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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 over 4400 HIV+ members.

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think



opinion & editorial . . .

You're invited...

by Paul Lewand

Two important BCPWA events are happening in August. The Society's summer Open House event takes place on Wednesday, August 1 and the Annual General Meeting (AGM) is on Saturday, August 18.

Although our doors are always open, our Open House is an opportunity for Board and staff to meet and mingle with our friends and supporters. New and long-standing members, representatives from area organizations, funders, donors, and other interested community members are invited to join us for an evening of refreshments, appetizers, brief presentations, and casual conversation.

The idea of planning regular Open House gatherings arose out of BCPWA's five-year strategic planning process, initiated in 2004. The goal was to encourage greater involvement in Society activities among existing and new members, and to provide a forum for discussion between the community and BCPWA representatives. The Open House offers a more relaxed atmosphere than a public meeting setting. Attendees are encouraged to ask questions about programs and services, operations, our funding structure, strategic plans, and other issues of interest.

The Society's AGM is another important gathering of our membership and supporters. The official business of the AGM involves distributing and presenting the annual report and financial statements, creating an arena to bring forward resolutions and amendments to the Society's by-laws, and electing a new Board of Directors for the forthcoming year.

From a member perspective, the AGM provides an opportunity to participate in

important decisions related to BCPWA, connect with other Society members, and participate in the election. Since the Board represents the voice of the Society's members, the election of the Board is especially important. Also, as a consumer-driven organization, BCPWA is unique in having a Board of Directors who are not only involved in the governance of the organization, but also in its day-to-day operations.

There are 11 seats on BCPWA's Board. Last year, to create a more stable structure of governance, staggered two-year terms were introduced. So, this year, five of the 11 Board members will be returning for a second term, while six vacancies will be filled by the election.

The AGM takes place on August 18 in the training room of the Society office at 1107 Seymour Street in Vancouver. Registration begins at 10:00am and the meeting starts at 11:00am. Lunch and refreshments are served. Your vote counts, so I hope you'll attend. If you aren't able to be there, you have the option of assigning your proxy to someone you trust. See page 19 of this issue for more details.

Whatever your preference—a casual Open House get-together and/or a more formal AGM—I hope you'll support your Society by attending one or both of these important and informative gatherings. ⊕



Paul Lewand
is the chair of BCPWA.



REALITYBITES

News from home & around the world



New group involved in St. Paul's Hospital debate

Friends of St Paul's Hospital, an initiative of the West End Citizens' Action Network, is taking the approach that engaging in conversation will provide people with information that will allow them to form their own opinions about the future of the downtown Vancouver hospital, says coordinator Gail Brown.

For the past five years, Providence Health Care has been working on plans to renew St. Paul's. These plans include the possibility of building new facilities at the hospital's current site or relocating St Paul's to east False Creek, while retaining some specialized services at the hospital's current location.

"Friends of St. Paul's left the Save St. Paul's Coalition because they were too political," Brown told Xtra West.

However, Aaron Jasper, chair of Save St Paul's, says the future of the hospital is political in nature.

Source: Xtra West

Serosorting risk can be high

Some public health experts have viewed serosorting, the practice of choosing to only engage in unprotected sexual activity with partners of the same HIV serostatus, as an effective HIV prevention tactic. But a new analysis, employing a mathematical model, suggests that serosorting may actually be associated with an increased risk of HIV infection, largely due to recently infected individuals still thinking and disclosing that they are seronegative.

The San Francisco Department of Public Health predicts that new HIV infections among men who have sex with

men (MSM) citywide will be about 20 percent lower in 2006 than in 2001. The department attributes this primarily to serosorting.

But according to a research letter in the May 31 issue of *AIDS*, effective serosorting—as a method of preventing HIV transmission, at least among HIV-negative individuals seeking unprotected sexual activity with other HIV-negative individuals—is highly dependent on knowing the true HIV status.

"Without lying, some HIV-infected individuals may mistakenly believe they are not infected and disclose as HIV-negative," say investigators.

Source: www.AIDSmeds.com

Tool to calculate prognosis for PWAs starting therapy

The Antiretroviral Therapy (ART) Cohort Collaboration, an international team of investigators, has updated its prognostic model predicting the risk of progression to AIDS or death in individuals starting antiretroviral therapy. Younger patients starting HIV therapy with a CD4 cell count above 350 cells had the lowest probability of progression to AIDS or death in the updated model, underlining the importance of timely diagnosis of HIV infection.

The model, which now makes predictions for five years after HIV therapy is started, takes into account factors such as age, CD4 cell count, viral load, and mode of HIV transmission.

The investigators' findings are published in the May 31 edition of *AIDS* and the prognostic model will soon be available online at www.art-cohort-collaboration.org.

Source: www.aidsmap.com

Foundation announces new price cuts for tenofovir

The Clinton HIV/AIDS Initiative has secured new and substantial reductions in the price of second-line antiretroviral drugs for low and middle-income countries, and also a price of \$339 a year for a triple combination, tenofovir-based once-daily pill for first-line treatment.

The Clinton HIV/AIDS Initiative has been charged by UNITAID (the international drug purchase facility through the World Health Organization) with achieving lower prices for second-line and pediatric antiretroviral drugs, chiefly by working with generic manufacturers to identify cost-saving improvements in the production's process. UNITAID is funded by airline passenger levies and other contributions from around 30 countries, including France, Chile, Norway, and the UK.

These price reduction offers all come from two Indian generic drug companies, Cipla and Matrix, who will receive a guaranteed volume of orders that will allow them to scale up production, leading in turn to economies of scale.

Source: www.aidsmap.com

Thai health program receives Gates Award

The Bill & Melinda Gates Foundation announced that the Population and Community Development Association (PDA) of Thailand has won the 2007 Gates Award for Global Health, in recognition of its pioneering work in family planning and HIV/AIDS prevention.

The \$1 million Gates Award—the world's largest prize for international health—honours extraordinary efforts to improve health in developing countries.

continued on next page



REALITYBITES

News from home & around the world



PDA was selected from more than 90 nominees by a jury of international health leaders.

Founded in 1974 to provide family planning education to women in rural Thailand, PDA is now the country's largest non-profit organization. Its full-time staff of 600, along with more than 12,000 volunteers, has reached more than 10 million Thais in nearly 18,000 villages and poor urban communities. PDA's HIV prevention and family planning programs are renowned in the global public health field, and they have provided models for other countries to follow.

Source: www.medicalnewstoday.com

Researchers find peptide that encourages HIV infection

UCLA AIDS Institute researchers have discovered that when a crucial portion of a peptide structure in monkeys that defends against viruses, bacteria, and other foreign invaders is reversed, the peptide actually encourages infection with HIV.

The findings, published in the April issue of *AIDS Research and Human Retroviruses*, could pave the way for the use of such peptides in gene therapy using HIV-based vectors as the delivery method.

Retrocyclin-1 is a circular peptide that studies have shown inhibits the infection of CD4 cells with HIV. RC-111 is also cyclic and has the same amino acid sequence as retrocyclin-1. In both peptides, the amino acids are strung like 18 beads along the molecule's backbone. The amino acids in RC-111, however, are in reverse order.

Researchers discovered that while retrocyclin-1 inhibited infection of CD4 cells with HIV by about 95 percent, the RC-111 variant enhanced viral infection five-fold.

Source: www.eurekalert.org

PWAs may need longer duration of TB treatment

HIV-positive people who receive the standard tuberculosis therapy consisting of six months treatment with a rifamycin-based regimen are significantly more likely to experience a relapse of their tuberculosis than are HIV-negative individuals treated with the same regimen, according to a retrospective American study published in the *American Journal of Respiratory and Critical Care Medicine*.

Investigators found that the only factors associated with relapse of tuberculosis among HIV-positive patients were shorter duration of tuberculosis treatment and being prescribed a regimen of anti-tuberculosis drugs involving intermittent dosing. HIV-positive individuals who received potent antiretroviral therapy during their tuberculosis treatment were significantly less likely to relapse, had a quicker response to tuberculosis therapy, and experienced fewer side effects related to their tuberculosis treatment.

The investigators noted that HIV-positive patients were significantly more likely than HIV-uninfected individuals to receive over six months of tuberculosis therapy. Nevertheless, 7 percent of HIV-positive patients who completed treatment experienced a relapse of their

tuberculosis compared to just 1 percent of HIV-negative patients.

Source: www.aidsmap.com

Rise in new HIV infections among gay men in Hong Kong

New HIV infections among gay men are on the rise in Hong Kong, and a government consultant warned that prevalence of the disease in this group could hit 30 percent by 2020 if nothing is done.

The government reported 91 new HIV infections in the first quarter of 2007, up from 89 in the same period in 2006. Of those, 35 were men who had sex with men. This compared with 29 new infections in the first quarter of 2006 and 19 in the same period of 2005.

Concern groups say the spike in new HIV infections among gay men is not confined to Hong Kong. High prevalence rates are observed in Thailand (28 percent), Nepal (4 percent), Taiwan (8 percent), Vietnam (8 percent) and Cambodia (14 percent), according to a report in August 2006 by the help group TREAT Asia. Gay men also make up a substantial portion of new HIV infections in South Korea and Singapore.

Source: *Reuters* ☉

FIGHTING WORDS



The home stretch

As affordable housing dwindles, the government needs to keep Olympic promises for social housing in the Downtown Eastside

by Wendy Pedersen

Throughout the Lower Mainland, there's an incredible amount of construction for the 2010 Winter Olympic Games, but all that residents in the Downtown Eastside (DTES) can see is a broken social safety net.

The Carnegie Community Action Project (CCAP), which advocates for a friendlier low-income neighbourhood in the DTES, recently met with tenants of three residential hotels purchased by a condo developer. A young Aboriginal woman cried as she told her story: her husband had blood poisoning from bedbug bites; a mouse in her mattress bit her bottom, which caused an infection; she was six weeks pregnant; and she was paying an exorbitant \$700 a month rent for a 100-square-foot room. The stress broke her relationship apart. When she moved out, the landlord accused her of breaking a toilet with a tampon and refused to give her damage deposit back.

Like so many others, this woman desperately needs affordable, safe housing. In a shelter or on the street, she'll have her baby apprehended. Survival sex work, serious addiction, violent predators, and serious illness may await her.

Glyn Townson, vice-chair of BCPWA, said at a recent press conference that unstable housing or homelessness puts people 3 to 9 times more at risk of HIV/AIDS. He noted that 20 percent of DTES residents are HIV-positive. That's a shocking 3,200 community members in total, and with escalating homelessness, many more are at risk of this disease. Tragically, PWAs likely reside in the cheapest housing in the area—the remaining privately-owned residential hotel rooms.

These tenants are under incredible pressure. Living conditions are bad and hotels are switching hands. In 2006, 22 hotels were sold, some at double or triple their assessed values. That year, 600 affordable housing units were lost. Thanks to the work of many advocates, illegal eviction is getting harder. Unfortunately, though, landlords are getting smarter. As tenants move out, new tenants pay higher rent.

We're desperate for a systemic solution. In the short term, we need to make the best of the Olympic promises. The Olympic organizing committee, VANOC, plus the three levels of government, actually signed a very important document related to homelessness. They made five promises on housing:

- ▷ Provide an affordable housing legacy
- ▷ Protect rental housing
- ▷ Provide temporary housing for Games' visitor and workers
- ▷ Ensure people are not made homeless as a result of the Games
- ▷ Ensure residents are not involuntarily displaced, evicted, or face unreasonable rent increases as a result of the Games

In March 2007, VANOC and the governments gathered 25 community and business groups plus housing experts to determine how to implement these promises. Five of the unanimous recommendations are:

- ▷ Build 3,200 units of mostly supportive low-income housing by 2010
- ▷ Acquire 800 rental units by 2010
- ▷ Convert 200 units of athlete housing to low-income housing after the Games
- ▷ Raise welfare rates by 50 percent
- ▷ End the barriers that keep people in need from accessing welfare

As of the writing of this article, 109 groups and respected individuals have endorsed the promises, including BCPWA. We could sharply reduce homelessness if the governments acted on these recommendations. Let's keep them to their word. ☺

Wendy Pedersen is the community organizer for the Carnegie Community Action Project, was the founder of the Potluck Café, and has been a resident of Vancouver's Downtown Eastside for 11 years.

What can you do to help?

There is no better time for us all to join together to help end this pressure on our most vulnerable neighbours in Vancouver. Here's what you can do:

- ▷ Join the City-Wide Housing Coalition by calling 604.839.0379.
- ▷ Get your union, church, community group to endorse the recommendations of the ICI Housing Table http://aycam.vcn.bc.ca/2010_inner-city_inclusivity_housing_table.
- ▷ Write a letter to your city, provincial, and federal politicians and urge them to implement their housing promises.
- ▷ Make housing an issue with candidates in the next federal election.



AIDS WALK FOR LIFE 07

The Walk will do us good.

Where the money goes

In addition to the BCPWA Society's Complementary Health Fund, funds raised from this year's WALK for LIFE will benefit 13 other AIDS and community 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 6 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 peoples 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.

The Lower Mainland Purpose Society is a non-profit organization based in BC's Fraser Health Region. Money raised from the WALK will go to support existing programs such as support services for people living with HIV/AIDS, referral and advocacy services, pre- and post-test counselling, harm reduction outreach services, and HIV/AIDS educational workshops for schools and community groups.

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: 307 people are currently on McLaren's wait list, all of whom qualify for, and desperately require, housing support.

National Congress of Black Women Foundation is a national charity that promotes and facilitates activities that foster advancement, recognition, health, and education of black women and their families. WALK funds will go toward such community-based services as HIV prevention and education

initiatives, community workshops, development of culturally-specific resources and programs, counselling services, and the UMOJA Resource Centre library.

Positive Living Fraser Valley Society's mandate is to support people living with and affected by HIV/AIDS, and to communicate and collaborate with others for the purposes of HIV/AIDS education, stigma reduction, and service development. Funds raised at the WALK will go to support future services including support group, nutrition resources, and a support worker.

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.

Vancouver Native Health Society was established to promote the physical, mental, emotional, and spiritual health of Vancouver's Aboriginal population. The Society's HIV/AIDS program, Positive Outlook, provides care, treatment and support services to all those living with HIV/AIDS with a focus on improving access to care for First Nations peoples. Funds raised from the WALK will go to support current programs.

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 its breakfast program, member dinners, member activities, and outreach supplies. ☉

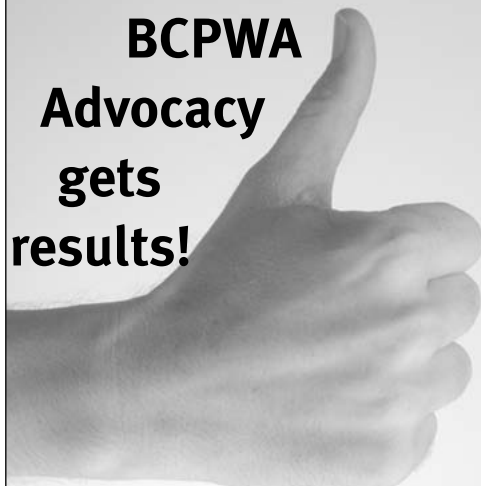
Join us for the AIDS WALK for LIFE!

WHEN: Sunday morning — September 23, 2007	WHERE: Stanley Park — Vancouver
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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**



**BCPWA
Advocacy
gets
results!**

The BCPWA Society's Advocacy Program continues to work hard to secure funds and benefits for our members. The income secured for February 2007 and March 2007 is:

- **\$39,485** in debt forgiveness.
- **\$57,522** in housing, health benefits, dental and long-term disability benefits.
- **\$225** monthly nutritional supplement benefits
- **\$2,250** in ongoing monthly nutritional supplement benefit for children

The unkindest cut

AIDS service organizations in Victoria are facing devastating budget cutbacks *by Miki Hansen*

In November 2005, the Minister of Health, the Honourable George Abbott, made a long awaited pronouncement in the BC legislature—his government was putting \$60 million into public health over the next three years (see the May/June 2007 issue *living* ☉).

The funding had several targets, including provision for “health authorities to work with AIDS organizations to assist us in trying to meet ambitious goals.” These goals included “reducing the incidence of HIV infections by 50 percent over a five-year period beginning in 2003 and increasing the proportion of HIV-positive individuals who are linked to appropriate care, treatment, and support service by 25 percent over the same period of time.”

AIDS organizations applauded. On Vancouver Island, there had been no increase in funding for these community agencies for over 10 years in spite of the rising incidence of infections and increasing demands for services.

The Vancouver Island Health Authority (VIHA), the public agency responsible for distributing its share of the \$60 million, then produced a document titled *Closing the Gap*, in consultation with AIDS organizations, aimed at reducing infections on the island. All the pieces were in place for action.

Then, in the first months of 2007, what seemed like a path to sustainable, integrated health care took a wrong turn when VIHA announced their new model of funding for HIV/AIDS. Not only did

the health authority not add any new monies to the budget for HIV/AIDS prevention and support services, but current funds would now be used to address hepatitis C instead of HIV.

Not only did the health authority not add any new monies to the budget for HIV/AIDS prevention and support services, but current funds would now be used to address hepatitis C instead of HIV.

Furthermore, VIHA would be allocating the funding according to a model that will, in their words, “geographically redistribute” funds across Vancouver Island. Spelled out, this means that \$450,000 will be moved out of the Southern Vancouver Island and “redistributed” to communities in the Central and North Island, despite the fact that 69 percent of cases of HIV are found in the South Island.

The cuts will be devastating to the three agencies affected: AIDS Vancouver Island, Victoria AIDS Resource and Community Service Society (VARCS), and the Vancouver Island Persons with AIDS Society (VPWAS).

“The impacts on ASOs [AIDS service organizations] will be significant,” says Ruby Black, executive director of VPWAS. “They will include increased pressures on front-line and secondary service providers, potential increases in HIV and HCV infections, and reduced health outcomes for people living with HIV and/or HCV.”

Victoria leaders responded quickly to VIHA’s announcement. Downtown social service providers, the business community, local MLAs, the City of Victoria and the police outlined to VIHA the clear fact that taking \$450,000 out of HIV/AIDS services on the South Island affects everyone, not just the agencies directly involved.

VIHA responded to the region’s outrage about the planned cuts by providing “transition funds” to the three agencies affected, thereby postponing the 37.5 percent funding cuts to the spring of 2008.

Agencies in Southern Vancouver Island continue to encourage VIHA and the Ministry of Health to re-examine their new model of funding, arguing that it’s heading in the wrong direction.

Says Karen Dennis, executive director of VARCS: “We ASOs are already operating at our limit and doing all we can with the resources we have.” ☉



Miki Hansen is the executive director of AIDS Vancouver Island.

Take action to stop the cuts!

If you’re concerned about the Vancouver Island Health Authority’s \$450,000 cuts to AIDS services on Southern Vancouver Island, write to the BC Minister of Health and VIHA’s CEO.

Make your voice heard!

**Hon. George Abbott,
Minister of Health
PO Box 9050
STN PROV GOVT
Victoria BC V8W 9E2**

**Howard Waldner,
President & CEO
Vancouver Island Health Authority
1952 Bay Street
Victoria, BC V8R 1J8**



To do or not to do

Who—and how—are we really helping?

by Paula Braitstein

From the time I was a little girl, I wanted to work in Africa. I grew up in the days of television broadcasts of famine-stricken Ethiopians and imagined myself spooning food into grateful people's bowls. I wanted to help relieve suffering, human or animal. Florence Nightingale was my first hero.

Fortunately, it didn't take me long to understand that spooning food into people's bowls isn't really helping them. Charity is important and will sadly always be required. But many large-scale tragedies are both preventable and predictable, and that is certainly true of Sub-Saharan Africa.

continued on next page

AIDS in Africa



There are innumerable examples of this elsewhere in the world. The tragic aftermath of Hurricane Katrina that hit the economically-poor, mostly African-American population of New Orleans wasn't caused only by the storm itself: rather, it was a combination of substandard housing, poor infrastructure, and bad leadership. Deforestation causes most landslides and a lot of flooding. And when you allow children to grow up abused and neglected, is it any wonder that they turn to drugs and the streets? Similarly, the explosive epidemic of HIV in Vancouver's Downtown Eastside was no accident, but rather the consequence of several disastrous public policy moves that resulted in large numbers of very vulnerable people on the streets, without housing or support but with access to cheap street drugs.

Sanitary and safe housing, clean water, freedom from oppression, and equal rights for women and children are all considered basic human rights. If we provided these rights universally, we'd avoid a lot of the suffering in world today.

Spoon feeding Sub-Saharan Africa

In the case of AIDS in Sub-Saharan Africa, charitable model interventions such as the US President's Emergency Plan for AIDS Relief (PEPFAR) are helping to metaphorically spoon food into people's bowls. To be fair, PEPFAR alone has provided antiretrovirals for 822,000 people in their 15 focus countries (mind you, half of them may have died after starting antiretrovirals, but since PEPFAR doesn't want to conduct any research, they don't know). I'm sure those individuals are very grateful. I, too, am grateful, because I work for one of PEPFAR's recipient organizations, which allows me to be a part of an effort to provide AIDS treatment in Kenya, one of the worst-hit parts of Africa.

PEPFAR often circumvents national and local governments by providing money directly to clinics or to US universities, the US Agency for International Development, the US Centers for Disease Control and Prevention, or the multinational pharmaceutical companies from whom PEPFAR-funded treatments must be purchased. This has one major advantage, in that rela-

Charitable model interventions such as PEPFAR are helping to metaphorically spoon food into people's bowls.

tively little money goes to graft—which is not to say that a lot of money isn't wasted anyway. The major disadvantage is that the money doesn't necessarily help national and local governments take responsibility for the pandemic themselves.

But will the US government continue to pay \$15 billion every five years forever? More importantly, is that enough

money? And will it last? The answers are perhaps (the US government has just announced it is increasing the PEPFAR budget to \$20 billion over the next five years), no, and who knows. As treatment programs in Sub-Saharan Africa grow and demonstrate success, the word spreads and very soon clinics are overstretched by too many patients, because only 1 in 5 people in urgent need of treatment are currently getting it.

Social justice model versus charity model

At what point should we be taking a step back and asking ourselves who—and how—are we really helping? PEPFAR is a prominent example of the limitations of the charity model. There are thousands of other examples, big and small. There used to be two big textile factories here in Eldoret, Kenya that employed hundreds of people. They both closed down a few years ago when large loads of used clothing from the US and Europe began arriving. So, although people could buy clothes much more cheaply, hundreds lost their jobs—and hundreds of families lost their livelihoods.

We must always ask, why are we really doing this? Is it to help them—or is to help ourselves? What will this action really do? That's part of what is so powerful about an empowerment-oriented organization like BCPWA—it's about helping oneself, and supporting one another to help oneself. It's about addressing root issues like poverty and discrimination that cause so much of the downstream suffering, and enabling people to do what they need to do to take care of themselves. This is the social justice model of doing good. If more money was invested in reaching the UN's eight Millennium Development Goals, thereby eliminating extreme poverty, PEPFAR and other "charitable" initiatives would play a much less important role.

We must always ask, why are we really doing this? Is to help them—or is to help ourselves? What will this action really do?

You probably know the old expression, "give a man a fish, and feed him for day; teach a man to fish and feed him for a lifetime." Guess what? Most men know how to fish! It isn't the not knowing how to fish that prevents the man from fishing, but the fact that he can't afford a boat, there are no fish left due to pollution and over fishing, and because of the mechanics of the world market his fish are worthless anyway.

Asking the tough questions

Why do people in Africa still have to drink contaminated water? Why do they still have to relieve themselves in holes in the ground a few feet from where they eat? Why do they still live in substandard conditions, with 10 people in an 8-square-foot shack, which, if they're lucky, has a tin roof? Why are we

surprised that a heavy rain floods out villages, causes mudslides, and leads to outbreaks of cholera and dysentery? Why are hundreds of thousands of people, especially children, dying of preventable and treatable diseases every day? And why, with all these terrible things happening, do we do little or nothing, and instead move on to the next crisis? Maybe it's so that we feel like we're doing something to make the world a better place without actually having to open our eyes.

One day I hope to understand what it is about human nature that prevents us from eliminating poverty and the resultant disease. I just think, perhaps naively, that if we all have the sincere intention to do justice that we'll succeed. Unfortunately, not everybody has that intention. Some people have that intent but because they mostly think about how they can help, rather than about what really would help, they

only serve to contribute further to the problem, and perhaps perpetuate it.

I guess it's no wonder that I often lie awake at night thinking that Africa will be helping me a lot more than I'll be helping Africa. ☉

Paula Braitstein is living in Eldoret, Kenya, working as the co-field director of research for the Indiana University Kenya Program. She is the former BCPWA senior policy advisor on health promotion.



The Tanzania diaries, part 2

While the AIDS epidemic is about more than just numbers, all Tanzanians are at risk of becoming the next statistic

by Jane Talbot

Sleep never came easily to me in Tanzania. Ever since I woke up in the middle of the night to find a lizard resting on my cheek, I had difficulty falling and staying asleep. As far as reptiles go, it was a rather small and apparently harmless creature, but still, it was on my face, in the middle of the night, in Africa. Laying in the darkness, I could feel its sharp, tiny nails and smooth underbelly on my cheek and then over the bridge of my nose as it darted off in the general direction of my bedroom window.

Unfortunately, the lizard wasn't the only annoyance.

Outside my window, all through each night, a disoriented rooster announced dawn every two hours. And if that didn't wake me, the astonishingly loud and violent sounds conveying the mating rituals of the local feral cats would. Whatever the cause, I would often wake up in the night and, having once again given up on reading *War and Peace*, would peruse either the previous day's newspaper or Tanzania's in-country report on HIV/AIDS. That was when my understanding of HIV in Sub-Saharan Africa began to take shape.

More than just inanimate numbers

It started with statistics. While I initially found them equally fascinating and tragic, they were just numbers—inanimate and clinical. But soon it sunk in that these numbers were *people*. I

learned that the estimated number of infections worldwide is 40.3 million people, with roughly 25.8 million of them living in Sub-Saharan Africa. In 2005, nearly 5 million people were infected and 3.2 million of them lived in the Sub-Saharan region.

That same year, 3.1 million people died of AIDS. In Sub-Saharan Africa, 2.4 million people died—more than every person in Greater Vancouver, and then some.

In Tanzania alone, 1 in 8 individuals are believed to be infected and, depending on which report you read, up to 75 percent of those infected are women and children. While the number of infections is steadily increasing, it's estimated that only 2 to 10 percent of HIV-positive adults receive antiretrovirals. It's a moot point whether that's because the drugs aren't available or because of the social stigma associated with taking them. The end result is that antiretroviral drug regimens, prevention methods, and testing practices are often met with skepticism, disregard, and in some cases, complete distrust.

The resilience and dignity of the market women

It wasn't so much that they distrusted us—the foreign volunteer HIV/AIDS educators. On the contrary, I think they immediately enjoyed the three blue-eyed women from North America and some might have even felt some vague sisterly bond. The formidable market women of Arusha had seen too much of life and death

AIDS in Africa



to accept anything we said without a healthy dose of skepticism. Unlike the high school students we taught the week before, these women wouldn't respect us simply for being there, especially when they couldn't envision any personal relevance to the sound advice we offered.

The first thing I noticed about the market women was that they seemed impervious to the drenching rains and the deep, nasty, pervasive mud. While my fellow volunteers and I squished about like rain-soaked mud rats, the market women were pristinely clean and seemed to walk above the mud in vibrantly colourful, crisp wardrobes.

The second thing I noticed—and the memory that will stay with me forever—was their look of dignity and quiet strength. Their regal bearing made us feel ludicrous and somewhat embarrassed to stand in front of them and tell them anything about life, even if it was how to decrease their odds of dying.

Lots of questions and misinformation

While it took some time to earn a working respect, it didn't take long for our group to bond. The camaraderie was unlike any other group we encountered in Tanzania. After only one morning of quiet reserve, the questions, sharing, and debating began: Can you get HIV through the hairdresser's equipment? How is it that a baby could possibly be born HIV-negative? Why should we use condoms when we've heard that they've been deliberately planted with HIV? Why do you say there's no cure for HIV when my preacher says that prayer can cure it and the witchdoctor cured my neighbour's HIV through garlic and lemon?

While in principle it all made perfect sense, in practice, however, much of what we were mandated to teach, to this particular group anyway, was not relevant and sometimes, in retrospect, possibly irresponsible.

We did our best to provide accurate information, and over the course of the week we spent hours discussing the basics of HIV, disease progression, modes of transmission, opportunistic infections, and the importance of proper nutrition. I felt we provided a valuable service to the women, and if we had stopped there I would have left with a handful of experiences and feel-good stories that might have made me feel naïvely satisfied, but would in no way reflect the reality of HIV/AIDS in Africa.

Where we faltered, and where I started to disassociate from our curriculum, was in the areas of prevention and testing. The process was flawed, and while in principle it all made perfect sense, in practice, however, much of what we were mandated to teach, to this particular group anyway, was not relevant and sometimes, in retrospect, possibly irresponsible.

The challenges of condom use

In addition to teaching the basics of HIV, our task was to discuss the importance of condoms, to encourage women to use them, and to advocate for testing. Within minutes of beginning this module there was an obvious shift in energy—the women became detached, reticent, and ill at ease. It was only in hushed conversations out of the classroom that they told us that insisting on a condom would be seen as a blatant act of disobedience and defiance. Suggesting condom use could easily result in a woman being beaten or raped and in some cases, murdered. Condoms, they told us, weren't worth the effort.

Advocating for testing proved as enlightening as the conversations around prevention. After giving one woman a myriad of reasons why she should be tested, she argued, "Why would I get tested when doing so could mean a positive result, and if my husband finds out I have tested positive, he will blame me for infecting him, for disgracing him, and for bringing shame to our family? If I test negative, I can't change my husband's behaviour and can't insist on a condom, so it doesn't really matter. If I come back with a positive test result, regardless of how I was infected, I could be killed and if not, I will certainly be beaten, thrown out of my home and my community and I will lose my family. My brothers and sisters would not take me in because I have AIDS. I then would have nothing. You tell me, then, why should I get tested?"

What advice, wisdom, or fact is powerful enough to dispel her reality? Though our assignment was to encourage women to get tested, a fellow volunteer simply replied, "You're right. It's better you don't know. Don't get tested."

There are no easy answers

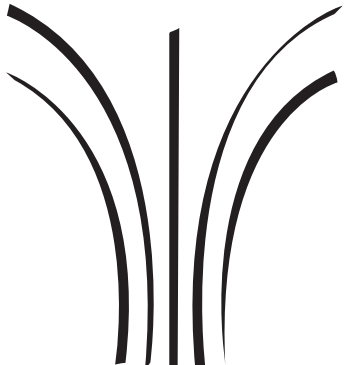
Right answer? Wrong answer? Can either extreme exist alone? In a country like Tanzania where gender inequality is so extreme, I still don't know. Two months in Africa by no means makes me an expert. The reality, though, is that this epidemic grows daily and the market women are still in Tanzania, spotless in spite of the mud, regal and practical. Any one of them could easily become the next statistic.

Much more than the lizards, roosters, or mating rituals of the feral cats, this awareness made it difficult to sleep in Africa.

No one has all of the answers. Many people and countries may be completely apathetic to the possibility of change. However, change is always instigated by a small few, never the masses. All we can do is keep trying, keep caring, keep advocating, and keep the faith that hope exists. Regardless of how large or small our contribution is, and no matter where in the world we make it, every tiny step eventually reaches the market women—not just in Tanzania, but everywhere. ☉



Jane Talbot is BCPWA's director of treatment information and advocacy.



ACCOLAIDS 2007

With all due respect

AccolAIDS gala honours heroes in the BC AIDS movement

by **Melissa Davis**

On April 22, the sixth annual AccolAIDS awards gala took place in the elegant Crystal Ballroom of the Pan Pacific Hotel Vancouver. This recognition and fundraising event, produced by BCPWA with title sponsors GlaxoSmithKline in partnership with Shire BioChem, honoured outstanding achievements of individuals and organizations working in the BC AIDS movement. A record-setting \$90,000 in proceeds, generated from the event, will be used to support BCPWA's programs and services for people living with HIV/AIDS.

In his opening remarks, BCPWA chair Paul Lewand invited everyone in attendance to raise their glasses in a toast to recognize an "entire room full of individuals who—in so many different ways—have improved the lives and circumstances of HIV-positive British Columbians through tireless dedication, commitment, and care." Similar sentiments were expressed by the Honourable George Abbott, Minister of Health, in an official message and greeting that was read by AccolAIDS event host and emcee, Senator Larry Campbell.

More than 40 nominees and eight award recipients were honoured. Winners of the 2007 AccolAIDS awards are:

HEALTH PROMOTION AND HARM REDUCTION **Carol Romanow**

Carol Romanow is deeply committed to ensuring that those who are most disadvantaged have a voice in constructing the programs and policies that affect their lives. She was director at Vancouver's Downtown Eastside HIV/IDU Consumers Board for many years, and was instrumental in establishing the needle exchange at the Washington Hotel. She has helped organize many community events, including the Consumers Board Annual AIDS Day, the first national Hepatitis C Day, and other AIDS and hepatitis C forums. She's a central force within Downtown Eastside organizations that promote health and aim to reduce harms. Since relocating to Victoria, Carol has worked with the Society Of Living Intravenous Drug users (SOLID), a remarkably successful needle exchange which she operates, on a shoestring budget, out of the back of her vehicle.

MEDIA **Nicholas Read**

Nicholas Read is currently a science reporter with the *Vancouver Sun* where he has been a reporter, feature writer, columnist, editor, and layout artist. He has been a journalist for 27 years, both in Canada and the UK, but has spent the majority of his career writing in Vancouver. As a journalist, Read believes passionately in giving a voice to those who may not always have one. Through his writing, he has made an important contribution to those living with HIV/AIDS, most recently through a front page story in the *Vancouver Sun* entitled "AIDS: 25 Years of Anguish." The feature was a frank and sensitive exposé of the experiences of several long-term survivors living with HIV. By exposing the human side of AIDS, Nicholas has helped promote greater understanding and improved social attitudes associated with the disease.

PHILANTHROPY **Nathan Fong**

Nathan is helping to extend lives of people suffering from HIV/AIDS and

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provide them with comfort and care. A top graduate of the Art Institute of Vancouver's Dubrulle Culinary Arts program, he has become one of Canada's premiere food and props stylists for culinary print and film advertising. Fong started fundraising for AIDS organizations for his fortieth birthday. He invited 200 of his friends and nine of his chef-friends for a lavish dinner that raised \$7,000 for *A Loving Spoonful*. This event led to his current work with the Dr. Peter Centre. Each year since 2004, Nathan has volunteered tirelessly to create their annual Passions dinner, a fundraising evening that has raised over \$100,000 in the past three years.

SOCIAL/POLITICAL/ COMMUNITY ACTION

Pivot Legal Society

Pivot Legal Society is a non-profit legal advocacy organization located in the Downtown Eastside. Many of Pivot's clients are people living with HIV/AIDS who experience extreme hardships due to poverty. Pivot's mandate is to take a strategic approach to social change, using the law to address the root causes that undermine the quality of life of those who are most disadvantaged. The Society contributes to the protection of community housing, health centres, drug treatment programs, and services for the prevention and treatment of HIV/AIDS. The organization's main campaigns are focused on addictions, child apprehension, housing, policing, and sex work. Pivot operates by taking informed direction from marginalized groups rather than providing legal services as charity.

KEVIN BROWN PWA AWARD John Spencer (posthumous)

In September 1985—a time of extreme AIDS fear, before AIDS services were even available—John Spencer co-founded AIDS Vancouver Island (AVI). He undertook many roles in the community and continued to be involved with AVI until his death. He served the community as director of the Vancouver Island Persons

With AIDS Society and as President of the Victoria AIDS Resource and Community Service Society. Spencer was often sent as a delegate to the Canadian AIDS Society Forum and AGM, and to the Pacific AIDS Network Forum and AGM. Despite many health challenges, he remained dedicated to advocating and improving the lives of people living with AIDS. He viewed his contributions as neither extraordinary nor glamorous—but simply an expression of his commitment.

INNOVATIVE PROGRAMS AND SERVICES

Positive Women's Network

Since its inception in 1991, Positive Women's Network (PWN) has been a vital service for women and their families affected by HIV/AIDS. PWN provides innovative and highly accessible support for HIV-positive women. The network is recognized for its effectiveness in addressing the diverse needs of its members through programs such as the Women and AIDS Virtual Education website (WAVE) and Women's Initiatives for Support and Education program (WISE). Most importantly, PWN is a safe environment where women can socialize and have a meal. "The programs at PWN have helped me to see the future and not the fear," says a recipient of PWN's services. "They have truly helped me with accepting my status, and speaking honestly and openly to others to help women who are newly infected, in denial, or lost."

SCIENCE/RESEARCH/ TECHNOLOGY

Caitlin Johnston and the staff of Vancouver Injection Drug User Study

The Vancouver Injection Drug User Study (VIDUS) is a project that provides a means of tracking HIV incidence and prevalence among injection drug users over time. VIDUS data has been used to justify the implementation of HIV prevention programs for injection drug users, including the expansion of the city's needle exchange, the first supervised injection

site, and the NAOMI Project. Most significantly, the data has resulted in policy interventions for persons with HIV and those at risk of infection. Caitlin Johnston has been the project coordinator with VIDUS since its inception, and she oversees research at the Downtown Eastside office. "The output from VIDUS is of utmost importance to those working with at-risk populations," says Dr. Julio Montaner, the director of the BC Centre for Excellence in HIV/AIDS. "Often the work is done with little or no recognition. This research has been the basis for many groundbreaking endeavors in Vancouver."

UNsung HEROES AWARD Sisters of Providence

St. Paul's Hospital in Vancouver was founded in 1894 by the Sisters of Providence to respond to the healthcare needs of the community. From the very beginning, the Sisters were committed to providing compassionate care for all patients, regardless of financial or social circumstances. In the early 1980s, St. Paul's Hospital was the only hospital in BC that willingly treated people with AIDS. Later in the decade, St. Paul's was the first hospital in Canada to take the extraordinary and progressive step of integrating AIDS patients into their palliative care unit. The hospital, under the tenure of the Sisters of Providence, viewed care of patients with HIV/AIDS as part of their mission. Their leadership inspired others inside the hospital and beyond its doors to respond with compassion to the AIDS epidemic. Because of this dedication, St. Paul's Hospital became home to the internationally renowned BC Centre for Excellence in HIV/AIDS. ☺

Melissa Davis is
BCPWA's acting director
of communications
and education.



Prevention power and change



Why are we still talking about the same HIV prevention issues for women?

by Janet Madsen

The other day, a nurse confessed to me that she had initially planned to skip a conference presentation on prevention that I was giving because she didn't want to become depressed. "You know," she said, "women's prevention issues just never seem to change. We've been talking about the same stuff for 20 years." Thankfully, she did come to my session and had interesting thoughts to offer. But her point was valid: why are we still talking about the same prevention issues for women so many years into the HIV epidemic?

I used to talk with an educator who would rush in before heading off to give HIV 101 workshops and ask, "What are women's issues again? Inequality, poverty, violence, and what else?" Once enlightened, he'd rush out again and do his session. He wasn't intending to be insensitive. I always got the impression that in the reality of so much information to present—particularly to unenlightened audiences—he had to take careful and yet strong steps in making his points. The audience might not be open to his message because there was still so much AIDS phobia, homophobia, judgment, and discrimination.

My conversations with the educator were many years ago, but, as that nurse highlighted in that recent conversation, the more things change the more they stay the same. We are still dealing with AIDS phobia, homophobia, judgment, and

discrimination. Women are still facing the same HIV challenges: yes, inequality, poverty, and violence—plus the issues of women's acute vulnerability to infection during penetrative intercourse, controlling partners who limit safer sex, and access to health care and support. There's also the social expectations of women as caregivers to immediate and extended family, expectations of motherhood, unequal economic power, and the fact that HIV treatments are still mainly tested in men. Against all these hurdles, HIV prevention for women seems insurmountable.

Women are still seen as second-class citizens

One of my pet peeves is the \$64,000 HIV prevention question, "Why don't women just use condoms?" Women, of course, don't wear condoms; men do—unless, of course, there's some fun going on with sex toys. It's easy to perceive the judgment that lies underneath the question, and it's infuriating, because prevention is so much more than giving people information. And while female condoms exist as a prevention option for women to use, if their partners are unwilling to cooperate, it complicates matters. It takes a certain amount of practice before women can use them without their partner knowing they're in place.

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Prevention is about power and women usually don't have it. Cultures worldwide continue to promote male domination over women, and societal norms are such that women are still seen as second-class citizens. Add HIV into the equation, and poof: an even lower social status. HIV-positive women who bravely disclose are ostracized, their lives threatened, their children shunned or taken away from them. They're told not to get pregnant (yes, still); if they're diagnosed while pregnant, their lives are turned inside out by HIV and dosing information so they don't pass HIV to their babies. (Luckily, if a woman uses combination therapy consistently throughout her pregnancy, the chances of her baby becoming HIV-positive are very low). Their lives change overnight.

One of my pet peeves is the \$64,000 HIV prevention question, "Why don't women just use condoms?" Women, of course, don't wear condoms; men do.

While we women certainly have a lot going against our prevention power, we're not alone. Gay men are vulnerable too. Think of the just-coming-out men who are newbies to the scene, the closeted "straight" who takes his pleasure anonymously and in denial of his queerness, the aging queen in the midst of the celebrated youth denizens.

The so-called norms of middle-of-the-road society are on everyone's minds: you must be financially successful, preferably white (by North American standards), and all-man. Straight men suffer from these stereotypes too: how could anyone be every ideal? We're all bound by these norms. And these norms affect how we perceive and experience our power in the world.

Harm reduction as an option

So, if your partner refuses to wear condoms and threatens to walk out on you and the kids if you keep harping on it, what are you going to do? If your partner is insisting on unprotected sex, and he claims he's negative, then what? One answer is to get out of there. That's great if you have the personal, financial, and social resources, but if you don't, perhaps the answer is to do the best you can with integrity and dignity.

Power is a force that can shift. Sometimes prevention is going to look more like harm reduction than the absolute prevention methods suggested in safer sex material. But hey, if you can get your partner to agree to oral sex instead of intercourse without a condom, you're practicing harm reduction and gaining some power. Harm reduction may be a possible option in what seems like a sea of no choice.

This isn't to say that women should always be viewed as victims—far from it. Women are strong and resourceful and vibrant. Women have creative ways of keeping themselves and their loved ones safe in the face of sometimes terrible odds. Women have taught themselves to roll on condoms with their teeth and to insert female condoms so their partners aren't aware of them. Women know how to be creative with money and resources so their kids eat and have clothes. Women know how to survive.

Nor do all men exert their power over their partners, female or male. There are many relationships where partners share the power of safer sex decision-making and discuss HIV risks. But it doesn't always happen that way, and this needs to be acknowledged. Acknowledging that power is not always shared doesn't mean people have no responsibility, it means we all need to look at what reinforces power and what undermines it—and to determine if we're part of the solution or the problem.

Celebrating successes versus failures

Because safer sex ultimately boils down to the two individuals actually engaged in the act of sex, the acknowledgement of power or lack of it comes down to that: one person to another. What are you doing, and who are you doing it with? What kind of risks are you aware of? What can you do to decrease the risk?

We can look at the situation for women as inherently hopeless and continue with our heads down. Or we can look at what women have accomplished: organized activist groups, spoken up about HIV-positive women and their unique needs, rallied around women who are newly diagnosed, lobbied for new prevention options, made national headlines at international conferences—like the International AIDS Conference in Toronto last year. Stephen Lewis, the then-UN special envoy for HIV/AIDS in Africa, participated in the women's march. There's one man who gets it.

We need prevention options like microbicides that can benefit both women and men, HIV-infected and uninfected. We need to ensure that girls worldwide are getting education about their bodies and their capabilities. We need to continue to advocate for additional prevention options, like vaccines and diaphragms, in research. We need to provide boys and men with education that supports their abilities to rethink their roles and make changes in their behaviours. We need anti-homophobia training and HIV sensitivity training. And so on.

There's a lot of work still to be done. Power differentials exist, and we can't ignore the role they play in relationships. But we've got to keep at it. Keeping our heads down helps us see our friends who need a hand to get up. Keeping our heads up helps us to see where we want to go. ☺

Janet Madsen is the communications coordinator at Positive Women's Network in Vancouver.



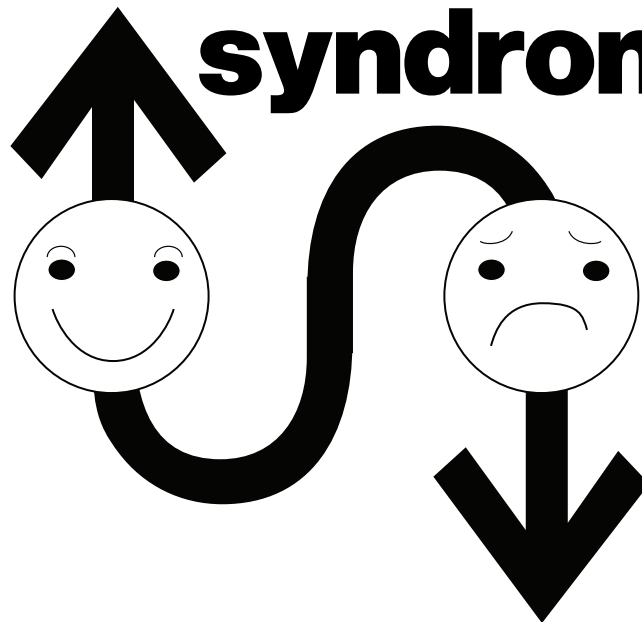
treatment. information

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

Immune reconstitution syndrome



**When your CD4 counts improve,
but your condition worsens**

by Carley Taylor

One of the goals in fighting HIV is to keep the immune system strong. For most people living with HIV/AIDS, antiretroviral therapy (ART) improves your immune response to a wide range of opportunistic infections. The medications help raise your body's CD4 count, indicating that your immune system is stronger. This immune reconstitution means that your body is better able to repair itself and fight off infections. That sounds like a good thing, right? Not always.

For some PWAs, something paradoxical happens, called immune reconstitution

syndrome (IRS): the strengthening of the immune system triggers an inflammatory reaction to a specific pathogen within a few weeks or months of initiating ART. The syndrome may result from an exacerbation of a partially or successfully treated opportunistic infection or from a previously undiagnosed one.

According to Dr. Peter Phillips—the medical director, AIDS Program and head, Infectious Diseases, at St. Paul's Hospital in Vancouver—IRS generally only happens to PWAs with CD4 counts below 250—but most often well below 100—who are starting

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antiretroviral therapy or are revising their therapy; their condition gets worse even though their immunity improves.

No broadly accepted definition

The symptoms of IRS can vary as widely as the different opportunistic infections that the immune system can recognize. As such, there's no broadly accepted definition of the syndrome. Dr. Phillips notes that there are three components to an IRS. The first is the development of an inflammatory lesion, usually secondary to an opportunistic infection—but that's not always the case. The second component is the relationship of the lesion and the timing of starting or revising ART. Usually IRS occurs within weeks of initiating ART, though it can happen months later.

The symptoms of IRS can vary as widely as the different opportunistic infections that the immune system can recognize. As such, there's no broadly accepted definition.

Finally, there's evidence of immune reconstitution, generally by an increased CD4 count or a significant reduction in HIV RNA. For example, in a person with tuberculosis (TB) who initiates ART after responding to treatment for TB, the warning signs for a diagnosis of immune reconstitution syndrome (rather than progression of the TB) would include new or worsening fever, new effusions, new or worsening swollen lymph nodes, and other uncharacteristic signs or symptoms.

The AIDS Education and Training Centers National Resource Center identifies the following common infections present in immune reconstitution:

- ▶ *Mycobacterium avium* complex (MAC)
- ▶ Tuberculosis
- ▶ *Pneumocystis carinii* pneumonia (PCP)
- ▶ Cytomegalovirus (CMV) infections
- ▶ Cryptococcal meningitis

According to an article in the journal *Clinical Infectious Diseases*, the incidence of immune reconstitution syndrome is estimated to be 10 percent among persons starting antiretroviral therapy, and as high as 25 percent among patients starting therapy who have a CD4 cell count of less than 50. The article acknowledges, however, that the true rate of IRS has yet to be determined due to the lack of consensus regarding a clinical definition.

Unmasking versus relapse IRS

There are really two forms of the disease: unmasking and relapse. Dr. Phillips explains that unmasking is when you didn't know the opportunistic infection was pre-existing and there were minimal or no symptoms before the initiation of ART. While there isn't a clear sense of how often the unmasking form of IRS happens, it appears to be less frequent than relapse disease. In BC, roughly three percent of persons beginning antiretroviral therapy with a CD4 count below 100 will develop MAC, usually over the next few months. It appears that TB unmasking is rare. Unmasking figures aren't available for other common opportunistic infections.

In terms of relapses, if you've already had CMV, you have a 60 percent chance of a relapse. For TB, MAC, and cryptococcal meningitis, about one-third of people will develop an IRS after initiating ART. The incidence of PCP IRS is less, ranging between 5 and 18 percent.

Investigating IRS can include such diagnostic tests as laboratory tests, imaging, and blood work. In many cases, immune reconstitution syndrome may be mild and can resolve without treatment. However, it can be a serious and sometimes fatal condition. Depending on the infection present, aggressive treatment may be necessary to prevent serious illness.

Don't stop taking ART

One management option includes treating the opportunistic infection. However, Dr. Phillips cautions that, except for TB where you have to treat the infection, there's no evidence to show that there's any benefit to additional drugs to treat the opportunistic infection. There is, however, anecdotal evidence to support using steroids or anti-inflammatory medications, such as corticosteroids and NSAIDs, to suppress the inflammatory process. Stopping ART is a consideration only in life-threatening cases where there's a severe steroid resistance.

The risk of IRS appears to be higher if you start ART soon after your opportunistic infection treatment has started and if your CD4 count rises sharply in the early weeks or month of ART. However, the optimal timing of ART initiation in relation to treatment of the opportunistic infection is not yet clear, and may depend on several variables. Dr. Phillips notes that ART may be delayed if a new opportunistic infection is diagnosed and efforts are being made to reduce issues arising from drug interactions or toxicity and reducing potentially severe IRS.

The bottom line? When you start antiretroviral therapy, contact your doctor immediately if you experience any new or worsening symptoms. ⊕



Carley Taylor is a volunteer with BCPWA's Treatment Information Program.



Look for your AGM package in the mail beginning July 10, 2007.

Notice of Annual General Meeting

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

Please note that SIX two-year term positions on the Board of Directors of the Society are to be elected for the period 2007-2009.

WHEN: Saturday, August 18, 2007 at 11:00AM

WHERE: TO BE ANNOUNCED

REGISTRATION: 10:00 – 11:00AM

MEETING BEGINS AT: 11:00 AM (sharp)

IMPORTANT DATES TO REMEMBER

By June 11, 2007

Resolutions from the Members to be submitted to the Secretary of BCPWA

Not later than July 20, 2007

Mail out of AGM packages

On July 31, 2007

For individuals who do not receive mail, AGM packages will be ready for pick up from Member Services (reception) desk

August 3, 2007

Last day proxies are mailed

August 3, 2007

Last day proxies may be requested for pick up

Members wishing to have business placed on the agenda for the Annual General Meeting should submit it prior to June 11, 2007. A letter to the Secretary of the Society containing:

- (1) a brief paragraph describing the specific intent of the business, and
- (2) a properly worded motion pertaining to the business should be sent to the Society's registered office at: 1107 Seymour Street, Vancouver, BC, V6B 5S8

If you have any questions or would like to receive a copy of the Society's Annual Report, please call Wayne Campbell, Secretary, at 604.646.5350 and leave a confidential message. To ensure accuracy, please spell your last name slowly and leave a contact phone number.

If you require ASL interpretation, please contact the Secretary of the Society.

A lunch will be served.

Feature Story

Treatment by the books

A guide to treatment guidelines

by Derek Thaczuk

To put it simply, HIV medicine isn't simple. Every question answered seems to raise 10 more. How do we choose the best combinations as new treatments pour out of the pipeline? When is it better to jump in and treat, and when is it better to hold off? What's the best way to deal with complications and toxicities, and how do we know we're not creating more problems down the road?

The art and science of treatment lies in finding the best answers to these and other questions. The best answers are, of course, a moving target: best practice depends on what we currently know—which changes with time, usually for the better. To some extent, best practice also depends on whom you ask. Few sciences are exact, and where definitive evidence is lacking, hard and fast rules give way to expert judgment.

Treatment guidelines, developed by expert panels, are the most systematic approach to the complexity and sheer sprawling bulk of medical evidence. Such guidelines serve several related purposes: first, they attempt to distill the vast amounts of clinical evidence to some sort of usable reference. They also comment upon, interpret, and provide context for that evidence: where clear-cut answers don't exist (inevitable in medicine), expert practitioners can provide their own best analyses and opinions.

Huge advancements in evidence-based medicine

The concept at work in such clinical practice guidelines (in HIV and other fields) has been formalized under the name of evidence-based medicine (EBM). The University Health Network

Centre for Evidence-Based Medicine defines EBM as “the integration of best research evidence with clinical expertise and patient values.” Evidence-based practice is hardly a new idea: medicine, one hopes, wasn’t just invented out of thin air before someone thought of this buzzword. However, the actual methods of EBM have made radical strides forward in recent years, largely due to considerable advances in information systems.

The standard EBM model also makes distinctions between quality of evidence—that is, clinically demonstrated evidence—versus expert opinion. Wherever possible, recommendations are ranked according to whether they were derived from randomized clinical trials (the strongest level of quality), laboratory results or non-randomized studies, or expert opinion.

The evidence base for HIV medicine has found its way into guidelines worldwide (see sidebar). The BC Centre for Excellence in HIV/AIDS (BCCfE) maintains its own version, making BC one of the few Canadian provinces to do so. Expert panels in the US, Great Britain, the European Union, and the International AIDS Society, among others, have developed other major sets of guidelines.

Why so many? There’s no great disparity between guidelines from one country to another. At least that’s true in developed countries with few serious resource limitations—though financial realities may come increasingly into play, even in resource-rich countries, as cost containment weighs more heavily into health care.

One of the main differences between guidelines is their actual size, scope, and level of detail. The US Department of Health and Human Services (DHHS) guidelines weigh in at 121 pages; many others are considerably more succinct. There are so many areas pertinent to HIV care and treatment that guidelines—particularly the DHHS—have an amoeba-like tendency to expand to encompass these areas. For instance, adherence issues greatly influence the outcomes of antiretroviral therapy, and thus have become a distinct component of the DHHS and several other treatment guidelines.

The ongoing question of when to start antiretroviral therapy

Apart from financial considerations—which, obviously, can dwarf all others—guidelines tend not to differ significantly on key treatment points. There are, however, some subtle and occasionally not-so-subtle differences. One key example is the question of when to start medications.

The when-to-start question is a prime example of how “the right approach to therapy” can change with time. The first data to significantly address this question came from a large US study, the Multicenter AIDS Cohort Study (MACS), conducted before the widespread use of antiretrovirals. A 1997 report from the MACS study was the first to confirm

what is now common knowledge: that higher viral loads and lower CD4 counts corresponded with faster progression. Treatment decisions could then be based on the risk of disease progression, with those at greater risk being treated most aggressively.

Early in the highly active antiretroviral therapy (HAART) era, though, the “hit hard, hit early” slogan was still prominent. Why delay treatment, many experts reasoned, when the end result—AIDS and death—is the same? We don’t wait around for people with tuberculosis to get sick before treating them, the argument went, so why should we defer treating HIV?

The trade-offs of early treatment

At first, this was a reasonable argument: until then, people had been subject to the ravages of untreated HIV disease, and now there was a way to prevent them. Why would anyone choose not to do so? The answer, of course, lies in the trade-offs, and the now well-known downside of treatment. Early, aggressive treatment meant subjecting people to the costs, toxicities, and daily burden of treatment. Eventually, as the impact became harder to ignore, the question resurfaced: when do the benefits of treatment begin to outweigh the burdens?

There is, of course, no hard line in the sand where treatment should begin: nothing magical happens between, for example, CD4 counts of 351 and 350 that signals the sudden need for treatment. Rather, CD4 counts mark zones where treatment should be started, deferred, or considered.

Treatment has always been recommended in any case where not treating would clearly present a danger—for example, when people are already ill, have significant HIV-related symptoms, or have CD4 counts below 200 (which put them at an immediate risk of *Pneumocystis carinii* pneumonia and other opportunistic infections). When there’s no clear immediate advantage—if people have high CD4 counts where the risk of illness is low—treatment is generally deferred, at the judgment of the patient and physician.

But there’s that gray zone in the middle. At intermediate values of CD4 count and viral load, the prospects of imminent health risks are also intermediate. Hence, the recommendation that treatment should be “considered”—a term that takes into account the physician’s judgment, the implications of clinical evidence, and (hopefully) the PWA’s own wishes and leanings. The aggressive, “hit hard, hit early” approach has weighted the risks of HIV disease over the downsides of treatment, even in this intermediate range.

The shift away from early treatment—then back again

There have also been regional differences in the approaches to the issue. European experts were skeptical about the benefits of the hit hard, hit early approach long before North Americans were, and this is reflected

Selected international HIV treatment guidelines

- ▷ Panel on Antiretroviral Guidelines for Adult and Adolescents. *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*. US Department of Health and Human Services, October 10, 2006. Available at www.aidsinfo.nih.gov under "Guidelines."
- ▷ "Treatment for Adult HIV Infection: 2006 Recommendations of the International AIDS Society—USA Panel." *JAMA*, August 16, 2006 – Vol. 296, No. 7, p. 827-843. Available at www.iasusa.org under "Guidelines."
- ▷ *European Guidelines for the Clinical Management and Treatment of HIV Infected Adults*, European AIDS Clinical Society, 2005. Available at www.eacs.eu under "Treatment Guidelines."
- ▷ "British HIV Association (BHIVA) Guidelines for the Treatment of HIV-Infected Adults with Antiretroviral Therapy," British HIV Association. *HIV Medicine*, 2006, 7, 487-503. Available at www.bhiva.org under "Publications and Guidelines."
- ▷ *Therapeutic Guidelines: Antiretroviral Therapy for HIV-1 Infected Adults*. October 2006. BC Centre for Excellence in HIV/AIDS. Available at www.cfenet.ubc.ca under "Therapeutic Guidelines."
- ▷ The HIV InSite website at <http://hivinsite.ucsf.edu> contains an extremely comprehensive and regularly updated list of international guidelines for HIV treatment, care, and prevention. Click on the "Treatment" tab.

in European treatment guidelines. Around the year 2000, US and North American clinicians began to move away from their more aggressive approach, and the 2001 revision of the US DHHS guidelines formalized the move away from early treatment.

This move away from earlier treatment gathered more momentum in 2000 when Dr Julio Montaner from the BCCfE presented a highly-publicized study. Montaner's study confirmed that treatment response was somewhat poorer for people who weren't treated until their CD4 counts fell below 200. However, the actual risk of death, while considerably greater for people with CD4 counts below 50, wasn't dramatically higher for those who started treatment with counts either above or below 200. This surprising finding ushered in a period in which many people chose to delay therapy until much nearer the 200 mark.

More recently, however, the pendulum has swung partially back in the other direction as the flaw in this sort of brinkmanship became more apparent. Studies, including several from BC, have reconfirmed that opportunistic infections and death are significantly more likely at counts below 200. In the real world, of course, waiting until just before CD4 counts fall below 200 often means that they actually do fall below that mark, needlessly increasing the very real risks involved at that stage of disease. Current BC treatment guidelines now state that the "optimal time for starting HAART when the CD4 cell count is above 200 and below 350 cells/mm³ has not been determined. Within this range, treatment decisions should be individualized, taking into account clinical and laboratory parameters (including CD4 percentage, viral load, and possibly rate of CD4 decline) as well as the patient's preference."

The US DHHS guidelines simply state that "asymptomatic patients with CD4 T cell counts of 201 – 350 cells/mm³ should be offered treatment." And in the UK, the British

HIV Association states that "treatment should start before the CD4 cell count has fallen to below 200 cells/μL... because of the higher risk of death or disease progression in patients who delay starting treatment until ... this level, and the reduced efficacy of HAART when introduced at a count of <200 cells/μL." ☉



Derek Thaczuk has worked in information and support services within the HIV community for over a decade and is now a freelance writer and editor.

Late-breaking news

Just as this issue was going to press, a new Dutch study was published in the *Journal of Acquired Immune Deficiency Syndromes*, showing that greater CD4 count increases are seen in people who start therapy with CD4 counts above 350. More than 73 percent of those who began treatment with CD4 counts above 350 reached counts of over 800 cells/mm³ within seven years of treatment—far fewer (46 percent or less) who started with lower counts reached this goal.

In an accompanying editorial, the BCCfE's Dr. Julio Montaner and Evan Wood note that "simpler and safer" newer regimens call for "a broader re-evaluation of the ideal time to start therapy, incorporating outcomes other than survival, such as the level of immune reconstitution" demonstrated in this study. — Derek Thaczuk

New online service

BCPWA introduces an HIV treatment blog and discussion board

by **Zoran Stjepanovic**

BCPWA's Treatment Information Program (TIP) has launched a new online service for HIV-positive British Columbians.

You can now participate in a dynamic exchange of HIV treatment information through BCPWA's treatment information blog. The discussion board allows you to post questions and comments about HIV treatments. The blog, accessible through a link from the front page of BCPWA's website or directly through www.hivtreatmentinfo.blogspot.com, is another way to provide information and share experiences.

New topics will be posted to the blog each Wednesday by BCPWA treatment information volunteers, allowing members to comment, ask questions, and share stories. Topics will likely include information on facial lipoatrophy, aging and HIV, managing side effects, new medications, hepatitis, and complementary and alternative therapies.

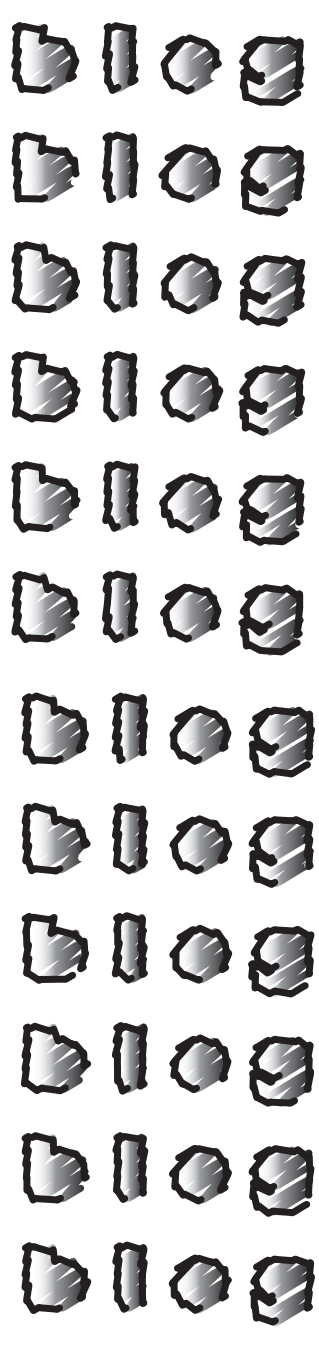
Blog visitors can start discussions by posting comments to the discussion board. You can post comments anonymously to protect your privacy. This isn't a live discussion board, so comments won't be posted immediately. Allow for up to 24 hours for moderators to review your comment and then post it for others to read. The moderator ensures that blog guidelines are followed; the moderator can also research and respond to questions.

In the links section of the blog, you'll find blog guidelines for participants along with a number of interesting websites related to HIV/AIDS and treatment.

Check out BCPWA's new treatment information blog, and add your comments and experiences to the discussion items posted ☺.

Zoran Stjepanovic is BCPWA's treatment information coordinator.

<http://bcpwatreatment.blogspot.com>



**BCPWA
Community
Discussion Board
for persons living
with HIV.**

**Different topic
each week on
treatment issues!**

**Treatment
Information!
Ask questions!
Share experiences!**

Antiretrovirals

In the long run

HIV treatment has changed over the years, based in part on the long-term consequences *by Dr. Marianne Harris*

In the early days of HIV treatment, the focus was on keeping people alive and managing their opportunistic infections. We didn't care so much if the drugs were difficult to take, or had nasty side effects, given the alternative of AIDS and certain death. Long-term side effects were the least of our worries, because most people with HIV would succumb to their illness and wouldn't live long enough to suffer distant consequences such as heart attacks.

Luckily, things took a turn around 1996 with the advent of highly active antiretroviral therapy (HAART). By that time, we had enough effective drugs that they could be combined in three-drug regimens that effectively halted HIV replication. The focus then became to make the drugs easier to take and more tolerable for life-long therapy. Now that people with HIV were living longer, the long-term consequences of HAART, such as lipodystrophy and cardiovascular disease, became more important. There was a subsequent shift to starting treatment later in the course of HIV disease, to avoid prolonged, possibly unnecessary exposure to potentially toxic drugs.

The pendulum is now swinging back to earlier treatment. There are a number of reasons for this shift:

- ▶ Treatments are now easier to take. Many of them only need to be taken once a day and with fixed-dose combinations (containing two or three drugs) that reduce pill burden.
- ▶ There are new drugs with fewer long-term side effects. For example, drugs are being developed with less impact on lipids (cholesterol and triglycerides), which translates into a lower risk of heart disease.
- ▶ There's a better understanding of the immune system and a realization that CD4 cell counts don't tell the whole story.

There are other aspects of the immune system that can't be easily measured but are being damaged, possibly irreversibly, by ongoing HIV replication.

- ▶ There's a better understanding of the role of HAART in preventing HIV transmission and the spread of the epidemic.

Nucleosides are still the backbone of regimens

HIV is now seen as more of a chronic disease, one that must be treated with a view to the individual's health and well-being as a whole. Now that we can choose from many different effective drugs, a number of other factors might also be considered when designing the optimal HIV treatment. Treatment is no longer a "one size fits all" proposition; in most cases, it can be tailored to suit the individual. Twenty years ago, it would have been incredible to think that, when choosing an HIV-positive person's therapy, we'd be worrying about the long-term risk of having a heart attack!

In terms of specific drugs, nucleosides—the first effective anti-HIV drug class, including agents such as zidovudine (AZT, Retrovir) and didanosine (ddI, Videx)—are still the backbone of therapy; first- and second-line treatment regimens usually include two nucleosides plus a third drug from another class. These regimens seem to be most effective in the long run, and many nucleosides (notably zidovudine) combat HIV in the brain, preventing AIDS-related dementia, which used to be very common before the availability of zidovudine.

A few years ago, a lot of research explored nucleoside-sparing regimens in an attempt to avoid the toxicities of these drugs, which could attack the liver, muscles, nerves, and bone

marrow. However, the newer agents in this class—lamivudine (3TC, Epivir), abacavir (Ziagen), tenofovir (Viread), and emtricitabine (FTC, Emtriva)—are generally much less toxic in the long run. Also, these agents are available in fixed-dose combinations (lamivudine + abacavir = Kivexa; tenofovir + emtricitabine = Truvada) meaning that the entire nucleoside backbone can be taken as one pill, once a day.

The main side effect of abacavir is an early allergic reaction, occurring in about 5 percent of people; this can now be predicted—and avoided—by an HLA blood test before starting the drug. Tenofovir can be toxic to the kidneys, but with our improved understanding of who's at risk and better management of background kidney disease, this complication has become relatively rare and generally manageable. Lamivudine and emtricitabine seem to cause very few drug toxicities.

Nevirapine and efavirenz as the third drug in regimens

The third drug in a HAART regimen will be either a non-nucleoside reverse transcriptase inhibitor (NNRTI, or non-nukes) or a protease inhibitor (PI). The NNRTIs nevirapine or efavirenz were often preferred over older PIs because of lower pill burden, simpler dosing, and less side effects.

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Nevirapine is often chosen due to a beneficial effect on the lipid profile and reduced cardiovascular disease risk. Concerns about the risk of severe liver disease with this agent have been largely overcome with the understanding that it is present mainly in people who start the drug with a higher CD4 cell count. Avoiding starting nevirapine in men with CD4 count over 400 or women with CD4 over 250 has considerably reduced the risk of liver toxicity with this agent. Liver problems and rashes, if they are going to occur, are mainly a problem during the first 18 weeks of treatment; after that, the drug is very well-tolerated.

In the past, Efavirenz was used less than nevirapine in BC due to its higher cost and frequent central nervous system side effects, such as vivid dreams, insomnia, euphoria, dizziness, depression, anxiety, and hallucinations. However, use of this drug has increased recently, in preparation for the upcoming availability of Atripla, a one-pill, once-a-day treatment comprised of tenofovir, emtricitabine, and efavirenz. This pill is generating a lot of excitement, however it will only be appropriate for people on their first HIV treatment (or in whom previous

treatments have not failed); it won't be suitable for people with drug-resistant HIV. Long-term studies show that efavirenz-based treatment regimens can be safe and effective for many years.

Increased usage of newer protease inhibitors

As for PIs, in the past the older ones were associated with complicated three-times daily dosing regimens, lots of gastrointestinal side effects such as nausea, vomiting, and diarrhea, and a negative impact on lipids—thus increasing the risk of heart disease. Newer PIs, particularly atazanavir (Reyataz), have overcome these problems, making the PIs more attractive for first-line treatment. Atazanavir can be taken once a day, it's well tolerated, and it's "lipid friendly."

A new tablet formulation of lopinavir/ritonavir (Kaletra) has made this PI more palatable and reduced the pill burden so that once-daily dosing is an option for some people. While the effects of Kaletra on lipids and lipodystrophy haven't changed, we have more long-term data available for Kaletra than for any other PI. A majority of people maintain undetectable viral loads over seven years of treatment with Kaletra and two nucleosides.

With a plethora of new treatment choices on the horizon, including drugs from new classes such as integrase inhibitors and CCR5 receptor antagonists, it's reassuring to have well-established treatments available with no surprises in terms of unexpected toxicities, at least until we have more experience with the newer drugs over a longer period of time.

Bone density conditions emerging as long-term complication

Speaking of long-term complications, one condition you'll be hearing a lot more about is osteoporosis (weakened bones which can break easily) and osteopenia (a milder degree of decreased bone density). It has been suspected for some time that HIV treatment, especially PIs and tenofovir, may result in decreased bone density; however, the data are conflicting and the jury is still out as to which, if any, agents are responsible.

What is clear is that HIV disease itself can cause osteopenia and osteoporosis. A recent study conducted in seven HIV clinics in the US showed that a remarkable 62 percent of HIV clinic patients had some degree of reduced bone density, as compared to 30 percent of the general US population. Risk factors include smoking, lack of weight-bearing exercise, and low intake of calcium and vitamin D; the role of specific HIV treatments remains under study. Bone density testing by a DEXA scan may soon be recommended at baseline and regular intervals for people with HIV, to enable doctors to monitor the condition of the bones and intervene with appropriate treatment if necessary. ⊕

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

Antiretrovirals

Coming of age

How does the aging process factor in for PWAs on antiretroviral therapy?

by Glyn Townson

Research efforts during the first two decades of the HIV epidemic focused on keeping people alive and relatively healthy. No one really focused on issues related to growing old with HIV—most people simply hoped to extend their lives by a few months. Discussions on health issues around HIV/AIDS progression mainly concentrated on side effects from the new medications, or from HIV itself.

Over the past decade, however, improvements in HIV medications and the development of new classes of drugs to treat HIV have produced a population of men and women who are living with HIV well into their fifties, sixties, and beyond. And as those of us living with HIV are getting older, there's a new wrinkle to the discussion of HIV/AIDS progression: the normal human process of aging. People living with HIV often face more challenges when dealing with common age-related problems and risk factors compared to the general population.

The current arsenal of medications available to treat HIV—combination therapy, or highly active antiretroviral therapy (HAART)—has only been in use for a limited time. Many of these drugs were fast-tracked due to demands for quicker access to deal with drug resistant strains of HIV. We still don't fully understand the long-term effects and continued use of many of these drugs in various combinations. There are some commonly experienced adverse effects from the different classes of antiretrovirals (ARVs) and they can have an amplifying effect on some of the normal issues associated with aging. Moreover, as new therapeutic agents become available, and new drug combinations are used, HIV-positive people will experience different adverse effects, thus adding to the confusion.

Is it HIV- or age-related?

It's often difficult to determine whether a problem is caused by HIV itself, HIV treatment, or the aging process. Physical symptoms



and illnesses related to HIV and its treatment—such as fatigue, weight changes, memory loss, depression, and atherosclerosis—can mimic typical age-related health problems. Both HAART and advancing age fuel other health issues, including cardiac, renal, hepatic, oncologic, neurological, and psychiatric co-morbidities. These conditions are often treated with other medications, leading to a potential for a high risk of drug-drug interactions.

As we age, we all must accept the reality and impact of a naturally weakening immune system, as well as the potential of adult-onset diabetes, heart disease, Alzheimer's disease, mental health problems, high blood pressure, and osteoporosis. Because the aging process itself lowers energy levels and results in restrictions in social routines that can cause emotional/psychological problems, older HIV-positive adults may endure more severe symptoms of depression.

Despite the known association between advanced age and the increasing incidence of dementia, few studies have investigated the complex interactions between HIV infection, aging, and neuropsychiatric diseases. We do know, though, that older age is associated with a more frequent diagnosis of HIV-related dementia as an individual's first AIDS-defining condition.

An increased risk of cardiovascular disease

In terms of other age-related conditions, older age has long been associated with an increased risk of cardiovascular disease, and on top of that, emerging evidence suggests that both HIV infection and HAART also increase cardiovascular disease risk. Metabolic toxicities of HAART and the pro-atherogenic state induced by chronic HIV infection may render older HIV-positive people particularly vulnerable to accelerated atherosclerosis (hardening of the arteries), which may also increase the risk of cardiovascular disease.

Older age is also associated with decreasing renal (kidney) and hepatic (liver) function. Studies of zidovudine (AZT, Retrovir) elimination through the kidneys found that the process was greatly reduced in older individuals, resulting in toxic serum drug levels.

Other studies that compared tolerability of protease inhibitors in older people versus younger people found that adverse events were much more common in older people. Decreases in albumin levels and liver function due to aging could be at the root of the increase in adverse events.

Osteopenia, or lowered bone mineral density, and osteoporosis (a decrease in bone density that results in more porous bones that are more easily fractured than normal) are both diagnosed more frequently in older individuals than in younger PWAs. This suggests that bone mineral density loss is greater in older HIV-positive individuals.

There are gender differences, too

How the aging process affects PWAs on antiretrovirals also depends on gender, since men and women have different

susceptibilities to adverse events from HAART. For example, an HIV-positive woman suffering from night sweats, skin changes, and bone loss could be experiencing side effects of HIV medication or common symptoms of menopause. As well, it isn't clear how hormone replacement therapy affects HIV-positive women, and whether they need it for menopause—or if it's even a good idea. Since most clinical studies on HAART have focused on the male population, this makes it difficult for women to determine whether HIV, HAART, aging, or a combination of the three is responsible for their adverse events from treatment.

It's often difficult to determine whether a problem is caused by HIV itself, HIV treatment, or the aging process.

All the current evidence suggests that those of us living into our golden years with HIV will have extra obstacles to overcome. On top of that, many health problems are exacerbated by smoking, obesity, and poor health behaviours that can lead to an increased risk of illness or death regardless of HIV status. In addition, since both alcohol and drug use are thought to confound the effects of neurocognitive functioning in older HIV-positive individuals, more research is essential to better measure and define neurological and psychiatric abnormalities in older HIV-positive substance users.

The bottom line is that, whatever your age, you should incorporate healthy lifestyle choices whenever possible. If you still smoke, consider quitting. Limit your intake of alcohol and recreational drugs. Eat a healthy diet. Try to stay active and physically fit. And try not to bitch-slap your doctor when he or she suggests that your symptoms might just be a sign of getting older. ☺

Talk to your doc

Talking with your doctor and keeping track of any changes you experience can help you understand what's happening with your body as you age. It can also help you to identify and manage adverse effects as they occur, before they get out of hand.



Glyn Townson is vice-chair of BCPWA.

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Managing HIV and nutrition

New brochure aims to help PWAs deal with nutrition issues

by Zoran Stjepanovic

Proper nutrition is of vital importance for HIV-positive individuals, yet eating food can be a challenge when you're taking antiretrovirals. Some common short-term side effects of HIV medications include nausea, diarrhea, and lack of appetite. In light of this, BCPWA's Treatment Information Program (TIP) has focused its efforts in the past year on providing education around nutrition and HIV.

First, there was a community forum in Surrey, and then in the autumn of 2006, a series of workshops facilitated by Diana Johansen from Oaktree Clinic. Most recently, TIP created a new, user-friendly brochure entitled "Management Guide for HIV and Nutrition." The brochure focuses on how to manage some of the side effects relating to nutrition. Here are some highlights from the brochure:

Diarrhea

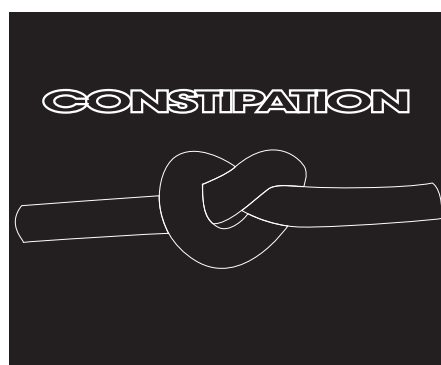


Diarrhea is an all-too-common side effect of antiretrovirals. A number of different medications can result in diarrhea, so it's difficult to point to just one medication. There are ways, however, to manage this unpleasant side effect:

- Eat a "BRAT" diet: bananas, rice, applesauce, and toast
- Avoid caffeine, spicy food, and beans
- Drink lots of fluid, including electrolyte replacements to prevent dehydration

- Take calcium supplements
- Take L-glutamine supplements; however don't take glutamine two to three days prior to blood work, as it can skew your blood lab tests.

Constipation



HIV-positive individuals experience constipation less frequently, however it can still pose problems. Constipation occurs when stools are difficult to pass, or when your stools are quite dry. There are a number of possible causes for this problem, including diets low in fibre, inadequate fluid intake, and some medications. While it does not appear to be a side effect of HIV medications; it can be a side effect from some other medications that PWAs may take, including antacids, antidepressants, and methadone. Lack of exercise and stress can also contribute to constipation.

If you're constipated, try these tips:

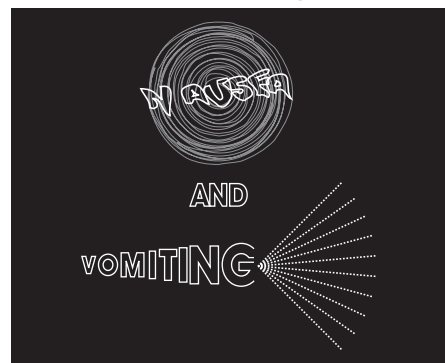
- Eat more fibre, such as raw vegetables and fruit, dried fruit, whole-grain cereals, nuts, seeds, and whole grain bread. A good tip is to gradually increase your fibre intake over several weeks, since gas and bloating may occur if you introduce high-fibre foods into your diet too quickly.
- Eat frequent and small meals.
- Drink plenty of fluids, including water, soups, juices, and milk.

- Be active and exercise to stimulate bowel movement.

• Try to avoid sugar and sweet foods. Some people will try to use a stool softener or very mild laxative, such as milk of magnesia.

If your constipation persists even after trying out some of these remedies above, consult your physician.

Nausea and vomiting



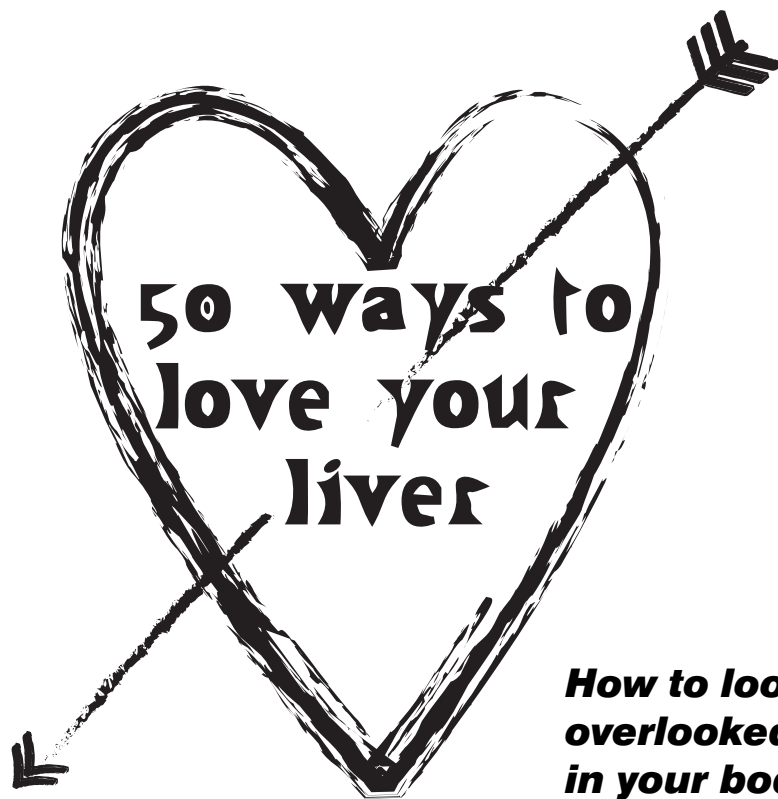
Some suggestions for treating nausea and vomiting:

- Eat dry and salty foods.
- Avoid very sweet foods.
- Nibble on raw ginger or drink ginger tea.
- Eat cold food.
- Choose low-fat foods instead of greasy foods.
- Use medicinal marijuana.

The brochure contains much more information on how to manage some other side effects, such as lack of appetite, and mouth ulcers (thrush). To have a copy mailed to you, contact the TIP office at 604.893.2239. ☎



Zoran Stjepanovic is BCPWA's treatment information coordinator.



How to look after one of the most overlooked—and largest—organs in your body *by Ashley Smith*

The liver, with its numerous functions, is the second largest organ in the body—at four pounds, it’s surpassed in size only by the skin. Yet despite its importance, the liver is often overlooked and underappreciated until something goes wrong. The liver is resilient, and has the ability to recover and cope with injury, so people tend to neglect caring for their liver.

The liver, made of two lobes, is located on the right side of the abdominal space. It’s the “metabolic factory” of the body. Its two separate blood supplies—the hepatic artery and the portal vein—contain 10 percent of the body’s blood at any one time. The hepatic artery provides fresh blood, rich in oxygen and energy, from the heart. This blood feeds the cells of the liver. The portal vein brings blood from the intestine and stomach to the liver. This allows the liver to process the nutrients absorbed by these digestive organs.

The functions of the liver are vast and vital to human health and survival:

- ▷ Production of cholesterol for hormones and bile
- ▷ Production of bile, which is made in the liver and then secreted into the small intestine, and is responsible for the breakdown of fats and fat-soluble vitamins
- ▷ Production of blood-clotting factors
- ▷ Production of essential proteins
- ▷ Storage of glucose or simple sugar, which is the “energy currency” of the body and stored in the liver as glycogen
- ▷ Formation of glucose from protein and fat when glucose is unavailable (known as gluconeogenesis)
- ▷ Inactivation of hormones
- ▷ Removal of old red blood cells to allow for recycling iron and proteins
- ▷ Detoxification of alcohol and drugs allowing for their removal from the body

Clearly, given all these functions, you want to make sure your liver stays healthy!

Liver damage can lead to other complications

Liver damage is an umbrella term that encompasses any disease or disorder that’s detrimental to the liver’s function. That can include swelling of the liver, fat accumulation on the liver, and chronic scarring of the liver tissue. These changes may lead to cancer and various obstructive changes in blood and biliary flow (movement of bile from liver to the digestive tract). Since one of the most important tasks of the liver is detoxification, the liver can be at high risk during illness. Other factors such as autoimmune diseases, metabolic diseases, and viruses may cause liver damage. (See the sidebar for signs and symptoms of liver damage.)

Viruses and toxins can cause hepatitis. Hepatitis is a generic term for the swelling of the liver cells. Viruses and toxins cause the cells to react and through the body’s defense mechanisms, become inflamed. This inflammation can result in a mild illness or irreparable liver damage. Viruses that cause hepatitis include hepatitis A (HAV), hepatitis B (HBV), and hepatitis C (HCV). Hepatitis B and hepatitis C cause the immune system to attack the liver, which results in liver damage.

Hepatitis may also occur along with fatty liver disease, which occurs when there’s an accumulation of toxins. If the toxins aren’t made water soluble, then they remain fat soluble and are stored in the cells of the liver, instead of being expelled from the body through the kidneys. Both fatty liver and hepatitis can lead to cirrhosis and cancer.

Cirrhosis, or fibrosis of the liver, is scarring that inhibits the normal function of the liver. Obstruction to blood flow, a common complication of cirrhosis, can create high blood

Signs & symptoms of liver damage

Because the liver is so resilient, people can go without signs or symptoms for a long time. If you notice any of these signs or symptoms, see your doctor.

- > Fatigue
- > Decreased motivation
- > Itchiness
- > Nausea and vomiting
- > Loss of appetite
- > Jaundice
- > Dark urine
- > Pale stool
- > Bleeding from the digestive tract
- > Confusion
- > Retention of fluids in abdomen

pressure around the liver (portal hypertension), which in turn can lead to an accumulation of fluid in the abdomen and enlarged veins in the esophagus.

HIV/HCV co-infection exacerbates liver problems

HIV adds another layer of complications for your liver. HIV-related liver damage can stem from both viral co-infection (HIV and HCV) and HIV treatment toxicity. A recent study also implicated the HIV virus itself in liver damage. A number of factors influence the extent of HIV-related liver damage, including genetic disposition, sex, and previous drug and alcohol exposure.

Antiretroviral drugs can sometimes lead to liver stress and damage. The liver recognizes all drugs, including antiretrovirals, as foreign substances that need to be removed from the body.

In studies, the progression to cirrhosis and liver failure is much higher in HIV/HCV co-infected patients than in patients only infected with HCV. The effect of HCV on HIV is not well understood. Liver damage appears to be controlled when HIV is managed with highly active antiretroviral therapy (HAART).

However, despite the positive effects of antiretroviral drugs, they can sometimes lead to liver stress and damage. The liver recognizes all drugs, including antiretrovirals, as foreign substances that need to be removed from the body. All drugs, therefore, result in some degree of work for the liver—not necessarily a problem, since it is such a resilient organ. However, certain medications can be particularly damaging. Both of the widely used non-nucleoside analogues—nevirapine (Viramune) and

efavirenz (Sustiva)—can be liver-toxic. Nevirapine has proven to be a particular risk for women with CD4 cell counts above 250 and men with counts above 400; it isn't recommended for use in these people. Liver toxicity can also be a risk with protease inhibitors, particularly tipranavir (Aptivus).

Nucleoside analogues can cause liver damage indirectly through the buildup of lactic acid in the blood (lactic acidosis). Lactic acid buildup can lead to a condition called hepatic steatosis—an accumulation of fatty tissue in the liver.

A recent study conducted in Paris found evidence of a rare liver condition called nodular regenerative hyperplasia (NRH) in people with HIV on antiretroviral therapy. NRH causes increased blood pressure in the portal vein, leading to fluid collection in the abdomen and bleeding in the digestive tract. This new finding may suggest that antiretroviral therapy may be liver-toxic in more ways than have been previously understood, although further research in this area is still needed.

Look after your liver!

There are things you can do to look after your liver (see sidebar). To help with early diagnosis of liver damage, visit your doctor regularly. Liver function tests (LFTs) measure liver enzymes, and elevated enzymes indicate liver damage. Have an open dialogue with your doctor and discuss the management of your drug regimen, removing any drugs that are causing the damage.

Alcohol is especially bad for your liver. It can increase the risks of liver damage if you're on HAART, since most of the HIV drugs are processed in the liver. HAART combined with alcohol can also increase the risk of cirrhosis. Alcohol also changes the way drugs are broken down and used by your body. The American Liver Association recommends only one alcoholic drink per day. Avoid it altogether if you have hepatitis.

Given all the work that your liver does, and how everything gets processed through it, it just makes good sense to take care of it and keep it happy. You'll be glad you did. ☺

Ashley Smith is a volunteer with BCPWA's treatment information program.

Tips for maintaining a healthy liver

- > Quit smoking.
- > Drink lots of water.
- > Avoid inhaling such toxins as paint thinner, nail polish, paints, cleaning liquids, and cigarette smoke.
- > Eat a healthy, well-balanced diet that's high in fibre, with lots of variety, and foods that are low in sugar and fat.
- > Maintain a healthy body weight—75 percent of obese individuals have a fatty liver.

Another bumper CAHR

Highlights from the 16th Annual Canadian Conference on HIV/AIDS Research

by Zoran Stjepanovic

This year's Canadian Association for HIV Research (CAHR) Conference, held in Toronto from April 26 - 29, once again brought together people from across Canada to share information and present some of the most important HIV research taking place in the country. Seven hundred investigators, clinicians, PWAs, service providers, and community group representatives participated in the conference, which focused on four key track areas: basic sciences, clinical science, epidemiology and public health, and social sciences.

The Canadian AIDS Treatment Information Exchange (CATIE) also held a learning institute session the day before the conference, which discussed HIV rapid testing and the integration of HIV treatment and prevention. There was also a presentation on how to understand HIV clinical research. The goals of the CATIE pre-CAHR session were to enable front-line community participants who provide HIV treatment information to maximize their learning experience at the CAHR conference and to build and support a national network of HIV treatment information providers.

Research on a group of women who work in Nairobi's sex industry revealed that in 10 percent of them, antibodies in their genital tract have been able to neutralize HIV.

Dr. Frank Plummer from the Public Health Agency of Canada presented at the opening plenary of the CAHR conference. Since 1985, he and his research team have been conducting research on a group of women who work in Nairobi's sex industry. The women were at a high risk of HIV infection because of their work, which entailed numerous

episodes of unprotected sexual intercourse with different partners. Yet the investigators discovered a natural resistance to HIV infection in a number of these women.

One would think that most, if not all, of these women would be HIV-positive after 20 years of active commercial sex work. However, 10 percent of the women have shown that they become less likely to acquire HIV infection over long periods of time. Antibodies in the genital tract of these women have been able to neutralize HIV. This research may be able to inform the development of an effective HIV vaccine or microbicide in the future.

There was also an interesting presentation on perinatal outcomes among HIV-positive pregnant women receiving antiretroviral therapy in B.C. There have only been three babies born with HIV in this province since 1995, and these were born to women on monotherapy in 1995/96. Some interesting findings in this study showed that there were twice as many pre-term births (before 34 weeks) in women on antiretrovirals compared to the general population. The study also showed that there were lower birth rates, gestational diabetes, and high blood pressure in pregnant women taking antiretrovirals regardless of what type of drug class they were taking. As for their ability to suppress the virus, this study showed that 80 percent of women on antiretrovirals were virologically suppressed with a mean time of 58 days to viral suppression. Factors that were associated with non-suppression included smoking, illicit drug use, co-infection, shorter treatment duration and poor adherence.

There were many other interesting research findings from the CAHR conference, so look for future articles in *living* on various topics that were presented at CAHR. ☉



Zoran Stjepanovic is BCPWA's treatment information coordinator.

HIV/AIDS Treatment Information

Questions About Your Health? We can help!

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What to expect?

Doctors?

Starting medications?

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Switching medications?

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HIV/AIDS Treatment Information
provided by
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Great source of information!
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E treatment@bcpwa.org

No appointments necessary.





STRAIGHT
from the source

what's new in research

Ritonavir and corticosteroids interaction

by Mark Hull

There's an important drug interaction between ritonavir (Norvir) and nasal and inhaled corticosteroids that you should know about.

Inhaled and nasal corticosteroids are the mainstay for managing certain lung conditions such as asthma, and they're also helpful for rhinitis (an inflammation of the mucous membrane lining the nose, which causes a runny or congested nose). These medications are prescribed in different strengths, depending on the type of corticosteroid and the dosage involved. The most potent of these medications is fluticasone (inhaled Flovent or Advair, and nasal Flonase). Other corticosteroid preparations include budesonide (Vanceril and QVAR) and beclomethasone (inhaled Pulmicort and nasal Beconase).

These medications usually have their effects at the lung surfaces or nasal tissues. There's usually little uptake into the body as a whole. If the drug is absorbed in the body, it's cleared in part through a common clearance pathway centred in the liver called the CYP3A4 enzyme system.

Ritonavir is known to inhibit this pathway, interfering with the clearance of other drugs. This is helpful when you're taking other protease inhibitors (PIs), because it allows you to take lower doses of them. Most PIs are boosted in this fashion. Some PIs are co-formulated with ritonavir, while others are combined with a separate ritonavir component.

However, this inhibition is thought

to be responsible for the interaction between ritonavir and the corticosteroid medications. When people use ritonavir, the inhaled corticosteroid levels can build up over time. As the levels rise, the body reacts by slowly reducing production of its natural steroid hormone, cortisol, made in the adrenal glands.

This leads to either a situation of steroid excess resulting from the increased levels of the inhaled medication within the body, or one of insufficiency (adrenal insufficiency), which can occur if you abruptly stop taking the steroid, as the body isn't be able to compensate quickly and restart natural production in time. People with steroid excess may develop rapid weight gain—particularly on the abdomen and back of the neck or face—loss of diabetic control, or even mood changes. People with adrenal insufficiency can develop symptoms of nausea, vomiting, dizziness, or low blood pressure after stopping their inhaled medication abruptly.

Of all the corticosteroid preparations, fluticasone is the most potent corticosteroid and is therefore thought to be most affected by ritonavir. Studies found that when used together, these medications led to a significant drop in the natural production of cortisol. Health Canada issued an advisory in 2004 cautioning doctors not to use these medications together if at all possible.

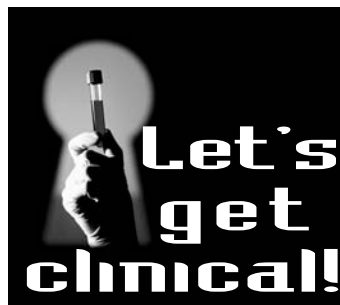
Usually a screening blood test—a fasting morning cortisol test, collected

between 7:00am and 10:00am—can detect the condition. If your morning level of cortisol is abnormally low, you'll need an ACTH stimulation test to determine if the suppression is due to the drug interaction or some other problem.

If it turns out to be the drug interaction, then ideally you should use the lowest dose of the least powerful medication—recognizing that if you have asthma, you usually require a steroid medication to control your condition; you'll require close follow-up with a family doctor or lung specialist. If you can't lower the dosage of the corticosteroid, then you should explore HIV regimens that don't require ritonavir. If you must use both drugs for medical reasons, then you should probably get the ACTH stimulation test done every few months to ensure that your adrenals aren't being affected.

You may need to be referred to an endocrinologist. If you have symptoms of adrenal insufficiency, you may require oral supplementation with hydrocortisone for a brief period until your body begins to make its own hormone again. ☺

Mark Hull is a specialist in infectious diseases at St. Paul's Hospital in Vancouver, currently completing the Canadian HIV Clinical Trials Network Postdoctoral Fellowship at the BC Centre for Excellence in HIV/AIDS.



Updates from the Canadian HIV Trials Network



Researchers seek answers to HIV/HCV co-infection

by Jennifer Chung

Why does liver disease progress more rapidly in people infected with HIV despite the use of highly active antiretroviral therapy (HAART)? Canadian HIV Trials Network (CTN) investigator Dr. Marina Klein of the Montreal Chest Institute hopes to answer this complex question as she leads a new observational study examining the effect of HAART on liver disease progression in HIV/hepatitis C (HCV) co-infection.

According to Klein, liver disease is becoming one of the major complications of HIV infection. Therefore, a study like hers will not only help researchers better understand this condition, but could also improve the lives of co-infected people.

The study will follow 950 participants at sites across the country over five years. Klein says a long-term study involving such a large number of participants will allow researchers to make better recommendations on the prevention, diagnosis, and treatment of HCV, as well as develop services that meet the particular health needs of co-infected people.

“Our current treatments for hepatitis C are quite limited because of their toxicity and degree of effectiveness,” says Klein. “With the large number of people involved in the study, we might be able to determine whether there is a preferable regimen of antiretroviral therapy, and who we need to target for early hepatitis C treatment to prevent liver disease.”

While liver disease progression is partly due to immune dysfunction from HIV infection, it's unclear why it doesn't improve with HAART, unlike other opportunistic infections.

By following participants co-infected with HCV over several years, Klein says her study will provide researchers with needed information on rates of liver disease according to type and duration of HAART regimen. Her team will also study the role of other factors that may contribute to liver disease progression, like alcohol and drug use and rates of chronic toxicities related to HAART.

The study is currently enrolling participants at 10 centres, including the Downtown Infectious Diseases Clinic in Vancouver. People who access services such as specialty clinics and outreach programs will be recruited for the study. As well, at-risk individuals, including active and former drug users, women, Aboriginal people, and hemophiliacs will be sought out to reflect the demographic of the epidemic in the country.

Researchers have received very positive responses from participants who feel they're contributing to a project that advances the knowledge of HIV/HCV co-infection.

“The community that's co-infected is very concerned about liver disease. They have seen friends who have died from this illness, so they want answers on how best to treat it,” says Klein. “This type of work can help move the field forward in terms of access and effectiveness of treatment.” ☺



Jennifer Chung is the information and communications coordinator at the Canadian HIV Trials Network in Vancouver.

Trials enrolling in BC

CTN 147 — Early Versus Delayed Pneumococcal Vaccination
BC sites: Downtown Infectious Disease Clinic (DIDC) and St. Paul's Hospital, Vancouver; Medical Arts Health Research Group, Kelowna General Hospital

CTN 194 — Peg-Interferon and Citalopram in Co-infection (PICCO)
BC sites: DIDC, Vancouver

CTN 205 — Valproic Acid and HIV
BC sites: St. Paul's Hospital, Vancouver

CTN 214 — Effect of a One-Year Course of HAART in Acute/Early HIV
BC sites: DIDC, Vancouver; Cool Aid Community Health Centre, Victoria

CTN 221 — NGX-4010 for the Treatment of Painful HIV-Associated Neuropathy
BC sites: DIDC, Vancouver

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

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Drop in and...

- o Join as a member or volunteer
- o Register for & attend information workshops or support groups
- o Collect Complementary Health Fund forms or cheques
- o Speak with an HIV treatment information counsellor
- o Access advocacy services for financial, medical, or housing issues
- o And much, much, more

**THE BCPWA LOUNGE
IS NOT OPEN
FOR EVENING
DROP-INS**

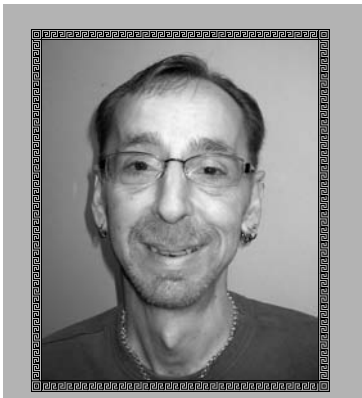


**British Columbia
Persons With AIDS Society**

Volunteering at BCPWA

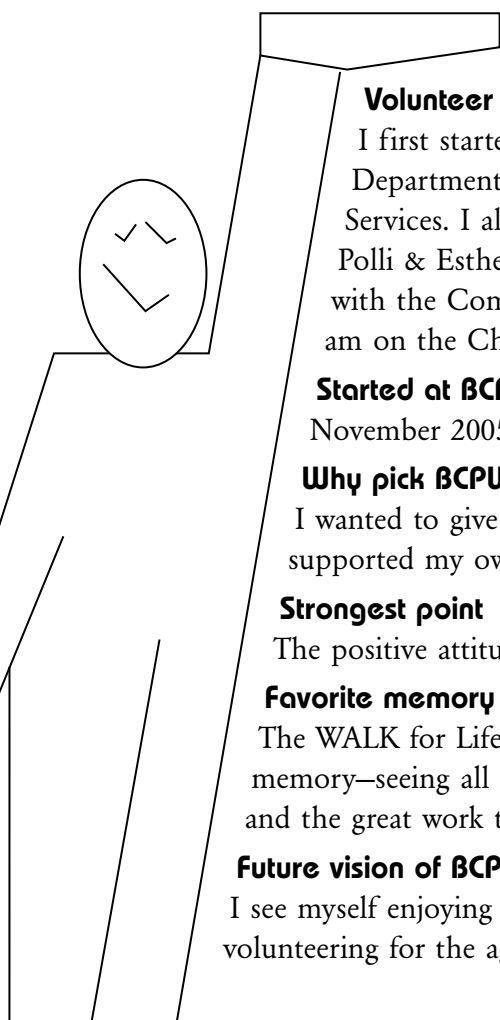
Profile of a volunteer:

Richard Theriault



Richard is a warm, open, eager young man who demonstrates his caring for the community while volunteering at BCPWA. When someone was needed to staff the reception in the evenings during our pilot project, Richard jumped in and, without complaint, has been on deck every evening shift. We can always count on Richard.

Jackie Haywood,
Director of Support Services



Volunteer history

I first started in the Communications Department, then moved to Member Services. I also worked in the Lounge and Polli & Esther's Closet. I am now working with the Complementary Health Fund and am on the Christmas Committee.

Started at BCPWA

November 2005

Why pick BCPWA?

I wanted to give to an agency that has supported my own needs.

Strongest point

The positive attitude of staff and volunteers.

Favorite memory

The WALK for Life would have to be my favourite memory—seeing all the people that supported it and the great work that was done.

Future vision of BCPWA?

I see myself enjoying more wonderful years volunteering for the agency.

Polli & Esther's Closet

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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@drpetercentre.ca
www.drpetercentre.ca

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.ca
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 1.866.877.0042
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 f 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
July 4, 2007	4:30	Board Room	Written Executive Director Report / Director of Support
July 18, 2007	4:30	Board Room	Executive Committee / Director of Development
August 1, 2007	4:30	Board Room	Quarterly Department Reports / Written Executive Director Report Standing Committees / Financial Statements — June
August 15, 2007	4:30	Board Room	Director of Prevention
August 29, 2007	4:30	Board Room	Written Executive Director Report / Executive Committee
September 12, 2007	4:30	Board Room	Standing Committees / Financial Statements — July & August
September 26, 2007	4:30	Board Room	Written Executive Director Report

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: Adriaan de Vries
t 604.893.2298 **e** adriaand@bcpwa.org

Community Representation & Engagement

Contact: Marc Seguin
t 604.646.5309 **e** marcs@bcpwa.org

Education & Communications

Contact: Melissa Davis
t 604.893.2209 **e** melissad@bcpwa.org

IT Committee

Contact: Marie Cambon
t 604.893.2280 **e** mariec@bcpwa.org

living+ Magazine

Contact: Jeff Rotin
t 604.893.2206 **e** jeffr@bcpwa.org

Prevention

Contact: Elgin Lim
t 604.893.2225 **e** elgin@bcpwa.org

Support Services

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

Treatment Information & Advocacy

Contact: Jane Talbot
t 604.893.2284 **e** janet@bcpwa.org

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 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

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living+

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 Vancouver BC
 Canada V6B 5S8

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

Last Blast

Dazed and confused

Had I lost my mind or was it my medication?

by Denise Becker

When I was young, my mind was like a steel trap. I could play the pairs card game and remember where each pair lay on the floor. I aced it every time. In my teens, I took up bridge and won a local tournament.

I became a human resources assistant at an accounting firm and had to remember the names of 250 people, with 30 new students every year. Piece of cake. When I stopped people in the street, I always knew their names and was smugly pleased when they had a hard time remembering mine (although, on reflection, maybe that wasn't such a good thing).

So I was amazed—and alarmed—when my steel trap got rusty and started to come ajar.

I guess I became aware that things were not quite stainless when I started missing appointments. Doctors' offices left messages on my phone, wondering where I was. My friends felt jilted when I stood them up one too many times or I didn't return their calls.

I put it down to absentmindedness and made sure that I not only wrote things down on the calendar but I also invested in a palm pilot. Problem solved—or so I thought. I proudly arrived at my doctor's office and said, "There! The power of the palm pilot. I'm 15 minutes early."

The receptionist looked at me with a sad look. "Yes, Denise, but your appointment's tomorrow."

Obviously, I needed a backup. So I purchased a desk diary and a daily card index, and started taking four Ginkgo biloba supplements a day. To no avail: I'd arrive home to find the light flashing frantically on my answering machine; I was still missing dates and appointments.

"Maybe it's menopause," a good friend suggested.

Aaah! No, no, no! But what if he's right, I thought. I had been getting night sweats: were they actually hot flashes?

A few weeks later, events took an even more worrisome turn. I left the pan on the stove and it boiled dry. I threw it out before my husband Lloyd could notice—he was already

telling me I needed to see a doctor. If only he knew how many times I had tried! Then one time I left the tap on in the kitchen. I was downstairs, talking to my dog, when I heard running water.

"Hmmm," I wondered, "who left a tap running?" Luckily, the water hadn't made it to the top of the sink by the time I reached the kitchen.

I started to think of possible physical causes. And I did the one thing you're told never to do: I did a Google search. By the end of the day I was convinced I had either a brain tumour or

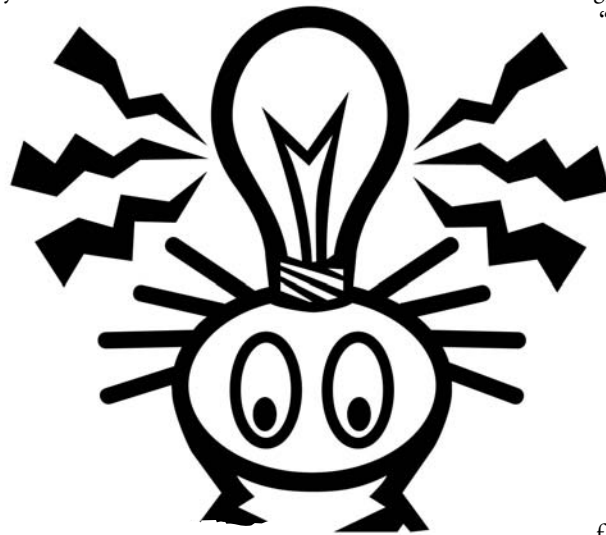
Alzheimer's. Then I noticed HIV was mentioned as a possible cause. Of course! It had to be my meds, or the virus, or both. The virus had probably finally crossed the blood-brain barrier (make note in all five diaries: remember to Google "blood-brain barrier").

I was in information overload. Bells were ringing in my head. Was I really going nuts? Was I going to wake up tomorrow and forget I had bills to pay? Or had that already happened?

I was starting to feel dizzy, mentally and physically. The dizziness got worse, until I eventually fell to the floor with a severe attack of vertigo. I was sicker than a dog and sweat was pouring off me.

I finally visited my doctor and he diagnosed Meniere's disease, a chronic inner ear problem that can cause "brain fog." It can affect people with autoimmune disorders more than others.

Sure, it can be debilitating and a terrible burden. Believe me, it's no picnic. But I was just so happy that I didn't have something that could kill me. ☺



Denise Becker is a board member of the Canadian HIV/AIDS Legal Network and the founder of the Hummingbird Kids Society. She lives in Kelowna.

