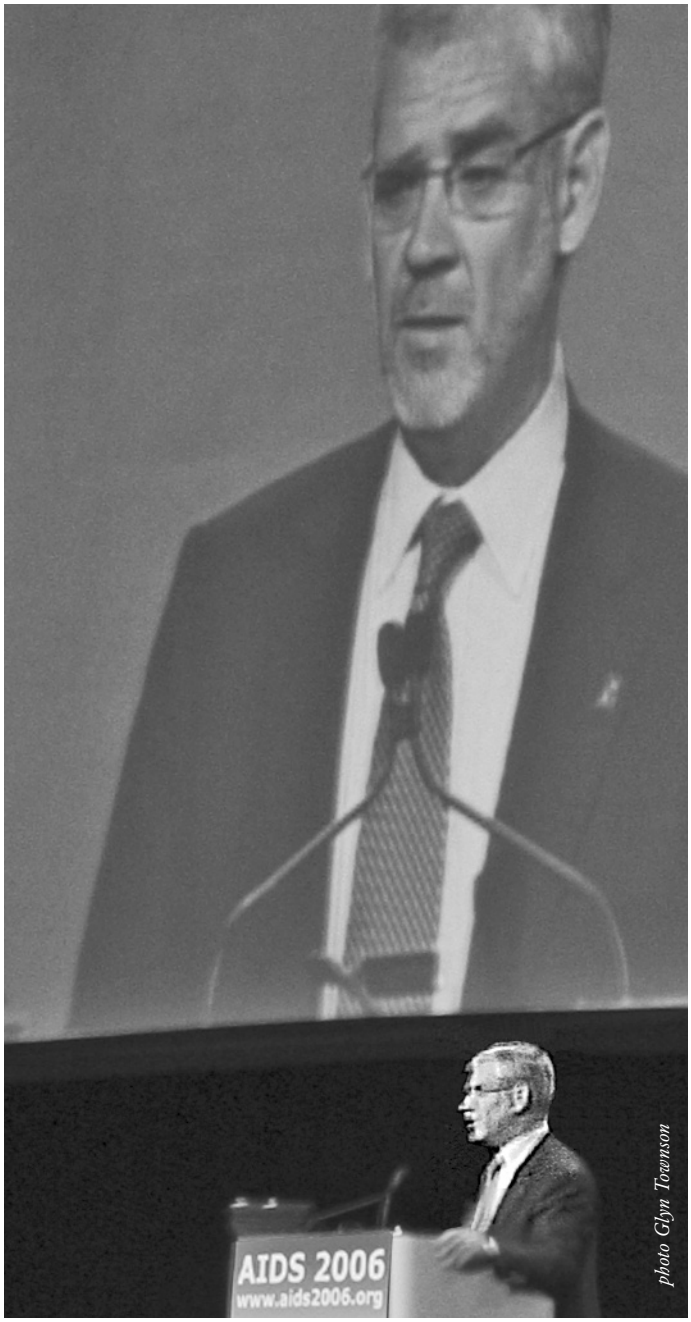
And although aggressive expansion of HAART is immediately impractical and impossible to implement, the strategy's underlying theme may be the tipping point for governments to increase access to life-saving drugs for HIV-positive individuals in need of treatment worldwide.

Dr. Julio Montaner, AIDS researcher and director of BCCfE, is betting his international reputation on it.

"The status quo is no longer acceptable," says Montaner, the strategy's lead author. "The current approach to the management of the HIV/AIDS pandemic is rapidly becoming unsustainable. Safe sex and other public awareness campaigns are critically important but they are clearly not sufficient. If we appropriately expanded HAART, the transmission of the virus could be dramatically reduced."

The BCCfE's global strategy is far from modest—however, neither is the aggressive threat of the HIV epidemic. UNAIDS estimates there were 38 million people worldwide living with HIV at the end of 2005, with new infections rising at a rate of more than 10 percent annually. The dire numbers will continue because HIV prevention strategies are only partly effective and a preventive vaccine or cure remain elusive.

The Lancet featured the BCCfE's strategy in a special HIV/AIDS-themed issue published to coincide with last



Dr. Julio Montaner presented the BC Centre for Excellence's new strategy at the Internatinal AIDS Confernce in Toronto.

month's XVI International AIDS Conference in Toronto. Montaner presented details in his plenary address to the conference.

As of press time, Montaner has received initial support from some of the HIV/AIDS community's biggest voices and leading foundations. A clinical study is currently in development to test the BCCfE's proposed strategy in BC.

Rethinking prevention: at the HAART of it

HAART has become nearly 100 percent effective in reducing the amount of HIV in a person's blood to almost undetectable levels, as well as boosting immune levels in highly adherent individuals. HAART has made what was once a certain death sentence into a chronic, but manageable, illness.

On the tenth anniversary since HAART regimens became available in BC, emerging evidence underlines that transmission of the virus is rare by people with undetectable viral loads of HIV in their blood, owing to the use of antiviral therapy.

HAART has reduced the amount of the virus not only in blood and body tissues, but also in both the female genital tract and in semen. By reducing a woman's viral load with HAART, mother-to-child transmission of HIV has become exceedingly rare in developed nations.

The strategy's underlying theme may be the tipping point for governments to increase access to life-saving drugs for HIV-positive individuals in need of treatment worldwide

Research in heterosexuals has previously shown that the lower the viral load, the less likely an infected individual will transmit the virus to his or her partner. Several studies have demonstrated that transmission was rare or non-existent if the infected partner had a viral load of less than 1,000 copies per mL (HIV-positive individuals can measure well over 100,000 copies per mL).

The BCCfE's strategy contends that if HIV-positive individuals are given access to HAART to reduce viral loads to undetectable levels, the virus is essentially put into quarantine and stops its transmission. Expanded use of HAART can then become a new cornerstone to a stronger prevention strategy, says Montaner.

"I must stress that I do not see HAART as a replacement for the prevention effort—including vaccine research—but rather as an essential new part of it," he cautions. "The transmission of the virus could be dramatically reduced with the appropriate expansion of HAART."

Studies from BC and Taiwan, for example, indicate that the introduction of free access to HAART could lead to an approximate 50 percent reduction in new HIV cases. The relative continued success in these two regions counters concerns that any possible benefit derived from the use of HAART would be offset by increased risky behaviour.

In the Taiwan study, the reduction in new HIV cases took place without a change in rates of syphilis—normally used as an indicator of risky sexual behaviour—over the same period. That shows that the decline in new HIV infections is not the result of increased condom use or abstinence, according to Montaner. He also notes that throughout the world, HIV transmission rates are also lower where HAART regimens are more readily available, compared to regions where access is limited.

The new world model

The BCCfE created a population-based model to provide a picture of both the potential costs and impact of an aggressive expansion of HAART. This purely hypothetical model represents the most optimistic, best-case scenario to give an impression of what would be the maximum impact that this new strategy could have in an idealized setting.

The BCCfE assumed that all HIV-infected people would receive therapy in the first year and that, after the first year, there would be no new HIV infections. The model shows HIV prevalence could be reduced by more than 70-fold over a 45-year period—from over seven cases per 1,000 people to less than 0.1 of a case per 1,000 people. The number of HIV-infected people could decrease from nearly 40 million to less than one million. In that vein, the cost of therapy could be about US $7 billion per year, with costs declining to $1 billion. Such a program could cost $338 billion over 45 years.

"The prospect of treating 40 million HIV-infected individuals worldwide seems daunting," admits Montaner. "However, in view of the limited effect of current efforts on global prevention of new infections, this approach merits consideration if it can offer a means to control the relentless growth of the pandemic. At the very least this should serve to re-energize the international community to finally deliver on the promise of making HAART accessible to every HIV-infected individual in medical need throughout the world."

Could it work?

Of course, the BCCfE's hypothetical model doesn't include many real-world challenges facing regions where HIV rates are the highest.

"The logistical and infrastructural challenges that lie ahead for this kind of approach are tremendous," Montaner acknowledges. "Many of the same structural obstacles that have faced HAART scale-up programs—such as poor health care infrastructure, a scarcity of trained healthcare workers, and rural-based populations—would be multiplied many fold."

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Opponents also counter that the model would also require testing and identifying all HIV-infected people worldwide, including countries where stigma is high, plus it assumes optimistic rates of testing when, in reality, up to 30 percent of people who are HIV-positive don't realize they're infected. Critics also argue that the model requires HIV-positive individuals to start taking antiretroviral drugs that may cause considerable side effects.

But even by providing HAART to partial percentages of the population, as the Taiwan and BC data show, the benefits can be substantial—not only in terms of lives saved, but dollars, too. A 50 percent reduction in new HIV cases would represent about 43,000 new cases in North America in 2005, which in turn translates to an averted HAART cost of $10.3 billion, based on an estimated lifetime treatment cost of $241,000 per person. The BCCfE's model demonstrates the short-term cost of treating all HIV-infected individuals in the world today would be more than offset by the number of new infections prevented.

Great improvements in treatment simplification—as well as reduced toxicities—provide a unique opportunity to expand global HAART programs. In particular, the advent of a new highly effective one-pill-a-day, fixed-dose drug combination offers a simple regimen without food or lifestyle restrictions, no refrigeration needs, and limited requirements for laboratory monitoring.

"The one-pill approach has a very significant potential, particularly among hard-to-reach populations," says Montaner. "The efficacy of these drugs given together has been excellent. They are the most promising combination in clinical trials to date."

The availability of rapid HIV testing also provides promise for improved HIV case finding.

Added ammunition to improve access

The need to expand current uptake levels of HAART to anywhere near 100 percent is imperative. The United Nations' 3 by 5 plan proposed to expand the use of HAART regimens to an additional three million HIV-positive individuals in the developing world by 2005. However, the number of new HIV infections in 2005 was more than double the number of individuals who started HAART in the same year. Current estimates are that between 30 and 40 percent of HIV-infected individuals globally need HAART. Most of the 38 million HIV-positive individuals worldwide who are already infected will become eligible for HAART therapy by the year 2015.

Even in BC, where drugs are provided free under the province's medical services plan, a significant portion of PWAs don't receive anti-HIV drugs. In 2003, the BCCfE revealed that one-third of people who died from HIV-related causes in BC didn't receive life-saving treatment. Those who didn't receive essential HAART treatment were most likely to be living in Vancouver's Downtown Eastside. Another BCCfE study showed that the lowest life expectancy for HIV-positive individuals in BC is injection drug users (IDUs) not receiving anti-HIV treatment.

BCCfE researchers suggest Vancouver's healthcare system may face a crisis over the next few years if large numbers of IDUs, infected with HIV in the mid-1990s, don't start accessing HAART treatment. It's believed that 35 percent of the city's estimated 15,000 IDUs are currently HIV-infected.

Promoting HAART as a way to save lives has met only marginal success generating the funding and political will necessary to increase clinical care to those infected. With the evidence that HAART can also reduce transmission rates and save money in the long haul, governments now have extra urgency to improve current uptake levels for HAART for those in medical need.

The model shows HIV prevalence could be reduced by more than 70-fold over a 45-year period. The number of HIV-infected people could decrease from nearly 40 million to less than one million.

"In the short term, if we can use these data to ensure that all those in medical need can secure access to HAART here and in the rest of the world, we'll be very satisfied," says Montaner. "Whether further expansion of HAART use is warranted, needed, feasible, ethical, or practical are important research questions that need to be urgently addressed."

Montaner is currently developing support for a potential pilot project in BC to provide proof to the world.

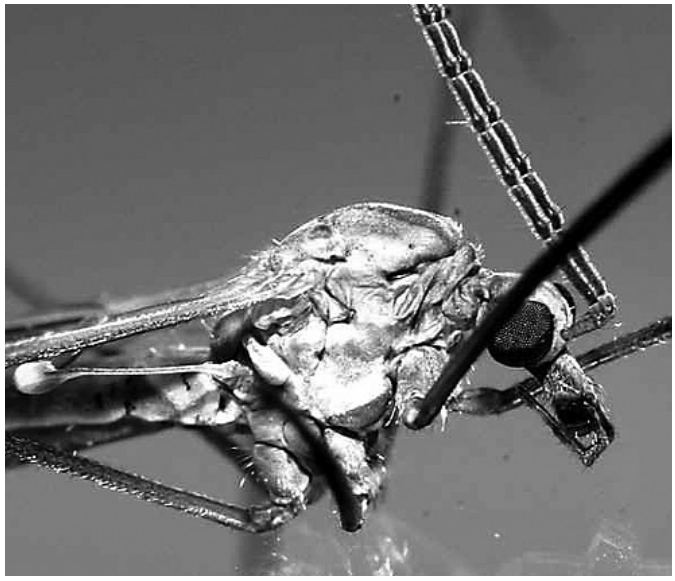
"We plan to expand HAART within current treatment guidelines in a controlled fashion within a very well-characterized setting, where we can determine its impact on HIV incidence rates—the results of which will be critical to informing health policy worldwide. This hypothetical but testable approach deserves to be urgently and thoroughly evaluated in highly-controlled environments."

Stay tuned. This could be the beginning of an exciting new era in the fight against HIV. ⊕

***Glen Edwards** is director of client services and media relations for Karyo Communications in Vancouver. Karyo has provided communications support for the BC Centre for Excellence since its inception in 1992.*

Double threat

Malaria in combination with HIV is a major health concern in sub-Saharan Africa



by Kath Webster

Malaria is one of the world's most common and serious tropical diseases. It is caused by a parasite that is transmitted to humans primarily by mosquitoes. Malaria kills more than one million people a year, with 90 percent of these deaths occurring in sub-Saharan Africa, the region that also has the globe's highest HIV rate. Given this geographic overlap, the incidence of HIV and malaria co-infection is extremely high. These two diseases impact each other in many ways, including risk of transmission, disease progression, treatment interactions, and pregnancy risks. The rate of co-infection has major public health implications.

Pregnant women and young children are particularly susceptible. Either HIV and malaria can cause serious complications during pregnancy, endangering the health of both the pregnant woman and her infant. When the two diseases occur together, the dangers are compounded. HIV-infected pregnant women are much more likely to contract malaria even if they were previously immune to the parasite.

In turn, malaria can cause HIV viral loads to nearly double in pregnant women. The placenta of co-infected women has a high chance of becoming infected with malaria, which puts the fetus at greater risk of both malarial infection and HIV. Co-infected women are at a very high risk of developing anemia. Children born to women who are co-infected often have low birth weight and may die during infancy.

Malaria is the leading cause of death in children under five years old in sub-Saharan Africa. As well, 90 percent of the world's children under 15 years old infected with HIV live in sub-Saharan Africa. Few studies have looked at the interaction of malaria and HIV in children. It has been reported that HIV-positive children may be at increased risk of severe malaria or death compared to HIV-negative children.

Generally speaking, studies have shown that HIV increases the risk of malaria infection, especially in those with advanced immune suppression, which may lower their natural immunity to malaria. Studies have also shown that HIV significantly increases the risk of developing severe or complicated malaria, most notably in people with low CD4 counts and who live in areas of unstable or infrequent malaria transmission and thus have lower immunity to malaria.

On the flip side, a study in Malawi suggests that malaria, especially if frequent or untreated, might lead to an elevation of viral load in HIV-positive adults; that, in turn, may result in increased rates of HIV transmission and disease progression.

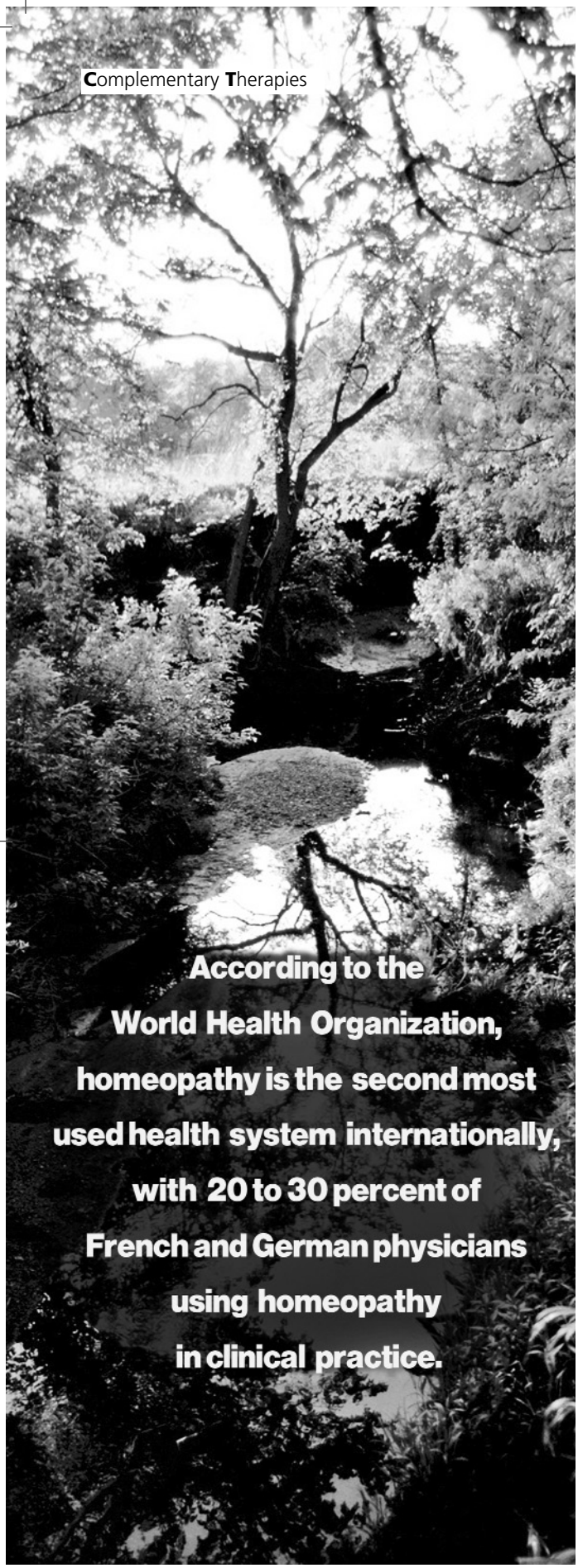
While malarial episodes can increase HIV viral load, effective anti-malaria treatment can reduce HIV viral load. However, reports suggest that HIV-infected adults with low CD4 counts may be more susceptible to treatment failure of anti-malarial drugs compared to those not infected with HIV.

On the encouraging side, recent research has shown that protease inhibitors, a class of drugs used to treat HIV, may also have an anti-malarial effect. Saquinavir (Invirase) boosted with ritonavir (Norvir) as well as lopinavir/ritonavir (Kaletra) have been shown to kill malaria parasites in test tubes and in mice. Studies in humans are underway.

Overall, the effect of malaria on the course of HIV has not been well studied and reports are inconclusive. More research is needed to investigate the impact of malaria on the natural progression of HIV.

Along with the need for more research, there is a need for coordinated efforts to prevent and treat HIV and malaria in areas where both diseases are endemic. Healthcare programs need an integrated approach in order to address all of the unique interactions and issues that these diseases raise. In particular, special care is needed for pregnant women and children who are infected with or at risk of malaria and/or HIV. ⊕

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



Nature's way

Homeopathy has been used to treat a variety of ailments for over 200 years

by Kenn Blais

Homeopathy is the original immune-enhancing medicine. No matter what kind of ailment is being treated, the homeopathic remedy stimulates the body's own defence system to make the desired corrections.

Instead of using strong medicines, homeopathy utilizes extremely low concentrations of plant, animal, and mineral substances that exhibit powerful biochemical effects in the body. The remedies are diluted to such an extent that there is no detectable substance remaining. What is left, however, is an electromagnetic energy pattern that sends information to the enzymes and other cellular communicators, stimulating the body to utilize its own innate immunity.

Shedding light using nanotechnology

In the past decade, the advance of microscopic instruments has allowed science to probe into the fundamental nature of matter at the supramolecular level, referred to as the nanoscale. Research shows that the behaviour of materials in the nanoscale is very different than at the larger normal scale. It was once believed that matter is consistent, but we now know that the shape and structure of solids change at smaller concentrations, and so do their properties.

This illustrates a basic principle of homeopathy where a substance that produces illness at a toxic dose can become a remedy for the same illness in a diluted dose. For example, phosphorus, which causes damage to the liver, is used in a homeopathic dose to treat hepatitis. Arsenic, which causes skin problems, is used to treat eczema.

Evidence of this polarity of action, used by homeopaths for over 200 years, is now coming to light thanks to nanotechnology. According to Dr. Neal Lane, former director of the US National Science Foundation, "nanotechnology is an area of science that will most likely produce the breakthrough of tomorrow."

According to the World Health Organization, homeopathy is the second most used health system internationally, with 20 to 30 percent of French and German physicians using homeopathy in clinical practice. Homeopathy, along with Ayurvedic medicine, is the most widely used system of medicine in India. It is commonly practiced in Italy, Switzerland, South America, Australia, New Zealand, and Mexico.

A 1994 survey showed that 50 percent of Dutch physicians practiced and supported the use of homeopathy in the treatment of people with AIDS.

Homeopathy through the centuries

Homeopathy grew from its impressive success in treating life-threatening, infectious illnesses like the epidemics of cholera, typhoid, yellow and scarlet fever, and pneumonia in the 1800s. Records from medical facilities show that homeopaths achieved far superior results in mortality and morbidity rates than the allopaths (or conventional medicine practitioners) with most diseases, including viral diseases.

The success of homeopathy has been well documented. Records from Broome County, New York in the mid-1800s show that people with diphtheria who were treated by homeopaths had a 16.4 percent mortality rate, compared to 83.6 percent for people treated by allopaths. Similarly, during the cholera epidemic in London in 1854, people treated by homeopaths had a 9 percent mortality rate, compared to 59.2 among people treated by allopaths. And it was the remedies of Dr. Hahnemann, the German founder of homeopathy, which cured Napoleon's troops when they were overcome by an epidemic.

As popularity of homeopathy surged in England in the mid-1800s, homeopathic hospitals and schools began to flourish in the US. But the growth in alternative medicines in the US met with serious opposition. At the turn of the century, a group of allopathic doctors concerned about the increase in popularity of homeopaths and chiropractors got together and formed a union to protect their interests. This new trade lobby, the American Medical Association, attracted wealthy and politically influential people who created policies to discredit the alternative sciences.

In Canada, the tactics were just as dirty. In his book ***Racketeering in Medicine: The Suppression of Alternatives***, Dr. James Carter notes that alternative practitioners had their offices raided, equipment confiscated, and were discredited.

In the 1990s in Nova Scotia, the College of Physicians and Surgeons harassed two respected homeopaths, Dr. Baker and Dr. LaValley. This brought about a huge outcry by an angry public whose homeopathic health care was being threatened, and led to the birth of the advocacy group Citizens for Choice in Health Care.

Despite these blacklisting tactics in Canada and the US, homeopathy is widely practiced throughout the rest of the world and often with government support.

Government support for homeopathy

In August 2005, the government of Uganda's National Drug Authority began the process to approve a homeopathic remedy to be distributed to the nation's HIV population. ***East Africa Business Week*** quoted Dr. Sigsbert Rwegasira as saying that the remedy, called Canova Method, improved the quality of life of patients in just three months since the Tanzanian government gave special permission for its use.

Studies at the Department of Cellular Biology of the Federal University of Parana in Brazil state that Canova Method, a medicine composed of five traditional homeopathic substances, increases the immune response through activation of macrophages and lymphocytes.

Government support for homeopathy is well established in Great Britain, dating back to the 1840s when Queen Victoria endorsed it. Over 30 percent of general practitioners now use homeopathy in Great Britain, and five homeopathic hospitals are part of the National Health System. In fact, the clinical director of the Royal London Homeopathic Hospital is also the official physician to Queen Elizabeth, a position that is traditionally held by a homeopathic doctor.

Studies of homeopathy on PWAs

Some homeopaths have conducted studies to evaluate the beneficial effects of homeopathy on PWAs. For example, Laurence Badgley, MD, a San Francisco physician and homeopath who has written such books on HIV as ***Healing AIDS Naturally*** and ***Choose to Live***, conducted a six-month study among 36 of his HIV-positive patients using homeopathy. He observed an average 13 percent increase in their CD4s. He found that cyclosporin (a fungus used in conventional doses as an immunosuppressive drug), typhoidinum (the symptoms and progression of typhoid are eerily similar to AIDS) and badiaga (fresh water sponge) were most beneficial in these patients.

Michael Strange is a homeopath at the Lavender Hill Homeopathic Centre in London, England working with PWAs. Homeopathic remedies that Strange has found helpful in treating the constitutional profile of his HIV-positive patients include arsenicum, phosphorus, natrum mur, pulsatilla, and sepia. He has successfully treated pneumocystis carinii pneumonia (PCP) using bryonia, china, pulsatilla, and sepia.

Dana Ullman, the founder of Homeopathic Educational Services in Berkeley, California, cites research using homeopathic dilutions of the antibiotic trimethoprim-sulfamethoxazole (TMP-SMX, Septra) to reduce its side effects. TMP-SMX is commonly used to prevent PCP, and up to 80 percent of patients experience reactions to it. Patients with a known sensitivity were given the homeopathic dilutions for two weeks prior to restarting the drug. Two-thirds of the group showed no further sensitivity to the antibiotic.

Homeopaths have noted some general observations among HIV-positive patients:

- HIV-positive patients require repeat doses
- Remedies need to be changed more frequently
- High-potency doses tend to be more effective even though low-dose remedies are usually used in chronic immuno-deficiency diseases
- High-potency doses also require more frequent repetitions—six times a day, though normally they are given three times a day
- The use of the miasms—medicines used for underlying genetic factors—of psora (scabies) and syphilium (syphilis) have been significant in treating the chronic aspect of HIV.

Everyone's biochemistry is different. Working with the body's natural intelligence rather than overwhelming it, homeopathy is a safe and effective adjunct in the treatment of HIV. ⊕

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

The body's own batteries

Your kidneys can give you zest for life. Learn how to keep them well charged

by Dr. Jennifer Hillier

According to Traditional Chinese Medicine, the kidneys are the Wellspring of Vitality: they act as the batteries for a long and healthy life. To maintain the charge on these batteries, we have to take care of them—and taking care of the kidneys involves taking care of your whole body. Working away quietly, these paired organs can be threatened by a multitude of problems. The target of everything from diabetes to medications, cardiovascular diseases to infection, the kidneys are a valuable resource to be protected.

In Western medicine, the kidneys serve to filter the blood and remove waste products that end up in the urine. As filters, they are exposed to everything you eat and drink, so the first step to keeping them healthy is to watch what you eat. Coffee, alcohol, and pop contain ingredients that can weaken the kidneys and decrease their ability to do their job. By reducing or eliminating these substances, you not only help the kidneys, but also improve your sleep, energy, and zest for life.

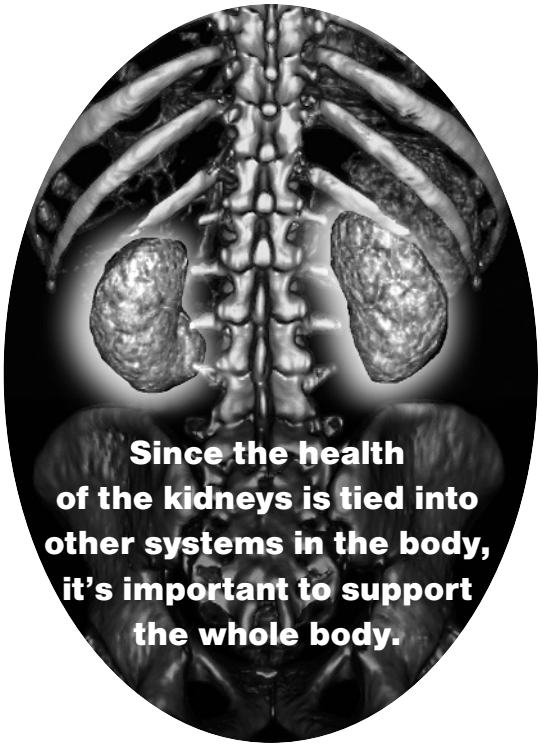
Large quantities of animal proteins can also affect kidney function, as the larger molecules present in meat are more difficult to process. When the kidneys are taxed, easily digestible rice protein can provide a welcome break. Look for it in protein shakes where it is processed and concentrated, since it takes large quantities of actual rice to get an adequate level of protein.

Since the health of the kidneys is tied into other systems in the body, it's important to support the whole body. Decreasing or eliminating refined (white or processed) sugars can reduce your chances of developing advanced diabetes, a major cause of kidney damage. Reducing bad sources of fat—such as fried foods, and processed fats like margarine and animal fats—can keep your heart and blood vessels healthy, maintaining the vital flow of blood.

It's always a good idea to include five to ten servings of fruits and vegetables daily, preferably cooked or steamed for easier digestion. The fibre in the produce helps to control blood sugars and reduce blood fats. Fruits and vegetables also contain vitamins and minerals that are important for healthy living.

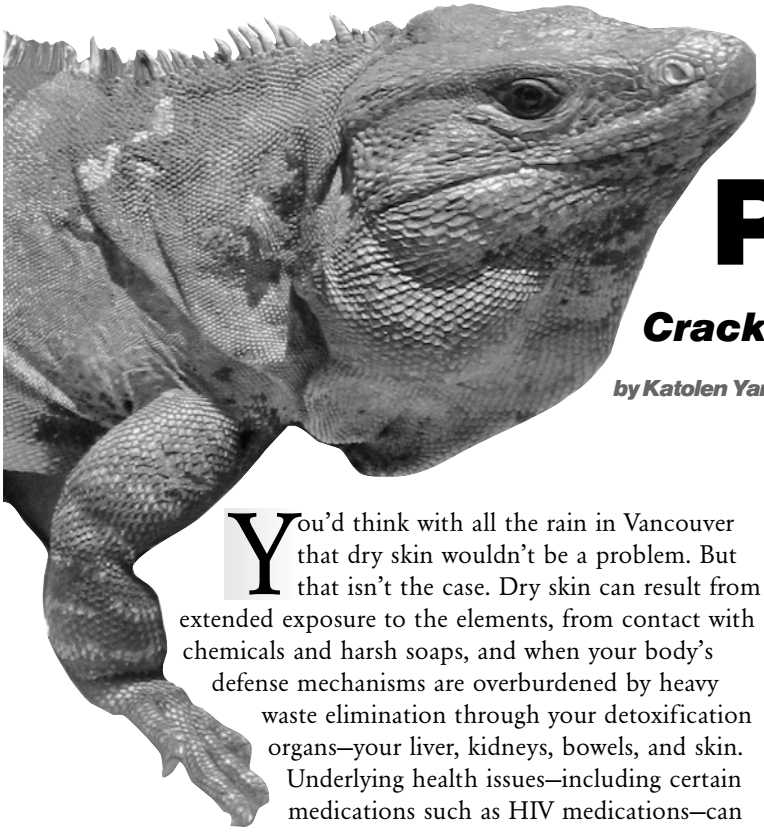
In terms of supplements, fish oils are a wonderful addition to a nutritious diet. Helping to reduce inflammation all over the body, the essential fatty acids contained in fish oil reduce the risk of cardiovascular disease, which can have a big impact on the kidneys. In addition, the supplement coenzyme Q10 can help the kidneys as well as the heart to function better while decreasing the amount of damage done by wastes.

Of course, drinking enough water is the most important and simplest thing you can do. When you drink two litres of water per day, it flushes waste from your kidneys, making the kidneys' job of elimination easier.



According to Traditional Chinese Medicine, the energetic and physical characteristics of the kidneys are affected by everything you do, from eating nutritious and balanced meals, to getting enough sleep and avoiding undue stress. Care for these organs, and in return they will provide you with energy to last a lifetime. ⊕

***Dr. Jennifer Hillier**, ND, is a naturopathic doctor practicing in Ontario and working with the BCPWA Society on the Living Well Lab community research project for HIV/AIDS.*



Plump it up

Cracking the dry skin dilemma

by Katolen Yardley

You'd think with all the rain in Vancouver that dry skin wouldn't be a problem. But that isn't the case. Dry skin can result from extended exposure to the elements, from contact with chemicals and harsh soaps, and when your body's defense mechanisms are overburdened by heavy waste elimination through your detoxification organs—your liver, kidneys, bowels, and skin. Underlying health issues—including certain medications such as HIV medications—can also dehydrate your skin.

Rough, cracked, and dry skin can be caused by the depletion of natural oils in the body or a lack of moisture on the skin, leading to discoloration and premature aging. Signs of dehydration include scaling, flaking skin that feels tight after washing, has a tendency to chap and crack, and is generally lacklustre.

Hydrating your body encourages skin cells that are plump and full of fluid. There are a number of holistic strategies to help your skin achieve a youthful, healthy appearance. Some key nutrients for the skin include Vitamin A and beta-carotene, which both strengthen and protect the skin. Vitamin B is known as the anti-stress agent and also assists liver function. Vitamin E protects against harmful free radicals that damage skin cells and speeds up the healing process. And omega 3-6-9—essential fatty acids found in fish, flax oil, and nuts—provide needed oil and moisture to the skin from the inside out.

There are also several herbs, known as blood cleansers, which can help your skin by improving the function of the liver and kidneys, thereby alleviating some of the skin's detoxification responsibilities. They can improve the texture of the skin and minimize dryness and scaly patches. These herbs include dandelion root and leaf (***Taraxacum officinalis***), blue flag (***Iris versicolor***), cleavers (***Galium aparine***), and nettle leaves (***Urtica dioica***). You can take them internally in tea or in tincture form.

Here are some nutritional suggestions to maintain healthy skin:

- Add flaxseed oil to salads, baked potatoes, or pasta.
- Increase your raw food intake, particularly orange and yellow vegetables, which are high in beta-carotene: carrots, tomatoes, squash, peppers, cantaloupes, and apricots.
- Eat unsalted and unroasted nuts: almonds, pecans, Brazil nuts, and pumpkin seeds.
- Eat wild salmon, which is an excellent source of essential fatty acids; it hydrates the skin from the inside out, assists in repairing tissues, and has healing, anti-aging properties.
- Avoid fried foods, animal fat, hydrogenated oil, sugar, potato chips, and chocolate.
- Drink six to eight glasses of water daily, and avoid caffeine and alcohol, which are diuretics that cause the body to lose fluids.

Some topical applications for treating dry skin:

- Apply aloe vera gel.
- Steam your face using two tsp of dried chamomile and lavender flowers per four cups boiling water. Cover your head with a towel and steam your face for two to three minutes. Afterward, apply a cold, wet facecloth to your face to close the pores.
- Create a face mask using half an avocado (or a ripe banana) mashed and mixed with lemon juice; apply for 10 to 15 minutes and rinse well.
- Brush your skin before bathing using a dry natural vegetable bristle brush on your torso, legs, and arms. Working up from your extremities, move the brush in a circular motion towards your heart. It's an excellent way to slough off dead skin, improve blood flow, rid your body of waste matter, and encourage lymphatic drainage and detoxification.

Finally, avoid too much sun. Proteins in the skin such as elastin, collagen, and keratin, which contribute to skin elasticity, are damaged through constant exposure to the sun. And don't smoke! Smoking constricts blood vessels and tiny capillaries that carry nutrients to the skin, leading to a dry leathery texture. And you don't want that. ⊕

Katolen Yardley
is a medical herbalist in private practice at the Tri City Natural Health Clinic in Coquitlam and at Alternate Route Healing in Vancouver.

Radical stuff

Vitamin E tackles those nasty molecules called free radicals that attack healthy cells in your body

by Diana Johansen

Vitamin E supplements have long been recommended for antioxidant protection in HIV and other diseases, and many people take it to prevent disease. Recently, vitamin E made headlines when researchers reported findings that people who took high amounts of it were more likely to die. This new information created quite a stir and vitamin E supplementation fell out of favour. So, then, what exactly are the benefits and risks of vitamin E?

Vitamin E consists of a family of eight chemical substances, including four tocopherols and four tocotrienols. It is a fat-soluble vitamin and an essential nutrient for humans. This means we can't synthesize it ourselves and we must obtain it from external sources, such as food and supplements.

Several forms appear to have a biological role, however alpha-tocopherol seems to be the most important because it's the only one actively maintained in the body. Vitamin E is absorbed from the intestinal tract with dietary fat and is taken directly to the liver. From there it's packaged with cholesterol and transported to the various cells throughout the body.

The benefits of vitamin E

Taking vitamin E supplements is a common practice in people with HIV and in the general population. Its potent antioxidant effect, especially in alpha-tocopherol form, may offer protection for the immune system, liver, arteries, eyes, nervous system, and brain. It may also have anti-cancer properties.

Antioxidant: Free radicals (highly reactive molecules that attack cells) are formed in the body during normal metabolism as well as during exposure to environmental factors such as pollution, drugs, and cigarette smoke. Free radicals make more free radicals and this process must be interrupted to protect cells and tissues: this is where vitamin E plays a major role. All cell membranes contain fats, which are especially susceptible to destruction by free radicals. Alpha-tocopherol neutralizes free radicals in the cell membrane, keeping the membrane intact and functioning properly. It works in partnership with other antioxidants, including glutathione, selenium, vitamin C, and ubiquinol (coenzyme Q10).

HIV: Because HIV infection creates an inflammatory response in the body, there is an increase in the production of free radicals, which leads to oxidative stress, a situation where free radicals' damage is greater than the body's ability to repair it. High levels of oxidative stress may impair immune function, increase viral replication, and cause more rapid disease progression. Vitamin E has a modulating effect on the immune system; studies on aging show that vitamin E can improve the immune system, which declines in old age.

About ten years ago, Alice Tang et al from Johns Hopkins University showed that HIV-positive men with higher levels of vitamin E in their blood had a lower risk of disease progression compared to those with low levels. Other studies failed to show that people with HIV actually have lower blood levels of vitamin E than their negative counterparts. In test tubes, the addition of alpha-tocopherol appears to decrease viral replication and prevent antiretroviral-induced atherosclerosis. Animal studies show that adding vitamin E decreases oxidative stress in mitochondria exposed to AZT (Retrovir).

Cardiovascular disease: Vitamin E is often used to prevent or treat cardiovascular disease. Its antioxidant properties may play a role in preventing the development of atherosclerotic plaques (fatty deposits containing cholesterol). This process occurs when LDL—or "bad"—cholesterol builds up on artery walls. The cholesterol undergoes a series of transformations that involve oxidation and cause damage to the arteries and encourage the development of plaques. Eventually, plaques can get large enough to block the artery and cause a heart attack or stroke.

In observational studies of large populations, those who took large doses of vitamin E seemed to gain a protective effect and were less likely to develop cardiovascular disease. However, in clinical trials of high-dose vitamin E compared to a placebo, the results have been inconsistent. A few studies have shown a decrease in angina or the incidence of non-fatal heart attacks, whereas others have not. Most trials don't show a decrease in mortality and some have found that individuals who already have heart disease may actually be at increased risk of harm.

HCV: People with hepatitis C experience greater levels of oxidative stress in conjunction with lower levels of antioxidant enzymes and micronutrients. Small studies of vitamin E supplementation (800-1200 IU per day) have shown improved liver enzyme levels, in particular ALT enzymes. It isn't clear whether this will translate into a decreased rate of progression of liver fibrosis, which is the formation of fibrous, scar-like tissue.

Cancer: Observational studies have associated higher blood levels of vitamin E with reduced incidence of various cancers, whereas lower blood levels of vitamin E has been linked to a higher incidence of lymphoma or leukemia in some populations. In animal and test tube studies, high-dose vitamin E, alone or in conjunction with other antioxidants, appears to have anti-cancer activity. A number of promising intervention studies of fairly

low-dose vitamin E have also shown a decreased incidence of, and mortality from, cancer.

Other: Vitamin E appears to have beneficial effects on the neurological system and may improve neuropathy and the progression of Alzheimer's disease. High blood levels have also been associated with reduced incidence of cataracts and age-related macular degeneration, which is an eye disease of the retina.

Sources of vitamin E

The daily recommended intake of vitamin E for adults is 22 IU from natural sources. The richest sources of vitamin E are plant oils such as sunflower, safflower, canola, olive, corn, soybean, and, especially, wheat germ. Unrefined cereal grains, nuts, fruits, and vegetables provide some vitamin E, and animal foods contain small amounts in the fatty portion. A number of US dietary studies found that many adults don't get the recommended daily amount, probably because of a low intake of these foods. However, clinical vitamin E deficiency is rare and hard to assess. It's most likely to occur in individuals with fat malabsorption.

Alpha-tocopherol supplements are commonly available as alpha-tocopheryl succinate or acetate. One type of supplement is called ester, which is more resistant to oxidation and has the same biological availability as free alpha-tocopherol. Gamma tocopherol and mixed tocopherols are also available, which may prove beneficial as we gain an understanding of the roles of the tocopherol family. The synthetic form of alpha-tocopherol is about half as potent as the natural sources because it isn't as complete.

The downside: toxicity

Vitamin E is considered a relatively non-toxic vitamin. The upper tolerable limit is set at 1,500 IU from natural sources (2,200 IU from synthetic sources). However, researchers recently conducted a meta-analysis of 19 clinical trials of vitamin E and concluded that people who took high doses were more likely to die from any cause. The analysis showed that the higher the dose, the higher the risk of dying. The risk rose sharply at doses of 400 IU or greater.

This analysis had some limitations in that most of the studies looked at people who were elderly or malnourished or already had heart or other chronic disease. Many of the 19 studies looked at vitamin E in conjunction with other antioxidants, so it may not be possible to separate out the effects of vitamin E alone. In spite of this limitation, it does give reason to reevaluate our approach to vitamin E supplementation.

Vitamin E is also a blood thinner and may increase the action of blood thinning drugs such as aspirin or warfarin. People who have a tendency to bleed from other conditions should be cautious with supplements, and people scheduled for surgery should stop high doses about one month before the procedure. Taking very high amounts of the vitamin could also cause gastrointestinal disturbances such as nausea, diarrhea, or flatulence, which is a reminder that it's important to check supplement regimens when experiencing gastrointestinal problems.

Although vitamin E has been generally considered safe even at high doses, new analysis of the research suggests there may be more risk than previously thought. Even without consensus, if there is any risk of harm you should reconsider optimal supplementation doses. The most common intake of 400 IU may, in fact, be too high for long-term use.

Until we have information, it would be prudent to cut back on vitamin E supplementation to 200 IU per day, which is still 10 times the recommended daily intake. Besides, you can't go wrong by increasing your daily intake of unrefined whole grains, wheat germ, nuts, and seeds. ⊕

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

Just do it

Don't let a negative body image ruin your life—take positive steps

by Angela Birnie

What went through your mind the last time you saw a smiling, attractive stranger in the street?

- ❑ I'll never have the perfect body. I need Häagen-Dazs to drown my sorrows.
- ❑ @#$%!* people shouldn't be allowed to be happy ***and*** beautiful.
- ❑ I need to get back to a strict diet and gym routine. Fat and carbs shall never again pass these lips.

If any of these sound familiar, read on.

Having a negative perception of your appearance can affect your self-esteem and behaviour. To have a positive body image, you don't necessarily have to love every aspect of your body. You may love some parts and accept others. The ultimate goal is to achieve confidence, self-acceptance, and self-respect. Or at least to avoid letting a negative body image dictate the way you live your life. So where do you start?

Feed your body and your soul. Eat a variety of nutritious, balanced meals. Aim for eating foods from the four food groups 80 percent of the time. Treat yourself the other 20 percent of the time. Be sure that you're not using food as your only reward, though. Consider rewarding yourself by getting a massage, buying tickets to a show, or watching a sunset on the beach.

Get moving. Regular exercise will boost your energy, mood, and immune function. Strength training will build muscle. Cardiovascular activity—including swimming, walking, cycling, and dancing—will improve your cholesterol, blood sugar, and blood pressure. Flexibility training, such as yoga, can help you focus on body awareness and prevent injury. Plus, you never know when flexibility will come in handy!

Make a list of the things you'd do "if only you looked better." Maybe your list includes wearing a fabulous piece of clothing, or starting a conversation with that new neighbour who just moved in, or signing up for a dance class. Pick something from that list to do today. Start with easier things and work your way up to the big things. Don't wait.

Sort through your closet. If clothes are too small, get rid of them. Donate them to a worthy cause. Saving clothes that don't fit only reminds you of the flaws you see in your body.

Help create an environment that reinforces a positive body image. Don't laugh at jokes about someone's appearance. Pay attention to the messages we get about our bodies from advertising, television, film, and magazines. If you don't like what you see, speak up. It can be very empowering to e-mail or write to corporations to complain about the messages they convey.

Pay attention to your thoughts. Do you think of yourself as a whole person, or a sum of body parts to be loved or hated? Do you criticize yourself using words you would never dare utter to a friend? You are better than the sum of your parts. Treat yourself as well as you treat your friends.

Think of your attitudes around size. What do you think or believe about people who are deemed underweight or overweight? Are your thoughts fair or accurate? Do you constantly praise others for their appearance? Don't forget to offer praise for other aspects as well—someone's intelligence, accomplishments, sense of humour, or thoughtfulness, for example.

If depression, anxiety, negative body image, an eating disorder, or compulsive exercising interfere with your life, talk to your physician. Also consider counselling to improve your mood, coping skills, or self-esteem. Visit the BC Psychological Association's Web site at www.psychologists.bc.ca to find a psychologist. Schools that train psychologists also offer low-cost counselling by Master's or PhD students. ⊕

***Angela Birnie** is a registered dietitian at St. Paul's Hospital in Vancouver and at the North Shore Stress and Anxiety Clinic in North Vancouver.*

Not so pointless

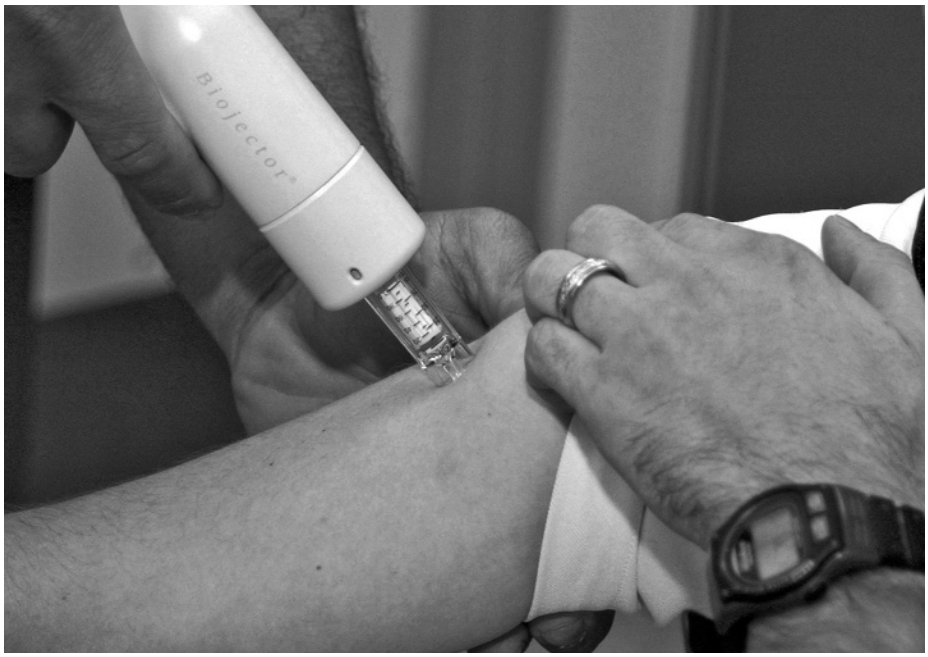
A needle-free alternative for enfuvirtide helps eliminate injection site reactions

by Anne Drummond

Enfuvirtide (Fuzeon) is the first of the fusion inhibitors and acts by preventing the insertion and attachment of the viral glycoprotein, thus preventing the integration of viral genetic material into host cell chromosomes. This new antiretroviral has proven to be effective in combination antiretroviral therapy, and what's more, studies to date suggest it is free of systemic toxicities. Enfuvirtide is taken twice a day in the form of a subcutaneous (under the skin) injection in a regimen with two other antiretrovirals. In the Phase III clinical trials—referred to as TORO 1 and TORO 2—that assessed the safety of enfuvirtide, local injection site reaction (ISR) was the main side effect noted, occurring at least once in 48 weeks in 98 percent of patients.

Researchers at the BC Centre for Excellence in HIV/AIDS (BCCfE) at St. Paul's Hospital in Vancouver recognized that needle phobia and continuous or very obvious ISRs might dissuade some HIV-positive people from using enfuvirtide. In addition, there was some concern that use of needles might trigger a relapse in recovering injection drug users. The Biojector, a needle-free gas-powered system for subcutaneous injection of medication was offered as an alternative to the standard syringe and needle system. Dr. Marianne Harris and her colleagues at the BCCfE recently published a study where the Biojector was compared with standard syringe and needles in terms of ease of administration of the drug, severity of ISR, and enfuvirtide plasma levels.

Thirty-two antiretroviral-experienced HIV-positive patients who had experienced or anticipated problems with needle-based administration of enfuvirtide participated in the three-month study.



Overall, patients felt the Biojector was significantly easier to use than the needle and syringe system.

Patients new to enfuvirtide treatment were instructed in the use of needles and used this system for a week before switching to the Biojector. Patients who had used needles to administer enfuvirtide were switched to using the Biojector after appropriate instruction.

Overall, patients felt the Biojector was significantly easier to use than the needle and syringe system. None found the Biojector harder to use, though some patients rated both systems easy to use. ISR scores were significantly higher when patients used needles to inject enfuvirtide. Furthermore, the method of injection did not result in any significant difference in enfuvirtide plasma levels.

These results suggest that Biojector usage is capable of reducing the pain and cosmetic concerns from ISRs associated with enfuvirtide injection, without any decrease in efficacy of the drug. The major drawbacks of the Biojector are cost and availability: the current retail price is US$995 plus the cost of consumables such as the carbon dioxide cartridges (US$66 per month).

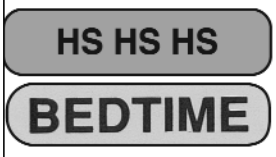
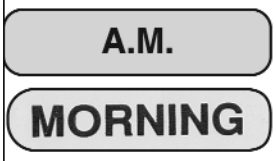
Despite the cost and limited availability, the Biojector does offer an alternative that might enable patients experiencing injection-related problems to continue taking enfuvirtide. ⊕

***Anne Drummond** is a Victoria-based college instructor and a freelance scientific and medical writer.*

Look before you leap

Here's a handy guide to the meaning of the many of the warning labels on your prescriptions

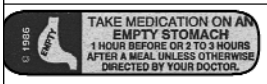
by Kristin De Girolamo

Label	What it means	What drugs it commonly appears on
	Even if you start to feel better or your condition appears to have improved, make sure you finish all the pills in the bottle unless told otherwise by your healthcare professional. You need to complete all the medication because with antibiotics and antivirals, it often takes the entire course of the drug therapy to kill off all of the bacteria or viruses. Stopping early will allow those bugs that are more resistant to the drugs to live and produce more drug-resistant bugs.	All HIV medications; antibiotics
	HS is the Latin abbreviation for "bedtime." Take the medication very close to when you are going to sleep. Drugs with this label may cause drowsiness and should not be taken during the day.	Sleeping pills
	Drugs with this label are meant to be taken relatively close to when you first wake up in the morning; taking them at night can cause you to sleep poorly.	Some antidepressants (e.g., Celexa); diuretics (drugs that make you excrete more fluid than normal)
	PRN is the Latin abbreviation for "as needed." Drugs with this label are meant to be taken only when symptoms are present.	Pain relievers
	Grapefruit juice is broken down by the body by the same enzymes that break down some common drugs. If you take grapefruit juice and the medication at the same time, the enzyme will not be to break down both of them, leading to an increase or decrease of the drug in your body. This can lead to overdoses or underdoses. Avoid grapefruit juice altogether while on the medication.	Cholesterol-lowering drugs such as Lipitor, Mevacor, Pravachol, and Zocor
	Drinking alcohol with drugs that already can have a sleepy effect will intensify the feeling, making you very drowsy and possibly dizzy.	Sleeping pills; metronidazole (an antibiotic); Tylenol 3
	Antacids work by lowering the acidity (or increasing the pH) of the stomach. Changing the pH of the stomach can decrease your stomach's ability to break down drugs so that they can be absorbed into the bloodstream. This decreases the action of the drug in the body. Take antacids at least two hours from the time you take your drug, or avoid completely if possible.	Delavirdine (Rescriptor); some antifungals (e.g., Nizoral); birth control pills

There are many possible warning labels that you might find on the bottles of your prescription medication, and sometimes the pharmacist may not get the opportunity to fully explain the labels to you. Below is a list of many of the common labels used, and what medications they commonly appear on.

This is by no means an exhaustive list of the warning labels you might find on your prescriptions, so if you come across one you don't know, ask your pharmacist for an explanation. You have the best chance of the medication working if you take it in the correct manner. ⊕

***Kristin De Girolamo** is a volunteer with the Treatment Information Program at the BCPWA Society, and a pharmacy student at the University of British Columbia.*

Label	What it means	What drugs it commonly appears on
	Having food in your stomach can change the acidity of the stomach and impede it from breaking down drugs effectively. As a result, the drugs will not be absorbed as well as they need to be in order to achieve the desired effect. Take one hour before a meal or at least two hours after a meal to ensure your stomach is empty.	Efavirenz (Sustiva); didanosine (ddI, Videx); indinavir (Crixivan)
	Having food in your stomach can help ease the stomach upset that some drugs can cause and can ease the resultant nausea and vomiting. Food in your stomach can also alter the acidity of the stomach, improving the absorption of some medications.	Zidovudine (AZT, Retrovir); all protease inhibitors except indinavir (Crixivan)
	Stat means take right away. You can take your first dose as soon as you have picked up the pills from the pharmacy.	Some antibiotics, such as amoxicillin
	Birth control pills are broken down by a certain set of enzymes in the body, and if a new prescribed drug is broken down by the same enzymes, the birth control pills may not break down as effectively. This can decrease the effectiveness of birth control pills. Use another method of birth control.	Anticonvulsants (e.g., phenytoin); antibiotics (e.g., penicillin); sedatives (e.g., barbiturates)
	The only exception would be if the weather got to over 30C, it would be best to store the medication in a shady, cooler area or the fridge for a short period of time.	Most medications
	Some medications need to be stored in the refrigerator to ensure that they remain effective. If the drug has an expiry date, discard the drug once that date has passed. For many liquid drug forms, it is important to also shake the liquid first until it is equally dispersed.	Ritonavir/lopinavir (Kaletra); amprenavir (Agenerase) liquid form; saquinavir (Fortovase); enfuvirtide (Fuzeon, T20) only once the suspension has been mixed; antibiotic suspensions (e.g., amoxicillin); most insulins-some are not shaken, while others require gentle shaking before drawing into the syringe
	For liquid suspensions that do not need to be stored in the refrigerator. Shaking the liquid mixes the drug equally to ensure each dose is equal in strength.	Abacavir (Ziagen) in liquid form; some antibiotic suspensions (e.g., zithromax)

What are mitochondria and why should you care?

by Dr. Marianne Harris

Mitochondria are ***organelles*** (little organs) within cells that generate energy for the cell's functions—essentially, the furnaces within cells. Cells that use a lot of energy, such as muscle cells, have a lot of mitochondria. If something damages the mitochondria, the cells can't work properly, and cells that use a lot of energy are particularly susceptible to this kind of damage. So, for example, if mitochondria in muscle cells are damaged, the muscles become sore and weak.

Unfortunately, the nucleoside antiretrovirals can affect the mitochondria. This is especially true of the older nukes such as AZT (Retrovir), ddI (Videx) and d4T (Zerit). These drugs seem to affect the mitochondria in certain tissues. For example, AZT can affect the muscles and heart, while d4T and ddI affect the mitochondria in nerves, causing peripheral neuropathy. D4T can also damage the mitochondria in fat cells, which is how it causes fat loss or lipoatrophy.

Luckily, 3TC (Epivir) and some of the newer agents, such as abacavir (Ziagen) and tenofovir (Viread), seem to have relatively little harmful effect on the mitochondria. However, some recent work by Dr. Helene Cote at the University of British Columbia indicates that tenofovir can damage mitochondria in kidney cells, especially when combined with ddI.

Kidney cells use a lot of energy to filter toxins out of the blood and into the urine, and to reabsorb the good things you want to keep—such as water and sugar—back from the urine into the blood. If the kidney mitochondria are damaged, these cells can't work properly, resulting in fluid and salt imbalances and kidney failure. That's why a small number of people taking tenofovir (with or without ddI) will develop kidney problems, and why doctors monitor kidney function closely in people taking this drug.

In order to look at the mitochondria in organs such as the heart or kidney, researchers have to look directly at the cells from a tissue sample under a microscope. However, in 2002, Dr. Cote, who was working at the BC Centre for Excellence in HIV/AIDS at the time, developed a blood test that can act as a "surrogate marker" for mitochondria in the tissues. This blood test has been used in a number of studies to show, for example, that mitochondrial levels in the blood improve when a person switches from a regimen including d4T to one with tenofovir. In other words, at least up to a certain point, the mitochondrial damage caused by drugs such as d4T is able to recover when that drug is taken away.

More recent research has shown that AZT may not be as harmful to mitochondria as originally thought, especially in the lower doses used today. A poster presented at the recent Canadian Association for HIV Research conference showed that people who took AZT and 3TC (as Combivir) with a third drug—either lopinavir/ritonavir (Kaletra) or nevirapine (Viramune)—had no more change in their blood mitochondria levels over the course of a year than those who took a nucleoside-free regimen of lopinavir/ritonavir plus nevirapine. So, different nucleosides may vary not only in which body tissues they affect, but also in how quickly they cause mitochondrial damage in those tissues.

Clearly, some people will develop side effects, such as peripheral neuropathy, due to mitochondrial damage from their nucleosides, while others can take the same drugs for many years without any problems. Some people appear to be more susceptible to the mitochondrial-toxic effects of nucleosides for reasons we don't yet fully understand. Luckily, in most cases, the mitochondria can recover and the side effects will resolve if the drug at fault is removed, provided the damage is not too severe. Also, most of the newer drugs in this class are quite benign towards the mitochondria and therefore safer to take in the long run.⊕

***Dr. Marianne Harris** is a family doctor with the AIDS Research Program at St. Paul's Hospital in Vancouver.*

FAQs on ADRs

Answers to some common questions about on-line adverse drug reaction reporting

by Zoran Stjepanovic

Do you know that you can report unexpected drug side effects and adverse events to Health Canada? HIV drugs can cause some serious adverse events, and it's important to report them—and you can do it yourself. Here are some frequently asked questions and tips for filling in your report.

1. What is a suspected adverse drug reaction?

A suspected adverse drug reaction is an unexpected side effect, not consistent with product information or labelling, when you take a medication. The side effect could result in hospitalization or disability, or it can become life threatening; however, you can report any unexpected side effect, regardless of its severity.

2. Why should I report my adverse drug reaction?

You should always report any unexpected side effect or reaction to drugs, especially from a drug that's been on the market for less than five years. Some side effects don't become apparent until the drugs have been used in real life circumstances. By reporting adverse reactions, you contribute to a better understanding of how new drugs work and may help identify rare or serious side effects. Physicians are also supposed to report adverse drug reactions, however there's no law mandating them to do so.

3. Why do they ask for personal information?

Sections A & D of the report asks for patient information and reporter information. When it asks to enter the identifier, all you need to do is enter your initials. Other general information that is required includes your age, gender, height, weight, occupation, and contact information. Health Canada needs this information to confirm that the report is coming from a genuine individual.

4. What is the "outcome attributed to adverse reaction"?

This question asks what happened to you as a result of taking the medication. The form provides some choices: "Hospitalization" refers to a one-night stay in the hospital or emergency room. "Prolonged hospitalization" means you were in the hospital for several days as a result of taking the medication. "Congenital malformation" refers to a physical defect in your child at birth as a result of the medication you have taken, and "required intervention" means that you were given medication or treatment for your reaction. If none of these apply, check "Other."

5. How should I describe my reaction or problem?

Give as much detail as possible. You can ask for assistance from a pharmacist, or come to the Treatment Information Program at the BCPWA Society for assistance.

The form also asks for relevant tests or laboratory data, as well as other health issues or pre-existing medical conditions. Relevant laboratory data would include CD4 counts, viral load, liver enzymes, kidney function tests and any tests you consider relevant to your adverse drug event. The form also asks for the dates of your tests.

6. How do I fill out the section on Suspected Health Product(s)?

The report asks for a lot of information on the medication you were taking that you believe may have caused the adverse drug reaction. You'll need to indicate the exact name of the drug, the dosage (in mg), and how you took the drug (that is, with food, on an empty stomach, orally, rectally, topically, by injection, by inhalation, etc.) You also need to report the date you started taking the medication, when you stopped, why you used it (that is, what it was intended to treat), other medications you were taking at the time, and if you took any medications to treat the adverse drug reaction.

If you have any further questions or need assistance reporting an adverse drug reaction, contact the BCPWA Treatment Information Program at 604.893.2243. ⊕

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

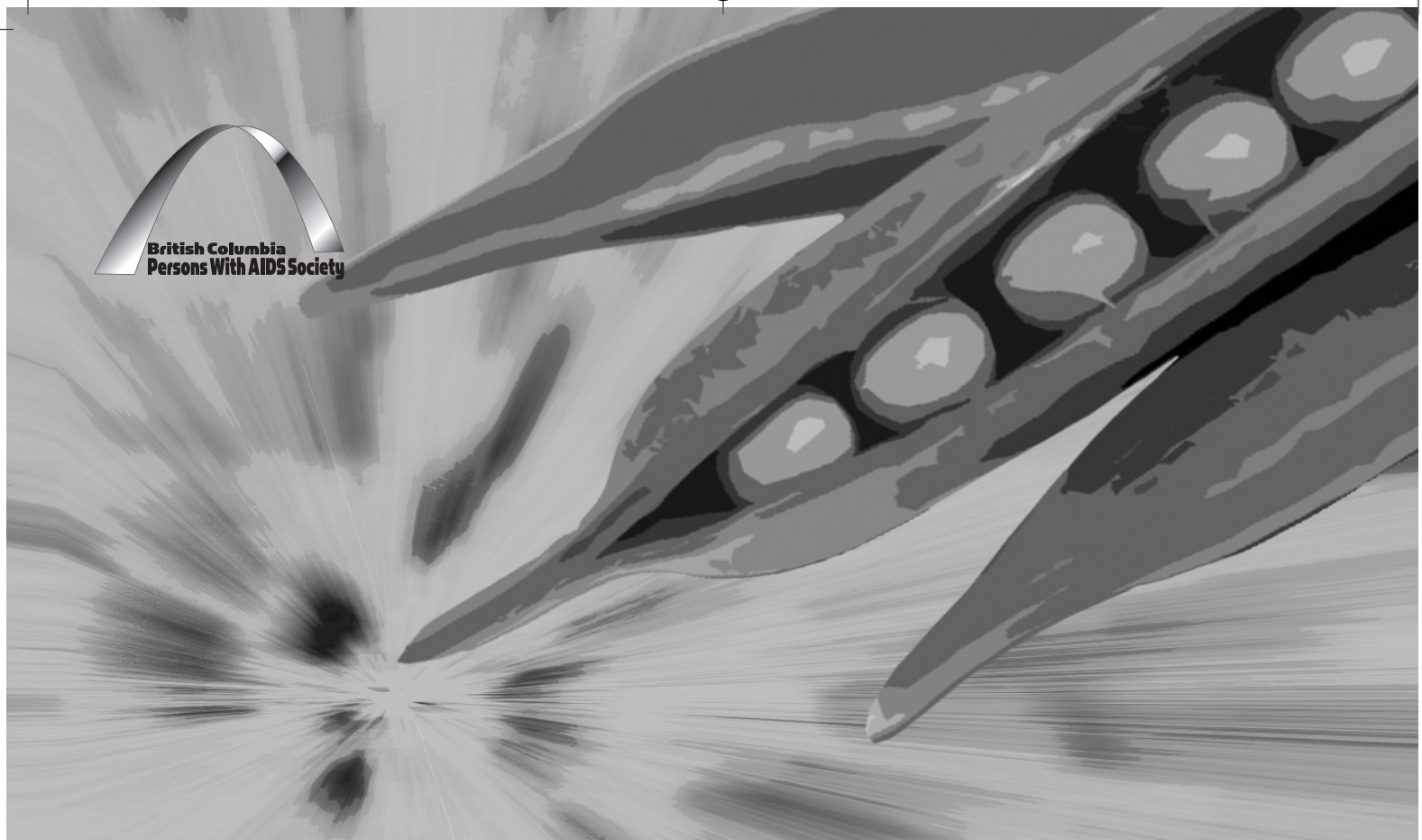
TO REPORT A DRUG REACTION

BY PHONE:

Call 1.866.234.2345 to be automatically routed to your region's centre.

BY MAIL:

Download and print the form available on-line at www.hc-sc.gc.ca/dhp-mps/medeff/report-declaration/form/index_e.html.



British Columbia Persons With AIDS Society

EXPLORING FOOD AND FITNESS

A 6 week nutrition & HIV workshop series

Presented by Diana Johansen, Oaktree Clinic & the BC Persons With AIDS Society

Tuesday, November 7th ⊖ **NUTRITION AND ADVOCACY ISSUES**
[monthly nutrition supplement benefit, diet allowance & food crisis benefits]

Tuesday, November 14th ⊖ **HEALTHY EATING & MEAL PLANNING**

Tuesday, November 21st ⊖ **VITAMIN & MINERAL SUPPLEMENTS**

Tuesday, November 28th ⊖ **LIPODYSTROPHY & NUTRITION**

Tuesday, December 5th ⊖ **EXERCISE**

Tuesday, December 12th ⊖ **A GROCERY TOUR**

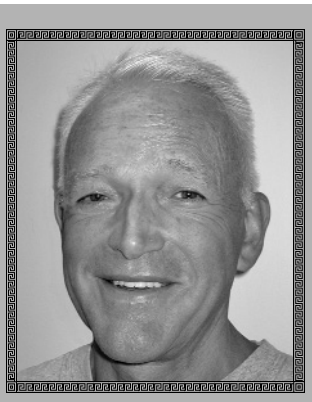
All workshops start at 6:30 PM at BCPWA, 1107 Seymour Street, Vancouver.

This is a free event. Open to persons living with HIV and other interested participants. Some snacks and refreshments provided.

Please RSVP by calling 604.893.2243 or email treatment@bcpwa.org

Volunteering at BCPWA

Profile of a volunteer: Colin Stewart



"One of the most dedicated volunteers I have worked with. Always a gentleman, Colin's welcoming energy and sense of hope and promise is shared with both newly diagnosed and long-term survivors. Two thumbs up!"

Jackie Haywood,
Director of support services

Volunteer history
Twelve years as a facilitator of the Body Positive Support Group. I also facilitated the Average Joe's social evening for four years.

Start at BCPWA 1994

Why pick BCPWA?
I have always admired BCPWA for being member organized, driven, and managed.

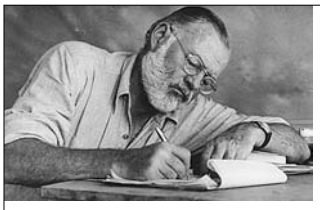
Why have you stayed?
For the most part the work is rewarding and the members and staff appreciate my efforts.

Rating BCPWA
I enjoy it here. Most members and staff are friendly and easy to get along with.

Strongest point
Volunteering is rewarding, especially when you can see a positive improvement to someone's mental or physical health situation.

Favourite memory
On several occasions people have arrived at the support group in desperation but have left the meeting with uplifted spirits. At Average Joe's, two guys met—one from Vancouver, the other from New York—carried on a long-distance relationship, eventually married, and came back to Average Joe's to volunteer as facilitators.

Future vision of BCPWA
I see the organization continuing to grow in numbers and in the utilization of the volunteer base. I see them continuing the fight for the rights of the infected and giving positive direction to those who are capable of fighting for themselves.



Interested in writing?

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

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

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

If you are interested in becoming a volunteer writer and/or 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
August 30, 2006	1:00	Board Room	Written Executive Director Report / Standing Committees
September 13, 2006	1:00	Board Room	Financial Statements — July
September 27, 2006	1:00	Board Room	Quarterly Department Reports / Written Executive Director Report / Executive Committee

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

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

BCPWA Standing Committees and Subcommittees

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

Board & Volunteer Development
Contact: 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

Yes! I want to receive living⊕ magazine

Name _____

Address _____ City _____

Province/State _____ Country_____ Postal/Zip Code_____

Phone _____ E-mail _____

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

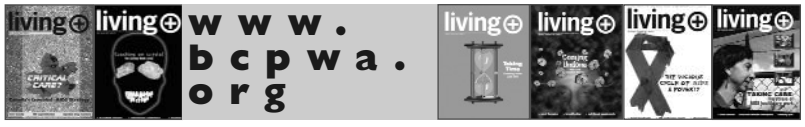
❍ $25 within Canada ❍ $50 (Canadian $) International
please send _____ subscription(s)

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

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

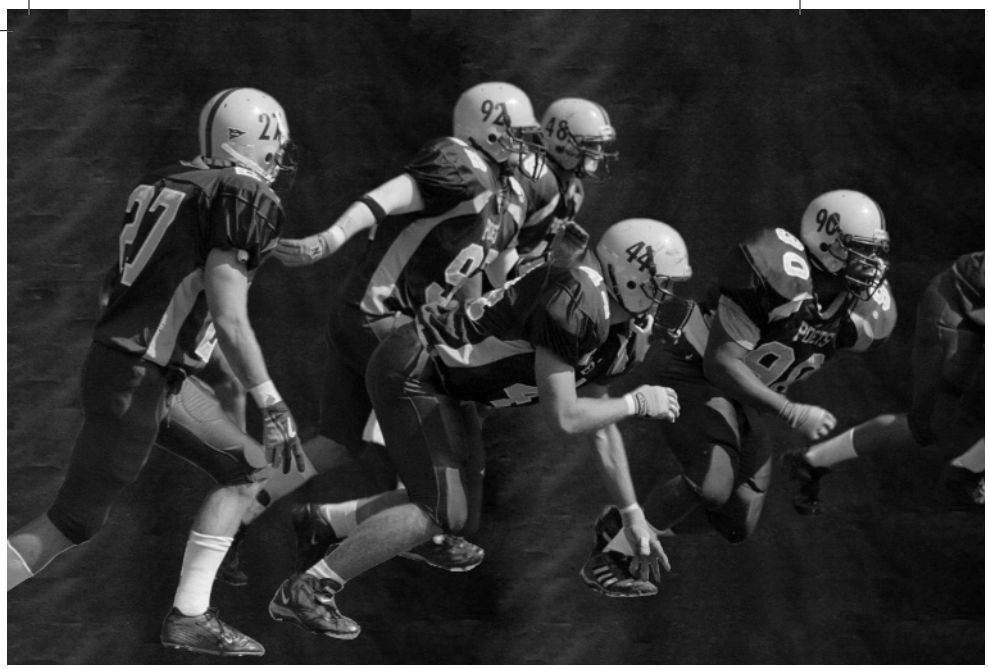
❍ Enclosed is my donation of $_____ for *living* ⊕

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



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

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



Pressing ahead

Our neophyte media rep quickly discovers the perks of the trade

by Glyn Townson

The AIDS 2006 Conference in Toronto was my first official media assignment for ***living*** ⊕ magazine and it didn't take long for me to capitalize on the benefits.

After the trauma of registration, which was a three-hour adventure, I headed to the Media Centre. Nice, very nice: banks of telephones, fax machines, computers, ISDN lines, live feeds, print centre, interview rooms. Saturday evening would be the last time it was this pristine and quiet.

The first major event was the opening ceremonies in Roger's Centre. I lined up with my friends, who were registered as delegates. When we reached the door, I was instructed that the media entrance was at Gate 7—which, of course, was at the other side of the building. I scrambled over to Gate 7, only to be told I needed to be at Gate 9. Finally clearing security, I was offered my choice of a seat in the media box or on the field. I was quickly getting used to this special treatment.

The following morning my friend Neil and I went to see the "Double Bill Show" with former US president Bill Clinton and Microsoft's Bill Gates. However, when we arrived at the entrance to the session room, we were told we had to clear the area and return at 10:15am. We begrudgingly headed up one level to the People Living with HIV/AIDS (PLHA) lounge to grab a coffee while we waited.

At precisely 10:14am, coffee in hand, we descended the escalator to a huge unruly crowd, all waiting to get into the Double Bill session. We listened with disbelief as volunteers announced that the session was at capacity, and no more people would be allowed in. Slightly indignant, I approached one of the volunteers and calmly explained that we had arrived earlier and were told to come back, and that we thought it was unfair we wouldn't be able to get in to the session.

Outwardly cool but inwardly panicking, I pulled out my trump card. After all, I had media accreditation and the badge to prove it. Suddenly giddy with this newfound power, I wasn't afraid to wield it. The volunteer then pointed to a separate, shorter media line near the front of the entrance. I deserted Neil, with his plain delegate badge, to his own fate among the increasingly unhappy mob. Media badge held high, I slipped through the crowd into the media line and sighed with relief as they announced that all media would have access to the session room before anyone else. Guiltily, I glanced back at Neil, who was being battered and crushed.

I had media accreditation and the badge to prove it. Suddenly giddy with this newfound power, I wasn't afraid to wield it.

When the doors finally opened, I raced over to the far side of the cavernous hall, which seats 6,500, and secured a seat on the far side of the room with a good sight line to the podium. The session started late, and as I looked around there were at least 100 empty seats behind me. Crowd control wasn't one of the strong points at the AIDS 2006 conference.

All I can say is it was worth it to pull rank, and I'd do it again. I admit I was star struck—after all, it was Bill Clinton and Bill Gates, two of the world's most powerful and influential men. Neil did manage to get into the session, a little bruised after battling through the crowds.

Later that day, to ease my guilty conscience for abandoning a friend to the wolves, I took Neil into the official media centre to get a closer look at the two Bills at their press conference. Media has its privileges, and this was the day I learned how to take full advantage of them. ⊕

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