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CORRECTION: In the July/August issue of *living*⊕ magazine, the face images in the cover design were photographed by Jane Talbot.

living⊕ is published by the British Columbia Persons With AIDS Society. This publication may report on experimental and alternative therapies, but the Society does not recommend any particular therapy. Opinions expressed are those of the individual authors and not necessarily those of the Society.

British Columbia Persons With AIDS Society

The British Columbia Persons With AIDS Society seeks to empower persons living with HIV disease and AIDS through mutual support and collective action. The Society has over 4400 HIV+ members.

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British Columbia

think⊕

opinion & editorial . . .

Our 50th issue

by Wayne Campbell

The planning and production of the 50th issue of *living*⊕ gave our editorial board the chance to look back—and ahead—at BCPWA's bi-monthly magazine.

The roots of *living*⊕ can be traced back to one of BCPWA's earliest resources. To publicize emerging support groups, events, advocacy issues, and treatment information, our first newsletter was printed in October 1986. Ten years later, with the release of protease inhibitors, the volume of information created a demand for a separate publication devoted exclusively to HIV treatments. *BCPWA News* and *TIP News* were produced in alternating months until it was decided to consolidate the two into a single bi-monthly magazine. The first issue of *living*⊕ was published in July 1999.

And the rest, as they say, is history.

History reminds us of the pioneering voices behind the magazine—contributors like Chester Myers, Tom Mountford, and Michael Linhart—who exemplified BCPWA's self-empowerment model in their writings about HIV treatments and public policy issues. Although, sadly, they are no longer with us, the spirit of a consumer-driven magazine has endured.

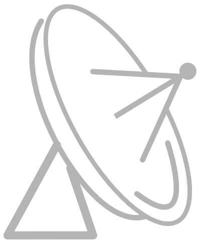
Living⊕ has been a critical tool in BCPWA's mission to foster PWA empowerment. More than 50 percent of the publication's content is contributed by HIV-positive writers. The magazine provides members with current information on prevention, treatment, clinical trials, complementary and alternative therapies, nutrition, and all aspects of disease management. And feature stories have covered local, regional, and global issues, from HIV in Vancouver's Downtown Eastside, to rural BC, to sub-Saharan Africa.

Over the years, the magazine has gained recognition and respect from throughout the AIDS community—HIV-positive readers, researchers, clinicians, traditional and alternative health practitioners, and activists. We've operated on a shoestring budget, with a part-time managing editor and art director coordinating content and design. Overall, though, it remains a volunteer effort: the editorial board generates story ideas, while our team of volunteer writers, editors, and proofreaders produce a publication of exceptional quality.

It is also said that the more things change, the more they stay the same. In reviewing early issues of *living*⊕, it became apparent that the political battles of that time are still being waged today. BCPWA remains grossly under-funded relative to increasing rates of HIV infection. And we're still battling the same social conditions that exacerbate stigma for people living with HIV: homophobia, sexism, poverty, and addictions.

As the editorial board envisions the future of the magazine, we are committed to producing content that reflects the changing face of the epidemic. We recognize that experiences of those newly diagnosed are very different from those diagnosed over 20 years ago. ⊕

Wayne Campbell *is the past secretary of BCPWA's board of diretors and the chair of the* living⊕ *editorial board.*



REALITYBITES

News from home & around the world

New BCPWA Board

On August 18, BCPWA members elected seven Directors at the Annual General Meeting:

John Bishop (two-year term)
Damien Callicott (two-year term)
Sandy Lambert (two-year term)
Brian McDonald (two-year term)
Keith Morris (one-year term)
Richard Theriault (two-year term)
Glyn Townson (two-year term)

The following Board Members, elected in 2006, are continuing the second year of a two-year term:

Ken Buchanan
Paul Lewand
Malsah
Neil Self

BCPWA back to regular hours

After nine months, BCPWA's pilot project in extended hours has ended. Between October 1, 2006 and June 30, 2007, BCPWA was open every Tuesday and Thursday evening until 9:00 PM, offering a variety of programs and services. While there was definite interest in evening workshops offered by various departments, drop-in services during the extended hours didn't attract members.

A survey of Lower Mainland members ultimately revealed that most simply weren't interested in drop-in services in the evening. Rather than continue to sustain the added expense involved in staying open later, BCPWA decided to end the extended hours.

BCPWA is once again open to members on a drop-in basis between 10:00 AM and 4:00 PM, Monday through Friday. The Body Positive and NA support groups will continue to meet on Wednesday night and Thursday night, respectively. And we will offer more evening workshops in the future.

Warning for HIV/HBV coinfected patients

The anti-hepatitis B drug entecavir (Baraclude) should not be prescribed to HIV-positive individuals unless they're taking potent anti-HIV therapy, the US Food and Drug Administration and Bristol-Myers Squibb (BMS), the maker of the drug, are warning.

BMS issued a letter to healthcare professionals warning that the use of entecavir by HIV-infected individuals who are not taking antiretroviral therapy could lead to the development of strains of HIV with resistance to drugs from the nucleoside reverse transcriptase inhibitor class.

Data presented to a conference earlier this year indicated that entecavir had enough anti-HIV activity to generate resistance in patients who were not taking effective anti-HIV therapy.

Source: www.aidsmap.com

Pharmas support generic drugs for Africa

GlaxoSmithKline (GSK) and Shire BioChem Inc. both recently announced that they will support Canada's Access to Medicines Regime to enable a Canadian company, Apotex, to manufacture generic antiretroviral medicines over which GSK and Shire hold patent rights. The medicines are to be provided at cost and used for the treatment of HIV infection in Rwanda.

Canada's Access to Medicines Regime is based on an August 2003 World Trade Organization (WTO) agreement that permits WTO member countries with pharmaceutical manufacturing capacity to authorize the manufacture and export of generic versions of patented drugs and medical devices to developing countries that do not have the capacity to manufacture the products themselves. Both GSK and Shire have agreed to waive any royalties.

Trial to compare Viramune vs. Reyataz

Boehringer Ingelheim has initiated and begun enrollment of patients in the ArTEN trial, which will compare the efficacy and safety of nevirapine (Viramune), a non-nucleoside reverse transcriptase inhibitor dosed once daily or twice daily, versus atazanavir/ritonavir (Reyataz), a once-daily dosed protease inhibitor. Both agents will be combined with a background regimen including tenofovir and emtricitabine (Truvada).

The ArTEN trial will enroll 561 HIV-positive patients, who have not been treated with antiretrovirals before, in 83 sites across Argentina, Germany, Italy, Mexico, Poland, Portugal, Romania, Spain, Switzerland, and the United Kingdom.

ArTEN may help to provide more information on selecting treatment options for first-line therapy in HIV-positive patients. It aims to help patients and physicians better understand the role of Viramune within today's treatment strategies. Trial results will be available in 2009.

Injection drug use in India could fuel spread of HIV

Injection drug use in India might be more widespread than previously thought, which some health experts and advocates say could fuel the spread of HIV in the country, according to a UNAIDS-supported survey recently released by the Society for Promotion of Youth and Masses.

The survey found that 60 percent of 3,300 injection drug users (IDUs) in 10 cities and towns in the northern Indian states of Punjab and Haryana shared needles and syringes.

continued on next page

REALITYBITES

News from home & around the world

According to official estimates, there are approximately 200,000 IDUs in India, although advocates say the number likely is higher. About 2.2 percent of all HIV cases in the country are transmitted through injection drug use, according to the National AIDS Control Organization. According to Denis Broun, head of UNAIDS in India, the figure likely is higher than 2.2 percent.

Broun added that many IDUs are married or visit commercial sex workers, which increases the risk of HIV transmission for their partners.

Source: kaisernetwork.org

Victoria wants safe injection sites

Victoria will request federal permission to set up a safe injection site—similar to the one operating in Vancouver—in order to tackle the city's growing drug-addiction problem.

A call for safe injection sites in the city is among the recommendations in a report released in June by the Centre for Addictions Research of B.C. The report estimates that there are as many as 2,000 injection drug users in Victoria—many of them in urgent need of help.

Victoria Mayor Alan Lowe said the city wants as many as three injection sites in a three-year pilot project. "I think that what Vancouver has is a different model than what Victoria is looking for and hopefully, we could use Victoria as a different pilot model for looking at a decentralized model," he said.

Source: CBC

New infection symptoms affect speed to AIDS

The sicker people are after becoming infected with HIV, the faster they'll progress to AIDS, new research confirms in the August 1 issue of the *Journal of Acquired Immune Deficiency Syndromes.* According to the report, the number of symptoms experienced during primary HIV infection can mean a higher viral load set point—a well-established marker of more rapid disease progression.

photo by John Kozachenko

On June 19, BCPWA Board members and staff joined others on the steps of the Vancouver Art Gallery to protest the lack of affordable housing in Vancouver. The event was organized by the Citywide Housing Coalition.

The University of California, San Francisco (UCSF) study involved 177 newly infected people. The volunteers reported their symptoms, including fatigue, fever, night sweats, and rash. The researchers found that each additional symptom was associated with a higher HIV spike after infection, which was predictive of the more stable viral load that is maintained for months or years if treatment is not started.

The researchers note that the small study involved mostly gay men. They do say, however, that these results mirror those of a more diverse group of patients.

Source: www.poz.com

Enzyme found that deteriorates HIV

Scientists have found a way to remove HIV from infected cells after German researchers engineered an enzyme that attacks the virus's DNA, then cuts it out of the affected cell. The enzyme is still in its early development stages, according to *Fortune* magazine, and not yet usable for treatment.

According to study data, it took three months for the enzyme, called Tre, to eliminate the virus from the infected cells.

"Numerous attempts have been made to activate these cells, with the hope that such strategies would sensitize the accompanying viruses to antiviral drugs, leading to virus eradication," Alan Engelman wrote in *Science* magazine about the findings. "Advances with such approaches in patients have been slow to materialize."

While there are still significant roadblocks ahead in developing the enzyme—safe delivery, administering the drug with low side effects—researchers are optimistic that Tre and other enzymes could be used to target various parts of HIV's DNA, eventually killing the virus. ⊕

Source: The Advocate

The Tanzania diaries, part 3

Learning lessons from the locals and their love of family, community, and life

by Jane Talbot

I could write every day for a year about my experiences in Tanzania and still have more to say. I could write about the stench of abject poverty or about the various dangers of Arusha and how 6:00pm was curfew because afterward it wasn't safe to be outside. I could fill pages on the orphan crisis and the fact that by 2010, Tanzania will be home to 4.2 million children who have lost one or both parents to AIDS; on the 33,000 Tanzanian babies who are born HIV-positive every year or who sero-convert during their first year of life; or on the pure injustice of it all. But doing so would inevitably perpetuate the myth that Africa is little more than poverty, despair, sickness, and death.

To me, Tanzania has become less about AIDS and more about the people and their love of family, community, and life. Once accepted into an African family, you join the entire community and people think nothing of making your life their business.

I still laugh at the memory of my first conversation with the father of the house where I was living. He started a somewhat paternal grilling that went something like this:

"Are you married?"

"I was, but I'm not anymore."

"Did he die?"

"No."

"Do you have children?"

"No."

"Who takes care of your home?"

"Me."

"You don't have a house girl?"

" No, I have a cat."

"Who drives you around?"

"I drive myself around."

"You drive?"

"Yes."

"What do you drive?"

"A truck."

"No!"

"Yes."

And so forth. I'm not sure if it was the fact that I visit prisons as part of my job or if it was the idea of a woman running a large department, but it became increasingly clear that he wasn't at all impressed with my lifestyle. Still, in spite of the fact that I was a prison visiting, truck driving divorcee with no children, a cat, and few cooking skills, I was accepted into his home and his community.

Once accepted, I became a project for my family. They made it their mission to fatten me up. After a few days of banana stew, fried spaghetti, and "special for Janie" french fries, I was in desperate need of exercise. One day my friend and I decided to go for a run, and while we knew Tanzanians had little concept of exercise for pleasure, we had no idea how foreign a concept it was.

> **To me, Tanzania has become less about AIDS and more about the people and their love of family, community, and life.**

Within moments of setting out, people were pointing at us, laughing, shaking their heads, and whispering to the people next to them. A couple of nurses laughed so hard they were slapping their legs and stomping their feet. At one point a young man on a bike rode up and said, "*Mazungus*, (white people) I call you Taxi?" Another yelled from his home, "Mazungus, you need me to call police?"

Tanzanians not only want to help you, they also want to understand and empathize with you. My heart will forever be touched by a 14-year-old girl whose parents had both died of AIDS. Wise and sensitive beyond her years, she engaged me in conversation by asking, "What is your tribe?" When I replied that I had no tribe, she softly touched my hand and asked, "Are you an orphan?" She genuinely cared about a perfect stranger.

Yes, Africa has poverty, sickness, and various degrees of instability, but on a much grander scale there is life, pure and pulsating, unabashed and unapologetic for feeling, expressing, and sharing the wealth of extremes that is their reality.

The Africans were no more equipped to fully comprehend my life in Canada than I was theirs in Arusha. I know they didn't envy my life, yet in a way that I may never be able to explain, I found myself envying theirs. ⊕

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

Give and take

If you're on welfare and don't report additional income, you could be charged with fraud

by Suzan K. and Taz Fletcher

Have you ever worked and not reported your income to welfare? Has a relative or friend given you money and you did not report it? Did you forget to report GST or fuel tax rebates to welfare?

If you answered yes to any of these questions, welfare could investigate you, your bank accounts, and tax returns for fraud.

When you sign the intake papers to receive welfare, you are agreeing to declare all monies that you make or receive, and all changes to residence and employment. When you don't, under the law, you may be committing fraud. People can—and are—being sanctioned for not declaring money received or changes in their residence/martial status. (See table 1 for details.) Sanctions include having a monthly amount taken off your cheque to repay the total amount not accounted for; receiving a three months' suspension, meaning you don't receive a welfare cheque for three months; or being banned from receiving assistance/welfare for the rest of your life.

Tips

You can't leave BC for more than 30 days in a year without informing welfare.

If you're being investigated, you need to contact an advocate, because immediate action is needed to appeal the decision to a tribunal. If you are granted a hearing, you can ask for an appeal benefit, which allows you to receive payments until your appeal is heard. If you are denied a tribunal before your next welfare cheque, you won't receive any money. If the tribunal decides that the Ministry was correct to cut you off, you will be cut off immediately.

What then? The first and most obvious suggestion is to return to the workplace, if possible, in hopes of receiving some Canada Pension Plan Disability Income later on.

Moving to another province and applying for assistance is an option, but eligibility requirements differ between provinces, so you or your advocate will want to research these issues before you move.

Other options include either filing a court challenge or a BC human rights discrimination suit, but both these options take months, sometimes years, and welfare won't provide assistance while you wait to go to court.

The best option is to follow the rules and not put yourself in a position to be sanctioned. This can be difficult, since the rules are often confusing, plus keeping track of your accounts can be difficult when you're dealing with illness or disabilities. If you're confused by the rules, contact a BCPWA advocate who can help develop a plan to keep you on track. ⊕

Suzan K. *is an individual advocate at BCPWA.*
Taz Fletcher *is a volunteer with BCPWA's advocacy department.*

Table 1: What income you can keep, what you can't keep

EARNED INCOME	UNEARNED INCOME	EXEMPT MONEY
Must report and don't get to keep	Must report and don't get to keep	Must report, but will get to keep
▸ Earnings from work over $500	▸ CPP benefits	▸ First $500 earned from work
▸ Pension plan refunds	▸ Lottery winnings	▸ GST rebates
▸ Income from babysitting	▸ Employment Insurance	▸ BC sales tax rebates
▸ Money for your birthday	▸ Long-term disability insurance	▸ Tainted blood payments
	▸ Financial assistance from another province	▸ Fuel tax rebates
	▸ Workers' Compensation Board benefits	▸ Family bonus
	▸ RRSP interest or payout	▸ At-Home Program payments
	▸ Rental income	▸ Rent subsidies
	▸ Training allowance	▸ Foster child payments
	▸ Insurance benefits (except from a destroyed asset like a home fire)	▸ Disability
		▸ Trust monies, up to $5,484 yearly
		▸ Money from a loan
		▸ Up to $50 a month of Veterans Affairs benefits
		▸ Criminal injury compensation

Persistent pest

Town hall meeting addresses Vancouver's continuing bedbug problem

by Melissa Davis

Over 80 Lower Mainland residents—including members of citizens groups, housing and healthcare organizations, and business representatives—packed a meeting room at the Vancouver Public Library on June 25 to learn more about the city's bedbug crisis, including practical strategies geared towards prevention and control. The free event, coordinated by BCPWA and moderated by MLA Vancouver-Burrard Lorne Mayencourt, brought together experts in the areas of environmental health, pest control, housing, health care, and community development, and concluded with an hour-long question and answer period.

"More than 100 inquiries have been received by our advocacy office—both phone calls and drop-ins—over the past year from HIV-infected members seeking information and support about bedbug infestations," said BCPWA vice-chair Glyn Townson in post-event discussions with the media.

Shelley Beaudet, senior environmental health officer with Vancouver Coastal Health, was the keynote speaker. She outlined the scope and severity of the problem in Vancouver, the key contributing factors that are exacerbating the problem, basic bedbug biology, as well as recommendations for prevention and control. While Beaudet claimed that bedbug infestations pose no public health risk, she admitted that the nuisance factor had increased in severity. She reviewed some recent efforts undertaken by Vancouver Coastal Health to minimize the problem.

The first panelist was Sean Rollo, quality assurance manager and technical advisor with Orkin Pest Control, who offered tips to reduce the risk of introducing bedbugs into homes and minimize their spread once they're in homes.

Then there was a discussion by Anne O'Neil, Bedbug Project manager with the Vancouver Area Network of Drug Users in Vancouver's Downtown East Side. O'Neil identified practical and community strategies for dealing with bedbugs. She stated that the most effective technique to combat the problem is collaboration. "I have found that the most important factor in getting bedbugs under control is ensuring cooperation between tenants, landlords, pest control services, and the agencies who coordinate funding to treat the bedbug problem," she said.

Dr. Rolando Barrios, assistant medical director at both St. Paul's Hospital's Immunodeficiency Clinic and the BC Centre for Excellence in HIV/AIDS, offered a healthcare perspective on the subject of bedbugs. Although blood-feeding parasites such as bedbugs have never been implicated in the spread of diseases to humans, he explained, they can cause a range of reactions, of varying severity, in humans. Bites from bedbugs can mimic bites from a variety of other insects, he said. Skin reactions are commonly associated with bedbugs, which result from the saliva injected during feeding. Some individuals don't react to these bites, while others react with a great deal of discomfort. Allergic reactions can also range from large welts with itching and inflammation, to more severe reactions, including anaphylaxis.

Panel presentations concluded with Martha Lewis, executive director of the Tenant Resource and Advisory Centre, who reviewed the legal rights and responsibilities of landlords and tenants for dealing with bedbugs. Lewis made an urgent plea for governments to assume greater responsibility for the growing problem, claiming that the issue must be recognized as a public health matter. ⊕

__Melissa Davis__ is the former acting director of communications and education at BCPWA.

Creating positive spaces

The future looks rosy for three new PWA resource lounges in the Fraser Health Region

by Edoye Porbeni

As the BCPWA lounge has demonstrated, drop-in lounges are a great way to provide safe environments for PWAs, where they can access peer support and connect to community services. The problem was, there were no lounges outside of downtown Vancouver. Until now.

Positive Spaces

Positive Haven
(Surrey)
t 604.588.9004
e hivaidscentre@surreyhealth.bc.ca
www.surreyhealth.bc.ca

The Comfort Zone
(New Westminster)
t 604.526.2522
e purposeaids@pacificcoast.net
www.purposesociety.org

The Lighthouse Centre
(Abbotsford)
t 604.556.6228
e hivaids@mccbc.com

Through funding by the Public Health Agency of Canada for an initiative entitled "Positive Spaces: Peers Creating Supportive Environments in the Fraser Health Region," the Fraser Health Region piloted three new resource lounges—places where PWAs living in the region can access services without having to travel downtown.

The lounges, located in Abbotsford, North Surrey, and New Westminster, were established through a collaborative effort of about a dozen stakeholders across the Lower Mainland—including community-based groups, public health agencies, and BCPWA—with the Lower Mainland Purpose Society for Youth and Families taking the lead.

In Abbotsford and Surrey, the agencies responsible for the lounges are the Positive Living Fraser Valley Society and the Surrey HIV/AIDS Centre Society, respectively. In New Westminster, the Lower Mainland Purpose Society runs the lounge.

Based on the model of BCPWA's lounge, the Fraser Region lounges offer services such as access to food, banking, volunteer opportunities, support groups, access to alternative therapies, social activities, and informational resources. Services differ from lounge to lounge.

The Positive Spaces project featured a marketing plan to spread the word about the new lounges, culminating in grand opening events on December 1 last year—World AIDS Day—for all three locations. Community and media involvement was strong and very encouraging, especially in Abbotsford.

The goal of the pilot project was to create sustainable lounges, and although funding for the project ended in March 2007, all three lounges are still operational. Each lounge was created in donated space and designed to be volunteer-run. While the lounges are only a few months old, current attendance is meeting projections, in accordance with the PWA statistics for the area.

According to the BC Centre for Disease Control, between 1997 and 2004, 916 people tested HIV-positive in the Fraser Heath Region. Fraser North sub-region—which includes Burnaby, New Westminster, Tri-cities, Anmore, Belcarra, Pitt Meadows, and Maple Ridge—accounted for approximately 50 percent of reported cases in the entire region. The Fraser South sub-region (Surrey, Tsawwassen, Delta, White Rock, Cloverdale, Langley, and Aldergrove) accounted for approximately 36 percent of reported cases, while the Fraser East sub-region (Abbotsford, Mission, Chilliwack, Hope, Harrison Hot Springs, Agassiz, and Boston Bar) accounted for 14 percent of reported cases.

Attendance statistics are expected to rise over time, as PWAs in the region learn about the lounges and feel comfortable accessing services in their communities.

The future of all lounges is bright, as all three hosting agencies are dedicated to continuing to provide this service to PWAs in the Fraser Health Region. ⊕

__Edoye Porbeni__ is a corporate and community team coach for BCPWA's 2007 AIDS WALK for Life.

Are you losing your marbles?

Dementia could be the effects of HIV or it could simply be the aging process

by Dr. Diane Fredrikson and Wallace Robinson

Of all HIV-associated illnesses, dementia may be the one that strikes most fear in the minds of people living with HIV. The fear of losing our ability to think, remember, or care for ourselves is universal, regardless of HIV status. Add to that concern the memory of so many people stricken with AIDS-related dementia in the early years of the epidemic, and many PWAs might feel doubly jeopardized.

But is this concern justified in the era of highly active antiretroviral therapy (HAART)? What's the impact of this worrying itself? What are the effects of HIV on the brain, and how can one distinguish between those effects and normal memory changes associated with aging? Finally, is dementia inevitable or is there something you can do to prevent it?

continued on next page

HIV affects the immune system and the brain

The fact is that HIV does affect the brain. The virus enters the brain within the first few weeks of infection, by infecting circulating immune cells and subsequently crossing the blood-brain barrier. Researchers are still studying exact pathological mechanisms, but they believe that the virus then infects glial cells (supporting brain cells), ultimately creating neurotoxins and inflammation that damage surrounding neurons. This can result in dysfunction in a variety of brain pathways. Consequently, a number of different symptoms can develop, including changes in cognition (memory and thinking), mood, perception, sleep, and movement. Remember, the brain is the master control system of the whole body.

Although HIV enters the brain in the natural course of infection, not everyone with HIV will go on to develop serious cognitive problems. The reasons for this aren't well understood, reflecting the complexities of brain/virus interaction. There may be genetic factors that make some people more vulnerable to developing dementia—including that associated with HIV—but this is still under investigation.

> **Although HIV enters the brain in the natural course of infection, not everyone with HIV will go on to develop serious cognitive problems.**

The development of highly active antiretroviral treatment (HAART) has significantly decreased the incidence of HIV-associated dementia (HAD), and can sometimes improve existing symptoms. More commonly, people with HIV may develop subtler cognitive deficits. This may be in the form of HIV-associated minor cognitive and motor disorder, or more general impairment of executive functioning (complex higher-order cognitive functions involved in planning, problem-solving, abstract thinking, coordination of working memory and attention, and adaptation to changing environments). Interestingly, viral load is not necessarily a good indicator of brain viral burden.

Normal memory changes versus illness related changes

While HIV can affect the brain, age can also bring unwelcome changes to the body, including to brain functioning. However, if you or others have noticed changes in your memory or thinking, it's worthwhile discussing it with your doctor rather than assuming these are just a reflection of getting older. You may find that you're becoming more forgetful, having difficulty focusing, having more troubles problem-solving, finding it hard to multi-task, or feeling mentally slowed.

The definition of HIV-associated minor cognitive and motor disorder

1. Acquired cognitive, motor, or behavioural abnormalities, meeting both A and B criteria:

- **A**. At least two of the following, present for at least one month:
  - impaired attention/concentration
  - mental slowing
  - impaired memory
  - slowed movements
  - uncoordination
  - personality change, irritability, or emotional lability (change instability)
- **B**. Objective confirmation of impairments by clinical neurological examination and/or neuropsychological testing

2. Mild impairment of work performance or activities of daily living

3. Does not meet criteria for HIV-associated dementia

4. Absence of another etiology to explain impairments

Depending on your overall health and HIV status, your doctor may want to rule out serious immunodeficiency-associated conditions, including opportunistic infections like toxoplasmosis, progressive multifocal leukoencephalopathy (PML), malignancies (e.g., non-Hodgkins lymphoma), and metabolic abnormalities. In addition, your doctor will need to evaluate other medical illnesses that can cause or contribute to cognitive dysfunction, such as cardiovascular disease, diabetes, and hepatitis C co-infection.

Motor impairment, such as clumsiness or walking problems, can also result from HIV-related brain changes, and will also need to be assessed.

Psychiatric conditions—such as clinical depression, bipolar-spectrum illness, and anxiety—are also very important to identify and treat, as most have associated cognitive effects. Psychosocial and lifestyle factors may also be at play. Common issues include sleep disruption, relationship tensions, fragmented social support, financial or employment stressors, and substance use. Bear in mind that if you already have cognitive dysfunction—irrespective of the cause—then you'll likely be more sensitive to the effects of stressors in your life.

Sudden onset of confusion may reflect a serious medical problem, and should be assessed by a doctor immediately.

It is very helpful to provide your doctor with specific examples of any changes that you or others are noticing. If possible, have your partner or trusted friend/family member accompany you to provide further information. Remember that cognitive impairment is often associated with changes in mood, and the underlying neuronal dysfunction can also exacerbate any pre-existing psychiatric condition or personality traits. Therefore, monitor for emotional or personality changes.

Your doctor may refer you to a neurologist or psychiatrist for further evaluation. Neuropsychological testing may also be helpful, but isn't easily accessible unless you're able to pay privately or have private healthcare coverage.

The definition of HIV-associated dementia

1. Acquired cognitive abnormality in two or more of the following, present for at least one month, and causing impairment in work performance or activities of daily living:
   - Attention/concentration
   - Speed of information processing
   - Abstraction/reasoning
   - Visuospatial skills
   - Memory of learning
   - Speech/language
2. At least one of:
   - Acquired abnormality in motor functioning
   - Decline in motivation or emotional control or change in social behaviour
3. Absence of clouding of consciousness
4. Absence of another etiology to explain impairments

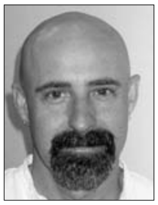
Adapted from the Working Group of the American Academy of Neurology AIDS Task Force.

Dementia prevention

HIV-associated dementia, which used to be known in the community as AIDS dementia and seemed so common and scary in the 1980s and early '90s, is a disease more closely associated with advanced or untreated HIV/AIDS. As mentioned, there are other health problems that have the potential to affect brain functioning as people living with HIV/AIDS become older and enter their senior years. The good news is that age related memory and thinking problems for people living with HIV don't seem to be that different from those of the general population, and there are things you can do to maximize the functioning of your brain:

- Use it or lose it. This is cliché, yet perhaps the simplest and most important advice that applies to everyone. Many studies show that challenging the brain to think in new patterns by learning new things, doing puzzles of various kinds, playing games that challenging thinking, reading, writing, help to develop or maintain your brain's power. Conversely, watching too much television has been shown to diminish intelligence over time, so keep the soap opera viewing to a minimum!
- Develop or maintain strong social support networks. In other words, friends, a companion or partner, acquaintances, and family (even though sometimes a lot of work!) can provide a sense of well-being. Studies have shown that this sense of well-being and connectedness with others is a factor in good mental health, while people who are isolated seem to be at higher risk for dementia or other memory loss. There are simple ways to increase your support network: join an organization or group; be more deliberate about calling your friends; invite people over; and look for opportunities to go out.
- Practice mindfulness. This is another way of keeping the mind active and, at the same time, managing or reducing stress. There are many different types of mindfulness, such as meditation, prayer, yoga, tai chi. They all have a similar goal: to increase a sense of peace and well-being, and decrease worry and stress.
- Be protective of your sleep. Sleep disturbance, no matter what the cause, often results in reversible cognitive dysfunction, mood fragility, and increased susceptibility to the effects of stress. Learn practical sleep hygiene strategies to optimize your ability to sleep soundly.
- Take care of your body. Keeping your body fit and strong, through exercise and healthy diet, has a direct benefit on the health of your brain. Regular exercise improves the health of the vascular system that nourishes brain circuits, can treat mild depression, and may be protective against developing dementia. In other words, it does your body good! Also, be aware that recreational drugs can be destabilizing to brain pathways involved in cognition, mood, sleep, and behaviour. This may be especially so if you're already experiencing HIV-related brain changes.
- Take your antiretrovirals. If your doctors recommend that you be on medications to control your HIV disease, be as adherent as possible. Taking your pills every day as prescribed strengthens your immune system, reduces the chance of developing resistance to the medications, and keeps your risk of developing HIV-associated dementia very low. Similarly, if you're being treated for a psychiatric illness such as depression, anxiety, or bipolar disorder, try to follow that recommended treatment regime. Untreated or poorly-controlled psychiatric conditions may contribute to a loss of brain power over time.
- Be alert to possible medication side effects. With the advice to take your medications as prescribed also comes the caution to be alert to possible side effects or interactions. Responses to medications are individual and varied, and they may have a particular and unpredictable effect on you and your mind. If you suspect something is happening, discuss it with your doctor or pharmacist.

As much as people living with HIV and the general population may fear the possibility of dementia, many people don't believe there's much they can do about it. There's a perception that if you're vulnerable to dementia, it's inevitable. But research consistently shows there is much you can do to prevent or reduce the effects of many types of memory loss or dementia. This is even more important for people living with HIV, as effectively managing the disease significantly reduces the likelihood of HIV-associated dementia. So put your mind at ease—while at the same time keeping your mind and body busy! ⊕



***Dr. Diane Fredrikson** (l) is a psychiatrist at St. Paul's Hospital in Vancouver. She worked previously in the HIV Psychiatry program, and continues to have an interest in this area.*

***Wallace Robinson** (r), MSW, is a social worker in the Immunodeficiency Clinic at St. Paul's Hospital.*

A MOVING ST

At a time when healthcare providers work with clients to plan and deliver services, it seems anachronistic that the St. Paul's Hospital folks didn't consult the public until they had already formulated their intentions. We've heard various stories: that St. Paul's will move, that only certain unspecified parts of it will move, that it won't move, that nothing's been decided. It all depends on whom you talk to—or even getting folks to talk at all. The messages vary: yes, St. Paul's is consulting the public; no, they're not consulting, they're "infomercialing."

It started with Providence Health Care looking at how to take their admittedly limited St. Paul's facilities into the 21st century and beyond. One option meant building on their existing site, replacing towers that are barely 15 and 25 years old, but preserving the heritage building in front. This poses huge obstacles if ongoing healthcare delivery continues simultaneously.

When a dot-com company backed out of a land purchase on False Creek Flats (north of the rail station by Main Street) part of that land was purchased by the Esperanza Society, formed just weeks before. Providence holds an option to use that land—an increasingly attractive option, as they consider limitations at their current site.

We've heard various stories: that St. Paul's will move, that only certain unspecified parts of it will move, that it won't move, that nothing's been decided. It all depends on whom you talk to.

This spring, a plan was completed entitled "Legacy Project Briefing Note: A Draft for Discussion" (see sidebar) and public consultations began. Before this, we'd heard that it was a done deal. At Providence's annual general meeting in June, attendees were reportedly told the move is going ahead. MLA Lorne Mayencourt has also heard it's a done deal, but insists that it isn't. "There's really been hardly any public consultation... not BCPWA, AIDS Vancouver, or Friends for Life," he says. "I can guarantee [the process of consultation] because I've told my government that if they try to do anything like this, that I'd cause a by-election... and I fully stand by that, absolutely."

Interestingly, Shaf Hussain, the Providence spokesperson, told this writer to "imagine as opposite a done deal as you can, and that's where we're at." He cleared up a lot when he said that they "are proposing a two-site solution," so that they can best use both the 6.5 acre site on Burrard and expand to the 18.5 acre site at False Creek Flats. The Flats offers the possibility of a brand-new research and teaching hospital, one of only two in the province.

Mayencourt points out that the BC Centre for Excellence's research can't be separated from clinical care. "When we're bringing hundreds of physicians down to Vancouver to teach them about how to treat someone with HIV/AIDS," he says "you want them to actually have patients there that they can work with."

Hussain says consultations are in progress. He expects a meeting with BCPWA soon. BCPWA treasurer Ken Buchanan expects the Board of Directors to meet with Providence officials as soon as possible. "We're on top of this," he says.

Ultimately, Hussain envisions a process similar to the province's Consultation on Health, with a website for information and comments, plus forums, panels, focus groups, and media interviews.

Mayencourt and Vancouver Mayor Sam Sullivan have indicated support for the hospital's current site. Mayencourt has the province's ears, while Sullivan has a zoning vote and a majority on city council. A few years ago, people said a new hospital would exist before 2010. That's impossible, now. However, if you want to be heard, time is running out, and options appear to be narrowing daily. ⊕

R. Paul Kerston *is BCPWA's treatment outreach coordinator and community representation and engagement (CRE) coordinator.*

What the Legacy Project Briefing Note says

While impossible to summarize the entire 36-page Legacy Project document, certain things stand out for BCPWA members.

If most of St. Paul's services move to the new site, Providence intends to retain "some primary care services to satisfy the needs of the West End residents at the present St. Paul's site."

Only two paragraphs later, however, the document states: "Currently, West End primary care needs are managed through the Three Bridges Community Health Centre. Vancouver Coastal Health proposes the following approach (funded separately through its primary care program) to meet the needs of West End residents if St. Paul's is relocated: Expansion of the Three Bridges facility (possibly to a new site, which could include the current St. Paul's Burrard location) to accommodate higher acuity patients, and the inclusion of an urgent care capacity to treat patients with non-life threatening conditions; (plus) the creation of a specialty HIV clinic, recognizing the clustering of HIV services around Burrard Street;...the implementation of currently planned changes to manage clients who frequently visit St. Paul's Emergency; (and) public consultation (to) identify additional uses e.g. urgent care and seniors services."

Current HIV specialty services include a renal program that treats HIV/AIDS-related kidney disease, an eye clinic which is the ocular HIV referral centre for BC, and, despite downsizing in HIV-related services, a mental health program.

The HIV/AIDS and Addiction Program is the largest comprehensive program in Canada, providing approximately 11 percent of all national hospital care for HIV-positive persons. Specialized HIV services include: primary and specialty care clinics; a 24-hour hotline service for physicians and pharmacists; a therapeutic drug monitoring program; and drug resistance testing. There is also a hepatitis C co-infection clinic, an anal dysplasia (precancerous cells) clinic, inpatient and ambulatory pharmacy services, viral load testing; CD4 cell testing, standardized lipid (cholesterol) testing, and research.

The Legacy Project document includes a timeline of who moves out of the Comox building, renovations of vacated space, and certain services returning to the revamped original site. Emergency services, however, seem to be moving. This raises some of the greatest concern among area residents and possibly among BCPWA members.

Providence has made the decision to move. Required consultations continue, and they may simply inform decisions about the shape of service delivery, plus which services remain at Burrard. Further information gathering is crucial as we define what "currently planned changes" means.

The discussion paper is dated May 3, and states: "There has been initial public engagement with stakeholder groups, including representatives of West End residents, Downtown Eastside/Strathcona residents, and the HIV/AIDS community." At deadline, this writer is unaware of such consultations.

Shunned by society

The plight of HIV-positive children in India

by Poonam Sharma

With much excitement and dreams of making new friends, a four-year-old boy enrolled in a government run preschool in the southern Indian state of Andhra Pradesh. For the teacher who manages the school of 30 students, this was cause for joy – especially since attendance rates at schools in this area are very low. However, just two days after the young boy started school, the teacher asked him to leave and not come back. Officially, the teacher stated that the "child was mischievous and beat up other children." In actuality, she had learned from other local residents that the boy and his mother were HIV-positive. Parents of the other children were threatening to withdraw their kids from the school if the child continued to study there.

This is not an isolated occurrence.

In the southern Indian state of Kerala, the HIV status of five children between the ages of five and 11 became public after they were photographed at a World AIDS Day program in December 2006. When parents of other children attending Mar Dionysius Primary School found out, the children were expelled from school. After the government intervened, the children were re-admitted to the school, only to be turned back the next day. The school claims that they are facing opposition from parents of the other schoolchildren. For now, these five children are being looked after at an orphanage called Asha Kiran (ray of hope).

> **Two brothers aged six and nine, who had been brought to an orphanage by an uncle, were asked to leave after they tested positive for HIV. The uncle refused to accept responsibility for the kids.**

In the western Indian state of Gujarat, two brothers aged six and nine, who had been brought to an orphanage by an uncle, were asked to leave after they tested positive for HIV. The uncle refused to accept responsibility for the kids. With nowhere to go, they were taken in by a non-profit organization, the Kutch Network of Positive People (KNPP). They are living with a volunteer while KNPP makes efforts to arrange for care for them.

These are just some of the incidents that have been reported in different parts of India, but they all stress the appalling lack of awareness about HIV and AIDS, and a high level of stigma towards people affected by it. Although the AIDS Prevention and Control Policy of India states that "HIV-positive persons should be granted equal rights for education and employment as other members of society" and that "HIV status of a person should be kept confidential and should not come in the way of right to employment," there is still a lot to be achieved in terms of education and awareness.

Children living at the DURGA Project, a first initiative in the fight against HIV/AIDS in the state of Andhra Pradesh. Photograph by Sarah McGowan

Among the many misconceptions is the belief that HIV/AIDS is only prevalent in sex workers, drug users, foreigners, and homosexuals. A Prevention Indicator Study undertaken by the National AIDS Control Organization (NACO) shows that awareness levels have increased from 68 percent to 94 percent in urban areas, and from 9 percent to 35 percent in rural areas.

Indian filmmakers have recently joined hands in an effort to educate people on the impact of AIDS. Funded by the Bill and Melinda Gates Foundation, the AIDS Jaago project plans to use the popularity of Bollywood films to increase awareness. Leading Indian filmmakers will produce short films to be screened before Bollywood movies, and one of the films focuses on the true story of a boy who was denied admission in school because his parents were HIV-positive.

Shunned by family and society, caught in the tussle between parents, schools, and the government, these innocent children are being denied the very basic of all rights: the right to a childhood and education. ⊕

***Poonam Sharma** is a Vancouver-based freelance writer.*

A loaded question

What body fluids do we need to consider when measuring viral loads and the risk of HIV transmission?

by Elgin Lim

Does an undetectable viral load in blood equate to an undetectable viral load in semen or vaginal fluids? That's the question being bandied about these days among HIV prevention folks. But the answer isn't so straightforward.

During the 2006 International AIDS Conference in Toronto, Dr. Julio Montaner, clinical director of the BC Centre for Excellence in HIV/AIDS, proposed that the widespread use of highly active antiretroviral therapy (HAART) could be an effective prevention tool to reduce HIV transmission and decrease infection rates. The backbone of this theory involves maintaining viral load levels at or near undetectable levels, thus significantly reducing the chance of passing the virus on to others.

While HIV is present in almost every body fluid in a person who is HIV-positive, when considering body fluids with enough virus to be infectious, we typically concern ourselves with four fluids: blood (including menstrual blood), semen (including pre-cum), vaginal fluid, and breast milk. The blood is most commonly used to test viral load. However, since HIV infections are typically the result of sexual transmission, we need to take a closer look at viral load levels in sexual fluids.

The virus can still be in semen or vaginal fluid

There's a strong correlation between viral loads in blood and semen and vaginal fluids. However, several studies indicate that suppressing HIV to undetectable levels in the blood doesn't always suppress the virus in the genital tract of men or women. In one study of men and women who had undetectable blood viral loads for up to two years, published in the journal *AIDS*, the virus was still found in the semen of one of twenty-one men and in vaginal fluid of two of two women.

In similar studies, up to one-third of women and just under four percent of men who had undetectable viral load in their blood had detectable viral load in their genital tract. The reasons for this discrepancy between viral load levels in the blood and those found in the genital tract is still uncertain.

That said, we have long known that HIV hides in various locations in the body, such as the lymph glands and the brain. Unfortunately, research also suggests that the virus may replicate and/or maintain reservoirs in different areas of the genital tract. For example, semen may serve as a sanctuary for HIV, even with use of potent antiretroviral treatment.

Certain antiretroviral (ART) drugs have the ability to reduce the viral load in the genital tract. But the ability of these drugs to penetrate specific areas of the body depends entirely on the

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drug. For example, research has shown that only some HIV medications are able to cross the blood-brain barrier. To further complicate matters, since combination ART regimens have been used in these studies, it's uncertain which drugs and drug concentrations are most effective in suppressing HIV levels in the genital tract. One study showed protease inhibitors were able to penetrate the female reproductive tract but only at suboptimal concentrations.

> **Several studies indicate that suppressing HIV to undetectable levels in the blood doesn't always suppress the virus in the genital tract of men or women.**

Whether an individual is on HAART also appears to have an impact on the discrepancy between blood and genital tract viral load. Individuals with low or undetectable blood viral load who are not on HIV medication have a greater likelihood of having a high viral load in their genital tract. Other factors that increase the risk of HIV transmission include urinary tract infections, sexually transmitted infections, and genital ulcers.

Not surprisingly, because of antiretroviral therapy, drug-resistant virus may also contribute to complications in using medications to prevent the spread of HIV. With the increases in drug-resistant HIV, additional studies are needed to identify the factors involved in sexual transmission and the presence of the drug-resistant virus in genital fluids.

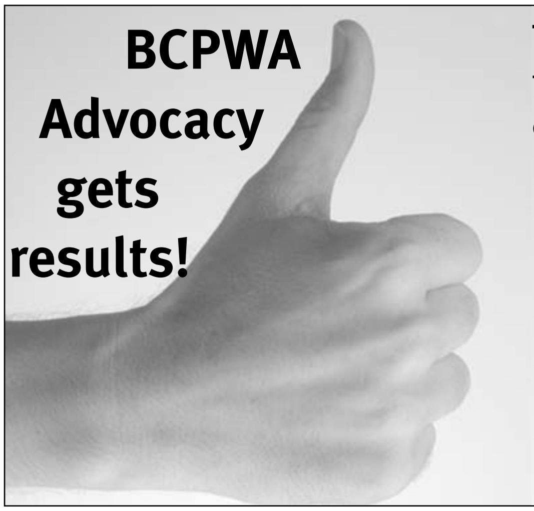
What amount of viral load makes you infectious?

Finally, in order to prevent HIV transmission, we need a better understanding of the amount of virus required to be infectious. The mere presence of HIV virus in semen or vaginal fluid is not enough to signify a risk of transmission. More information is required to make informed risk assessments based on viral load levels.

Overall, ARV treatment can result in a significant drop in the viral load of semen and vaginal fluids. Clearly, there's a public health benefit to therapeutically lowering the viral load levels of HIV-positive individuals. However, the ability to prevent new infections using ART medications on an individual basis is complex.

Having an undetectable blood viral load is not a license to have unsafe sex. Achieving an undetectable viral load may reduce your risk, but safer sex practices—including proper condom use—remains the most effective safeguard against HIV infection and transmission. ⊕

***Elgin Lim** is BCPWA's director of prevention.*



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

- **$1,100 in debt forgiveness.**
- **$58,801 in housing, health benefits, dental and long-term disability benefits.**
- **$0 monthly nutritional supplement benefits**
- **$2,250 in ongoing monthly nutritional supplement benefit for children**

treatment. information

TREATMENT INFORMATION PROGRAM MANDATE & DISCLAIMER

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

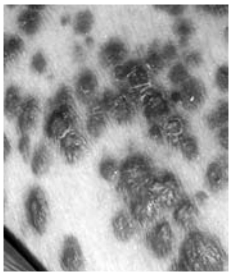
The Treatment Information Program endeavours to provide all research and information to members without judgment or prejudice. The program does not recommend, advocate, or endorse the use of any particular treatment or therapy provided as information. The Board, staff, and volunteers of the BCPWA Society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

A rash of HIV-related skin complications

by Rob Gair

Skin complications in people living with HIV are common, and in the years since the AIDS epidemic began, different patterns of skin problems have emerged. Before there was effective antiretroviral therapy, HIV-related skin problems were caused by immune system dysfunction. Since the advent of highly active antiretroviral therapy (HAART), skin complaints have decreased dramatically. Nevertheless, many of these conditions still occur, especially in people who are not responding to HAART or for whom HAART is not available. As well, HAART itself may be responsible for some skin problems.

Kaposi's sarcoma



Perhaps the most visible and well-known HIV-related skin disorder, Kaposi's sarcoma (KS) was very common before the advent of HAART and was directly linked to declining immune status. It usually first appears as small reddish-purple nodules on the skin, which become increasingly uncomfortable and disfiguring. KS is a type of cancer, associated with a herpes virus infection, causing uncontrolled growth of blood vessels. Its presence in internal organs is more serious because it may go undetected until it starts to cause organ damage.

KS is treated with standard cancer chemotherapy and radiation. Improved immune function with the introduction of HAART has dramatically reduced the occurance of KS.

Herpes virus

The herpes virus is responsible for a number of skin conditions in people with HIV. Herpes simplex virus (HSV) occurs in two predominant types: HSV-1, which is typically associated with oral cold sores; and HSV-2, which is associated with genital herpes outbreaks. However, either type can reside in both areas of the body.

Both types of HSV cause painful watery pustules, which typically take up to two weeks to heal. The common notion that genital outbreaks are more serious and difficult to treat is untrue. Early treatment with antiviral agents like acyclovir may reduce healing

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time. People with recurrent outbreaks may take prophylactic antivirals to prevent outbreaks.

Herpes zoster—also called varicella zoster—is responsible for chicken pox, a benign infection in children. After childhood, the virus becomes dormant but may reactivate in older adults or in those with immune disorders, typically appearing as shingles, an extremely painful, blister-like rash that surfaces along nerve pathways in the skin. The rash may take weeks to heal, but early treatment with high-dose antivirals can speed healing; this may also decrease the incidence and duration of post-herpetic neuralgia, a nerve pain that persists after the rash has disappeared.

> **Since the advent of HAART, skin complaints have decreased dramatically. Nevertheless, many of these conditions still occur.**

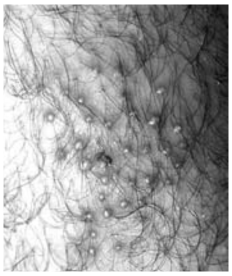
A vaccine for herpes zoster reduces the occurrence of shingles in older people. The vaccine is recommended for people over 60 years, but has not been studied in the setting of HIV-related herpes zoster.

Venereal warts

Genital warts are caused by the human papilloma virus (HPV). Lesions appear as small, pimple-like nodules on the genital or anal area. In more advanced cases, the nodules become more wart-like in appearance and may develop in clusters. HPV is the cause of cervical cancer in women and it is also associated with anal cancer in gay men. For women, regular Pap smears screen for cervical cancer, however similar screening methods for men have not been widely developed.

Treatment is usually more effective in people with good immune function; options include podophyllin (Podofilm), liquid nitrogen, or electrical cauterization. A vaccine recently became available that protects for specific cancer-causing strains of HPV; however it's expensive and isn't currently covered by health plans.

Eosinophilic folliculitis



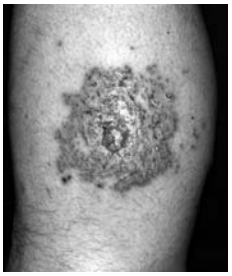
Eosinophilic folliculitis is a chronic inflammation of the hair follicles that happens more commonly in advanced HIV disease. It appears as an itchy, red, pus-filled bump around the hair follicle, resembling a pimple. The bump is usually quite painful if squeezed, and the lesion is slow to heal. The cause is not clear, although fungi or skin parasites have been implicated.

Treatments have included oral or topical antibiotics or antifungals, ultraviolet light, antihistamines, and permethrin, with varying effectiveness.

Molluscum contagiosum

Skin-coloured lesions caused by the molluscum contagiosum virus may appear in large numbers in people with declining immune status. Typically, the lesions have a pit in the centre or they may look like a wart, and they may be itchy. Molluscum contagiosum is often treated like warts with podophyllin or liquid nitrogen; some reports suggest that topical imiquimod (Aldara) can also help.

Eczemas



Eczema and related conditions generally present as dry, flaky, itchy areas of skin. Seborrheic dermatitis is quite common in people with HIV; it appears as yellowish greasy scales on the scalp, face, or torso. Treatment usually starts with topical anti-dandruff shampoos and steroid creams, or coal tar preparations. UVB light therapy may also be effective.

Atopic dermatitis is a dry, itchy skin condition with an allergy component. It's often accompanied by other allergy problems such as asthma and hay fever. Treatment includes moisturizing lotions and antihistamines.

HAART-related skin problems

Medications used in HAART have themselves been associated with skin problems. For example, non-nucleoside reverse transcriptase inhibitors like efavirenz (Sustiva) and nevirapine (Viramune) are commonly associated with rashes, especially in the first few weeks of therapy.

Lipodystrophy or fat wasting, while not technically a skin disorder, appears to be associated with use of older nucleoside analogues such as zidovudine (AZT, Retrovir) and stavudine (D4T, Zerit). It isn't clear how much protease inhibitors contribute to this problem.

Finally, reduction of viral load following introduction of HAART is sometimes associated with immune reconstitution syndrome, especially in people with low CD4 counts or opportunistic infections prior to starting HAART. Those who develop this syndrome may encounter a variety of new or worsening skin complications generally associated with advanced HIV infection. ⊕

__Rob Gair__ is a pharmacist at the BC Drug and Poison Information Centre.

What's New in 2007?

Presented by

British Columbia
Persons With AIDS Society

3 Doctors Answer Your Questions

Come and see a panel of 3 physicians talk about HIV today.

Date: Thursday, October 4th • **Time:** 6 PM

Location: Best Western Chateau Granville
(corner of Granville & Helmcken)

Open to persons living with HIV and any other interested participants. Dinner provided.

Please RSVP by **Oct 2nd** to **604.893.2274** or
email **treatment@bcpwa.org**

Sick and tired

Is treatment fatigue a sign of the times?

by Glyn Townson

Over the past couple of years, some troubling deaths among HIV-positive individuals have occurred that, on the surface, appear preventable. These are people who made a conscious decision to stop taking their HIV medications. These stories are becoming all too common.

Steve (not his real name) was a young, intelligent man on antiretroviral medications (ARVs). A member of BCPWA, he was well connected and part of a strong social network. He had a good knowledge of the lifecycle of HIV and its potential complications. One day, Steve stopped taking his ARVs. He didn't tell anyone within his support network. After a couple of years off the medications, he developed an untreatable opportunistic infection related to HIV, and died. Steve's death sparked a fair amount of discussion among friends and colleagues; some were hurt and angry, others expressed disbelief.

Another incident involved a friend of mine, Peter (not his real name). He learned of his sero-status when his partner died suddenly in the late 1990s. The attending doctor informed him his partner had been HIV-positive. In addition to having to deal with the death of his partner, Peter had to cope with a new HIV diagnosis. He was in a state of despair. Shortly after his diagnosis, he started his first round of ARVs on the recommendation of his own doctor. He experienced severe side effects. "I felt fine before taking these pills,' he said at the time, "and now I feel terrible."

Peter argued that he felt much better without the medications. Compliance was an issue: he had trouble remembering to take all his doses. He discontinued his ARVs and went on with his life for the next several years, blithely ignoring his HIV. Eventually, his health declined and he tried another round of ARVs, this time with newer drugs. For a while, they seemed to work, but again, in his mind and body, the side effects outweighed the perceived benefits. Once again, he stopped taking them. Eventually Peter developed an infection that landed him in the hospital. By this time, his immune system was severely compromised and he passed away.

Similar to condom fatigue in the '90s

There are many similar stories out there. Have we reached another juncture in this pandemic where treatment fatigue has become a part of our reality, as we saw condom fatigue start to appear in the late 1990s? Treatment fatigue could be viewed as inevitable, a consequence of HIV becoming a treatable disease.

The complication with HIV is that the treatments to date are not very forgiving and in order to work properly require a 95 percent compliance rate (meaning that if you're on a twice-daily regimen, you can only miss one dose every two weeks). Other diseases are more forgiving and you can still get therapeutic benefits at a 60 to 80 percent compliance rate. Add the various common side effects of the current ARVs—including diarrhea, vomiting, rashes, fat redistribution, high cholesterol, liver problems, fatigue, neuropathy, myalgia, insomnia, and fevers—and it's easy to see how compliance can become a challenge.

As we gain more knowledge about HIV, the treatment picture becomes clearer. The vast majority of people infected with HIV will require ARV therapy, at some point, to extend their lives and remain healthy. It's also likely that the first line of drugs will stop working after a period of time and they'll have to consider other combinations of ARVs.

Fortunately, there have been a lot of advances with new classes of drugs, and the development of simplified regimens with fewer reported side effects. Many of the drugs now come in combination formulations, or have had the number of pills per dose decreased, reducing pill burden. Still, as with all medications, some have more side effects than others. And because HIV is an individual disease, what may work for one person won't necessarily work well for someone else. On top of that, having HIV may mean taking medications for the rest of your life. And all these factors can lead to treatment fatigue.

Taking things one day at a time

Regardless of how diligent you are about taking medications, the longer you're on them, the more likelihood there is for you to become complacent and/or make mistakes. Rather than focus on a lifetime of pills, it's often easier to focus on what needs to be done today. Tomorrow will take care of itself.

Some changes to our current medical system—better access to psychiatric and mental health services, for example—could mitigate some of the problems that can lead to treatment fatigue. Healthcare professionals need to fully explain the potential side effects of each ARV. When their patients complain of side effects, they need to take these reports more seriously and provide proper follow-up. They could also suggest complementary and alternative therapies that can help their patients deal with side effects before they get out of control. Using available resources such as support groups and counselling can also help lessen the burden of taking ARVs.

> **The complication with HIV is that the treatments to date are not very forgiving and in order to work properly require a 95 percent compliance rate**

If you're having problems with your medications, it doesn't necessarily have to be that way. Another member of BCPWA had major compliance problems due to the side effects of his ARVs. Less than a year ago, he was admitted to the hospital and not expected to leave. With new medications and drug level testing, doctors were able to adjust his medications so that his side effects were no longer an issue. He's now happily living his life and back at work.

There have been many times over my 12 years of various combinations of medications and horrific side effects where it would have been easy to throw in the towel, and give in to

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Tips on how to stay on track with your meds

Sometimes it might seem impossible to stick with your treatment regime. But if you're proactive, it can lessen the chances that you'll experience treatment fatigue. Here are a few handy tips:

Keep a daily diary of your general health status. It doesn't have to be complicated or lengthy. Note your feelings, list any side effects or symptoms you're experiencing, and keep a log of when you take your medications. By tracking daily statistics before going to bed, on the rare occasion that you miss an evening dose, you can take it and merely note it as late. It's also handy to review these diary notes before your regularly scheduled appointments with your doctor or pharmacist. Reporting side effects is important; in some cases, there may be simple remedies that can lessen the symptoms. If these symptoms continue over a long time and you neglect them, they can easily lead to treatment fatigue.

Make your medication schedule work for you. The more easily you can incorporate your antiretrovirals (ARVs) into your life, the better. If it means adjusting your dosing schedule by an hour or two, do it. HIV and its medications affect all of us differently. What works for one person may not work for another. Be flexible and work with your healthcare providers. Depending on your regimen, you may find that switching certain medications from evening to morning and vice versa can reduce side effects. If you're on once-daily medications, which is becoming more common, plan to take your medication when it's most convenient and conducive to your schedule.

Keep some medication on hand at all times in case you're delayed. If you travel on a regular basis, it's wise to stash a dose or two in a secure location, or with a friend. It takes the pressure off having to go back home. Resentment can build if you feel that medications control your life.

Pay attention to your medication schedule when you're busy with activities outside your normal routine. While you're on vacation or participating in new activities, it's easy to get distracted and miss doses. Some people use alarms on their watches, pocket computers, or cell phones as a reminder to take medications.

Manage side effects before they get out of hand. Half of HIV-positive people on ARVs complain of acid reflux—when the contents from your stomach travel back up through your esophagus or swallowing tube. Sometimes you can address this by taking medications an hour or two earlier, or by elevating the head of your bed a few inches.

If you start to experience body changes, such as lipodystrophy or lipoatrophy, make sure you inform your doctor and pharmacist. Sometimes dosages of particular medications can be altered, or other drugs can be substituted before major permanent damage occurs. The psychological effects of these body changes can have far deeper emotional consequences if left unattended.

Keep track of the state of your mental health. We all have our ups and downs, but if you find that you're in a constant downcast mood, seek help. The reality is that the majority of us living with HIV will at some point experience depression that will require treatment. Left untreated, depression can easily translate to missed doses of ARVs.

HIV. But after living through the 1980s and early '90s, before effective treatments were available, I don't have to think too hard about whether or not it's worth it to take the medications.

Making an informed decision

However, if you do choose to take a break from your HIV medications or decide to stop taking them altogether, you should maintain contact with your doctor and have regular blood work done. Depending on your particular combination of ARVs, it may be wise to consult your doctor or pharmacist about how to discontinue your drug regimen safely—without providing the HIV virus an opportunity to become resistant.

BCPWA continues to hold the position that any HIV-positive person has the right to refuse treatment, even if that places the person's life at risk. There are going to be times when some people will disagree with another person's decisions. However, the basis of our Society is empowerment, to increase the capacity of individuals to make choices that work for them and to transform those choices into desired actions and outcomes. That includes death. ⊕

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

In good hands

Take the first step towards a healthier life with reiki

by Dave Boyack

If you're seeking something peaceful, calming and relaxing, look no further. Reiki is a simple and easy way to cope with the ordeals of daily living.

Reiki can alleviate many ailments and symptoms related to disease, stress, and other health-related problems, but it should only be used as a complement to your medical treatment, not to replace it.

Many cultures, for many centuries, have healed people simply through the sense of touch or use of the hands. Originating in Japan, reiki is one such ancient form of healing therapy. Today's form was adapted by recent masters who researched the ancient form and modified it for use in Japan and the West.

Reiki (pronounced RAY-key) is a Japanese name consisting of two words, *rei* and *ki*, which mean spiritually guided life energy. This universal energy is all around us. Reiki is a form of spiritual healing where this universal life energy is channelled through a reiki practitioner in order to harmonize your body, mind, and spirit.

> **Reiki is a form of spiritual healing where this universal life energy is channelled through a reiki practitioner in order to harmonize your body, mind, and spirit.**

Many Eastern medical philosophies stress the importance of maintaining good health rather than curing illness. Being healthy is more than being free of disease. Reiki is considered to have preventive and curative qualities because it can help promote overall general health and longevity. So, when you receive a reiki treatment, you benefit in more than one way. It helps you grow emotionally, mentally, and spiritually and, thus gives you health benefits in a much broader sense.

A reiki treatment is very simple. You just relax, fully clothed, lying down or sitting in a chair while a practitioner holds his hands on or above you. The reiki hand positions are so easy to learn that some people even practice reiki on themselves. Unlike other forms of healing and massage, there is no pressure on the body or kneading of the muscles. The life energy flows over you; often you can feel a warm sensation or tingling in your body. A reiki treatment is ideal for reducing stress, as well as relieving pains and headaches, stomach aches, back problems, asthma, menstrual problems, anxiety, and much more.

There are two basic principles behind the practice of reiki: the cleansing of the meridians and the balancing of the chakras to achieve a harmonious energy flow in your body. This is all done simply through the positioning of the hands.

Meridians are like a circulatory system for your life energy or life force, what the Chinese call *chi*. The meridians transport the universal life energy throughout your body in a fashion similar to the way your circulatory system transports blood. Sickness occurs when the meridians are blocked. There are two polar forces to chi: the yin and the yang. When these polar forces are balanced, you are physically healthy. Illness appears when the yin and yang are unbalanced. Reiki helps to balance the yin and yang, and aids in the smooth flow of chi throughout the body.

There are seven major chakras in your body, and each chakra corresponds to a different spot or organ(s): top of the head, forehead, throat, heart, solar plexus, the navel, and the bottom of the pelvis. *Chakra* is a Sanskrit word that means wheel. Chakras spin, like a wheel, quickly or slowly according to the energy level in your body. Each chakra has a corresponding organ (and one of the major glands in your body), so the condition of the chakra is a reflection of the condition of the respective organ(s). Chakras can be overactive, under-active, or in balance. Through reiki, your chakras can be balanced so your organs are healthy and your glandular systems are functioning properly. ⊕

***Dave Boyack** is a volunteer with BCPWA's Communications Department.*

Book an appointment at BCPWA

BCPWA members can now book a reiki appointment with Mikey, a reiki master with 15 years of experience. Mikey's style of reiki includes guided visualization and breathing exercises—a great treatment, he says, for cleansing the organs of toxins and balancing the chakras. Call for your reiki appointment and experience one of the most relaxing and soothing treatments in your journey to a healthier life.

Hack attack

Alternative treatments for bronchitis and lower respiratory infections

by Katolen Yardley

Winter is just around the corner. That means rain, cold weather, and cold symptoms. For some people, a cold is just a cold, but for others, it spells trouble and nasty respiratory problems—like bronchitis.

Bronchitis is an inflammatory condition that usually begins with a dry cough and leads to a buildup of mucous. Caused by the irritation and infection of the bronchi, the passage from the trachea to the lungs, it often follows a cold or upper respiratory infection, and can be aggravated by dust.

Some people are more susceptible to bronchitis: individuals with a lowered immune system who are on numerous meditations and dealing with chronic viral infections, including HIV; cigarette smokers; people who consume excess alcohol; and people in an environment of second-hand smoke and/or chemical pollutants.

Symptoms of bronchitis include shortness of breath, a dry shallow cough or a painful deep productive cough, chest tightness, increased mucous, wheezing, and fever. Long-term bronchitis can increase the probability of developing emphysema later in life.

There are many ways to treat bronchitis naturally. A natural approach involves enhancing your body's ability to fight infection, while stimulating the removal of mucous from your body.

At the onset of a cold or other infection, immediately increase your intake of vitamin C blended with bioflavinoids, or take them daily as part of an ongoing immune enhancement program. Vitamin C contains antiviral and antibacterial properties and helps with the proper functioning of the immune system by enhancing the white blood cells' ability to fight infection. Vitamin C also increases levels of interferon—a chemical in your body that fights viral infections—and it strengthens the mucous membranes lining the respiratory tract. Choose a non-chewable vitamin C, because they're unsweetened. If you experience loose bowel movements, cut back on the amount of vitamin C you consume.

Lifestyle changes can help, too

There are also lifestyle changes you can make to treat bronchitis. Avoid smoking and contact with second-hand smoke. Cigarette smoke irritates the lungs, and the body automatically produces excess mucous in an attempt to protect the sensitive mucous membranes from chronic irritation and prevent further inflammation.

Incorporate regular moderate exercise into your daily routine. Fresh air is important; try to avoid air conditioned buildings and recycled air. Deep breathing also helps. In that vein, blowing balloons is a useful practice to help strengthen your lungs and ease breathlessness.

Watch what you eat!

Nutrition also plays a role in bronchial health. A diet low in fibre (that is, lacking fruit and vegetables) and high in red meat and processed and prepackaged foods is linked to lung weakness. Instead, choose foods that have a healing effect on the lungs, like watercress, seaweeds, daikon radish and other radishes, cabbage, and ginger.

There are many other foods that can help bronchitis. For example, add fresh garlic, onion, and leeks into your diet. They contain volatile oils that are antiseptic in nature, and disinfect the membranes lining the lungs and respiratory tract as they are excreted from your body.

Avoid sweets and sugar, such as fruit (including orange) juice, sucrose, and honey. Sugar competes with vitamin C for absorption into the white blood cells, affecting the motility of white blood cells and inhibiting immune system function. The higher your intake of sugar, the greater the impact on the immune system. A high intake of sugar reduces the white blood cells' ability to engulf and destroy foreign agents. It's thought that a high intake of sugar and increased insulin levels compete with vitamin C for membrane transport sites on the white blood cells. Vitamin C and sugar have opposing effects

Natural herbs for respiratory problems

Mother Nature supplies plant remedies with expectorant properties that help liquefy sticky mucous and remove it from the body; antispasmodic herbs for a raspy spastic cough; and soothing herbs for raw inflamed mucous membranes, which can be taken in tea, tincture, or capsule form.

Elecampane root, *Inula helenium*. An herb with antibacterial and expectorant properties used for chronic coughs and removing mucous from sinuses.

Fenugreek seeds, *Trigonella foenicum grecon*. An herb containing soothing mucilage properties, producing a protective coating over irritated mucous membranes. It's soothing for a dry cough and bronchitis.

Thyme, *Thymus vulgaris*. An antiseptic antiviral with antispasmodic properties, it's excellent for a dry cough, sore throat, or bronchi infection. You can also prepare thyme tea as a gargle for a sore throat or drink it as a tea for deeper respiratory complaints.

Wild cherry bark, *Prunus serotina*. An antispasmodic herb used traditionally for a deep raspy cough, whooping cough, and asthma.

Lobelia herb, *Lobelia inflata*. THE respiratory antispasmodic herb, a relaxant that helps to dilate the bronchial passages, allowing more air into the lungs. It's also helps with difficult, restricted breathing.

on white blood cell function, as both require insulin for membrane transport into the tissues.

Avoid excess alcohol. A high alcohol intake increases your susceptibility to infection; just like sugar, the higher your intake of alcohol, the greater the impairment of white blood cell mobility. Individuals who consume alcohol daily are also known to have a higher incidence of pneumonia.

Eliminate dairy products! Cheese, milk, and other dairy products are highly mucous forming, creating more mucous in a body and further contribute to the problem we are trying to address.

Increase your intake of fluids, in the form of homemade soups (staying away from cream-based soups and instead choosing broths with tomato or bouillon-based flavouring–and make sure they're monosodium glutamate-free!), water, and herbal teas. Avoid juice and pop.

Soothing relief from a mustard poultice or a steam

Placing a heating pad or hot water bottle on your chest at bedtime can go a long way to reduce lung inflammation and help manage bronchial congestion and infection. Better yet, try a mustard poultice, a traditional home remedy for removing chest congestion. It's excellent for bronchitis and pneumonia.

It's simple:

- Mix one part dry mustard powder with three parts flour, adding just enough water to form a paste.
- Apply the paste onto a thin cotton tea cloth, tea towel, or cheesecloth.
- Apply a thin layer of barrier cream onto your chest to protect your skin from blistering, then apply the poultice on your chest.
- Don't leave the poultice on too long or your skin may blister.

You could also try steaming. Steaming with essential oils is an excellent application for colds and flus, an antiseptic for the lower respiratory passages, and it reduces congestion from the sinuses. Essential oils are antiseptic in nature and contain antiviral, antibacterial, and expectorant properties to assist in the removal of mucous from the lungs.

Some essential oils for steaming:

- Eucalyptus, *Eucalyptus globules*, is a great decongestant oil for steaming and adding to a sauna or bath.
- Basil, *Ocymum basilicum*, is useful as an antispasmodic and for chest infections.
- Thyme, *Thymus vulgaris*, strengthens your body's resistance to infection, and is useful for respiratory infections.

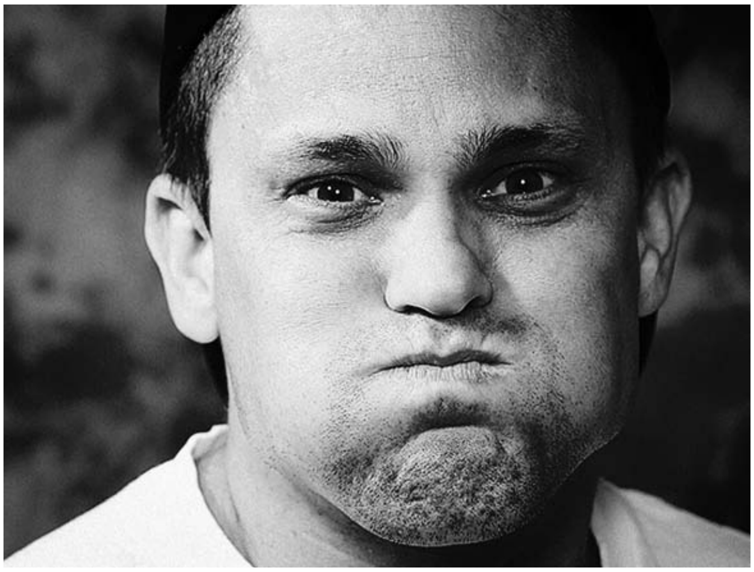
Anti-mucous tea recipe

Lemon – 1 fresh
Cayenne pepper powder – a pinch
Elderflower – 2 tablespoon
Cinnamon – 1 teaspoon
Grated ginger – 2 tablespoon
Green onions – 6 chopped
Add into 2 cups of water, bring to a boil,
then reduce the heat to a simmer,
covered for 10 minutes.
Drink frequently throughout the day.

With any of these natural remedies, as they loosen mucous from your lungs, don't swallow the loosened mucous; instead, bring it up and out of your body.

Focusing on a healthy lifestyle and optimal nutrition will help ensure you have healthy lungs. During times of lowered immunity and times of increased susceptibility to infection, incorporating some additional support from Mother Nature can offer numerous options to help keep the body functioning at optimal levels. ⊕

***Katolen Yardley**, MNIMH, is a medical herbalist practicing at Alchemy & Elixir Health Group in Vancouver and Coquitlam.*



Waiting to exhale

COPD is a nasty pulmonary disease—and HIV-positive smokers are particularly susceptible

by Ashley Smith

Smoking is notorious for its negative affects on your health, and it's implicated in a variety of diseases in the lungs and throughout the body. One of those diseases is chronic obstructive pulmonary disease (COPD), best described as a group of diseases characterized by an obstruction to airflow when breathing out. It's the fourth leading cause of death worldwide–and it's persistently under diagnosed.

COPD is actually an umbrella term for chronic bronchitis, emphysema, and other lung disorders. The obstruction or limitation of airflow is due to thick secretions lining the tubes leading to the lungs, as well as a loss of the elastic ability of the lung tissue. That means air can't move from the lungs to the mouth and out, since the secretions cause narrowing in the passageway and the tissue is too floppy to snap back into place.

Signs and symptoms of COPD are different for everyone, however shortness of breath, increased chest secretions, coughing and wheezing, are common. The condition is diagnosed through spirometry, or breathing tests conducted at a doctor's office or in a pulmonary function laboratory in the hospital. It's reversible at early stages–in fact, you can slow and even stop the progression of the disease by stopping smoking–but damage becomes permanent as lung changes begin to occur. COPD is treated with inhalers such as Ventolin and Atrovent.

Chronic obstructive pulmonary disease is the fourth leading cause of death worldwide—and it's persistently under diagnosed.

A recent study, reported in an issue of the journal *Chest*, showed a strong relationship between HIV and COPD. The research showed that HIV-positive smokers were almost 50 percent more likely to have COPD then their seronegative counterparts. The study didn't address the reason for the correlation; however, the researchers questioned the role of bacterial pneumonia, as it was more common in HIV-positive smokers with COPD than with HIV-positive smokers without COPD.

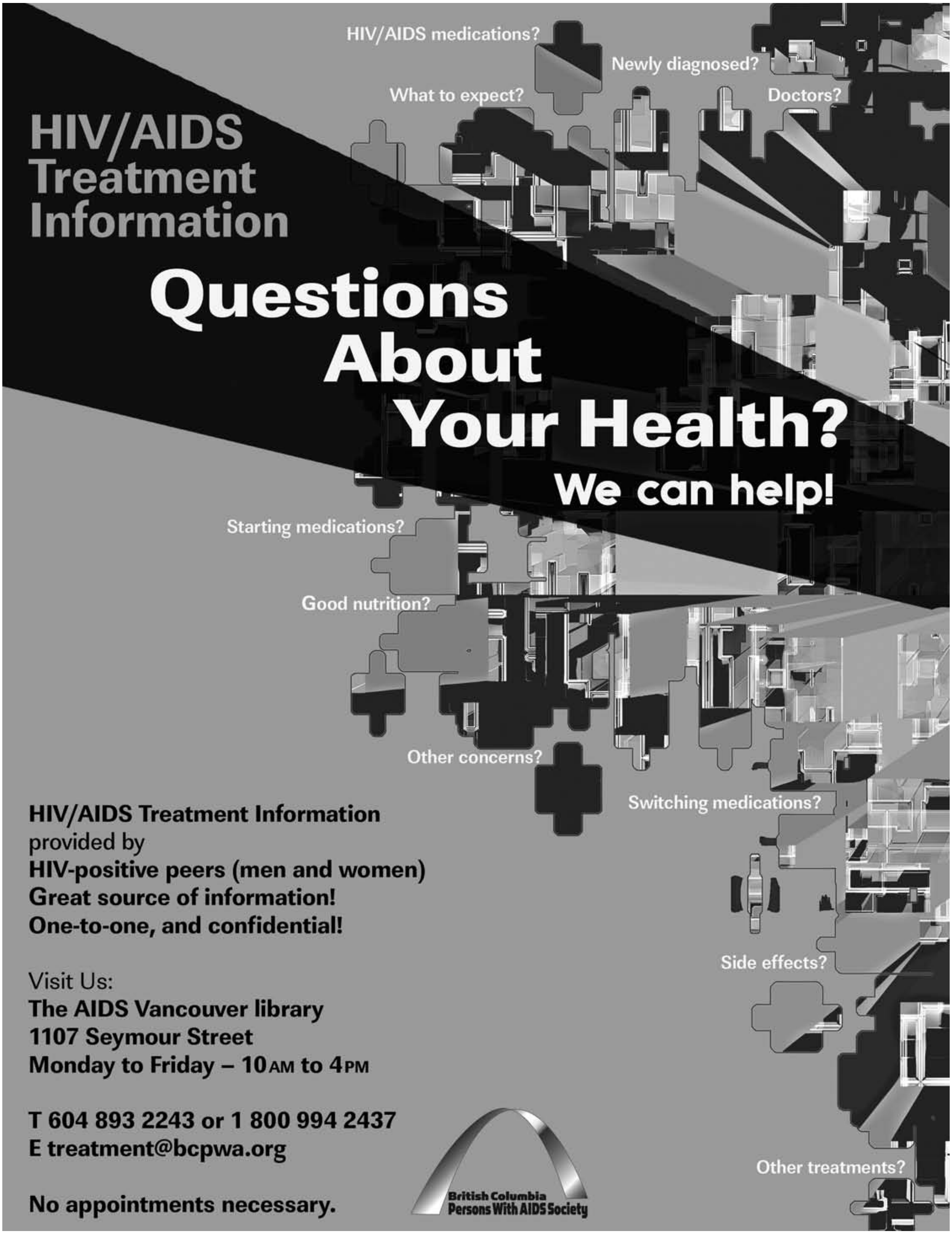
Did the lung injury due to the bacterial infection lead to the COPD? Or does COPD lead to the pneumonia? Researchers couldn't draw any conclusions about the causation; however, they did notice an association with bacterial lung infection and the development of COPD in seropositive smokers.

This study once again highlights the importance of beginning a smoking cessation program. Quitting smoking can be a daunting task, however research shows that the more you attempt to kick the habit, the more likely you are to quit some day. ⊕

__Ashley Smith__ is a respiratory therapist at Vancouver General Hospital and a fourth-year cellular biology major at the University of British Columbia.

For more information on quitting smoking

Great information on lung health and smoking cessation is available on the Canadian Lung Association's website at **www.lung.ca**.



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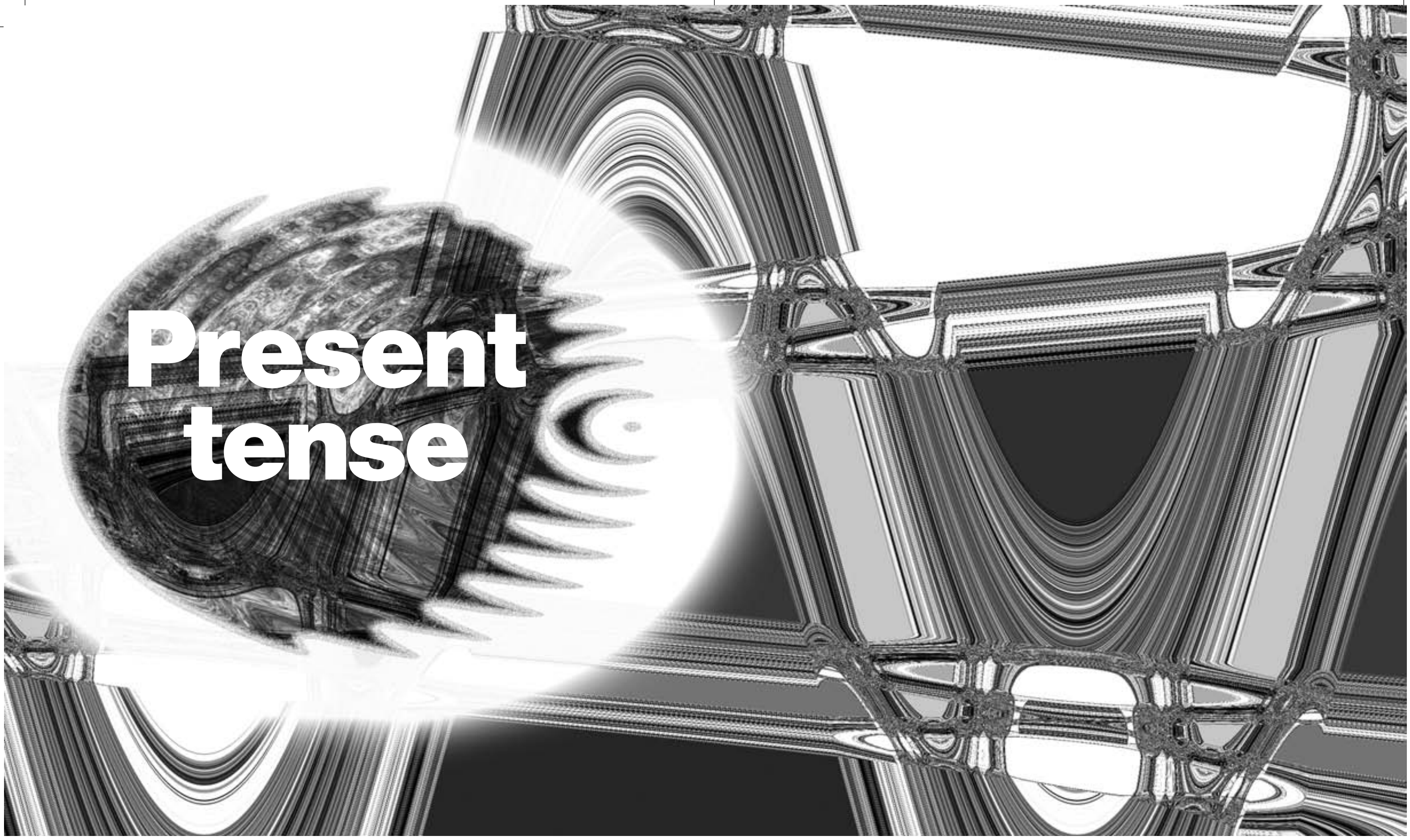
Present tense



Do our lived experiences help us move forward, or do they hold us back?

by Devan Nambiar

As PWAs, many of us have a myriad of experiences in coping, managing, and overcoming the challenges of living with HIV/AIDS. These lived experiences transcend culture, religion, community, race, ethnicity, gender, sexuality, education, and social status. We bring our experiences into meetings, conferences, committees, volunteer work, and the workplace. They are validated and used as educational tools by our peers, organizations, and communities, and can be empowering. But these lived experiences can also be limiting—do they allow us to let go and move ahead?

It's empowering to receive validation for triumphing over challenges. But how relevant is it to keep the past alive? Do past triumphs validate our present existence? Or is it good to be rid of the past circumstances entirely? Does it truly help us to relive the emotional pain and scars of living with HIV/AIDS, over and over again? There are more questions than answers.

In my personal life, I have been exploring and chewing on my own lived experiences. How many of those experiences are truly valid 20 years after my diagnosis? As a South Asian PWA, I've lived through experiences of grief and the loss of lovers, partner, and family; opportunistic infections; unemployment; failed relationships; anxiety; racism, stigma, and discrimination—both before my seroconversion, and after.

Language and health

Since the 1980s, I've heard many complementary medicine practitioners and spiritual teachers speak of the impact of language, emotions, and thoughts on our health and the physiological responses in our bodies. How does our use of language relate to past, present, and future events?

It got me thinking about the people I know of who had an AIDS diagnosis in the 1980s and still refer to themselves as having AIDS, instead of thinking of themselves as living with HIV. Does the past AIDS-specific diagnosis impact their current health and how fully they live their life? Have they projected their past health issues forward and has that become a lived reality? There is also a feeling of fear evoked by many issues in the HIV community: drug resistance, sexually transmitted infections, side effects, and disclosure, to name a few. Fear does not empower anyone to make an informed choice. What is the impact of fear on our current health?

The record player

Our experiences affect all our emotions and thoughts from a cellular level to the physical level. When we relive experiences mentally, every cell of our body reacts as if we're experiencing incidents over and over again. The field of psychoneuroimmunology—the study of the relationship between the psyche, brain, and immune system—notes the impact of the mind on the immune system. What's the impact of this retelling on our immune system, and on sexual, spiritual, physical, mental, and emotional health? The lived experience is in the past tense. Why do we want to keep going back numerous times to relive

unpleasant experiences? How does this help us live in the present, to embrace life fully without fear of the past or projecting into the future?

While each lived experience is valid and authentic, I believe it has a shelf life. We must be aware of when to drop it and embrace life in the present. For me, HIV is a magnifying glass that amplifies the issues in my life; the retelling of lived experiences only serves the audience and speaker a couple of times. We need to let go, and not hang onto them like a Nobel Peace prize. Honour the experiences, learn from them, and let them go.

The mind

In meditation, we learn to go beyond our mind and thoughts to experience the true essence of our being. The mind holds on to all past experiences as a survival tool. It tries to define who we are. The more we define ourselves, the more confined we become. The mind also plays events over and over, fueling past experiences as if they were a dramatic mini-series. It thus becomes hard to separate the past from the present.

> **When we act on a present based on past experiences and a history of stored memories, the outcome of the future is the same as the past. It's a survival process. But it's a vicious circle.**

Many spiritual teachings clearly state that time is a man-made concept to provide structure for living. Certainly, you need your mind and a sense of time to function in this world. But when these take over your life and events, you are stuck in a cycle of repeats.

Being present

Living in the past is safe. It's reassuring and familiar with predictable outcomes. But it doesn't create new experiences. And when we act on a present based on past experiences and a history of stored memories, the outcome of the future is the same as the past. It's a survival process. But it's a vicious circle.

So how do you break the pattern of repeats? How do we choose a future that's free of that past? How can you live life in the present?

Take a breath; focus your attention on your feelings. Acknowledge those feelings, emotions, and the lived experiences. Just observe them, don't process them. Be the silent watcher and see what unfolds.

Be authentic to yourself. Be creative versus reactive. An artist doesn't paint on the same canvas repeatedly. Why, then, do we paint our new experiences with the same strokes? Living fully is to be present to your thoughts and cultivate consciousness. Take responsibility for your thoughts and outcomes. Whatever you resist, will persist. Life is an ebb and flow of joys, insights, pain, challenges, and unknowns.

Here's another simple exercise: When you're talking to someone, become aware of what you're saying. Be the silent observer of yourself. When you are having an emotion, allow yourself to watch the emotion. Detach yourself and just watch the emotion. Don't react; just be present to what's going on in you. Spiritual teacher Ramana Maharishi always said, "Be the watcher in you." As you watch and observe yourself, you start to become aware of your thoughts and reactions. Your mind will want to draw you into the drama, but just watch patiently.

Getting to the core

Start becoming aware of the programs you've downloaded into your mind. Examine your core beliefs. Become aware of why you do what you do, the consequences of your actions, why you react the way you do, why you buy what you buy, why you eat what you eat, and so forth.

As for me, I always ask myself, "If there was no HIV, what would my life be like?" Did all my challenges in my life stem from my HIV diagnosis? Can I live my dreams to their fullest? How many of the limitations in my life are self-imposed by my mind?"

I believe HIV can be a huge stepping stone to fulfilled dreams rather than dashed dreams.

Living life in full awareness is a full-time responsibility, but it isn't impossible. It brings numerous rewards and insights. Quality of life is within our reach if we choose to exercise our free will and not let fate and the past dictate our outcomes. ⊕

Devan Nambiar *works in the HIV sector and teaches a self-development program series, Attaining Nirvana. He lives in Toronto.*

Recommended reading

- Robin Sharma, *The Monk who Sold his Ferrari: A Fable about Fulfilling your Dreams and Reaching your Destiny.* Harper Collins, 1988.
- Eckhart Tolle, *The Power of Now: A Guide to Spiritual Enlightenment.* Namaste Publishing, New World Library, 2004.
- Ramana Maharishi, *Who Am I?* www.ramana-maharshi.org/books.htm.
- Swami Muktananda, *The Play of Consciousness: A Spiritual Autobiography.* SYDA Foundation, 2000.
- Swami Vivekananda, *Raja Yoga. Conquering the Internal Nature.* Eighteen Impression, 1982.

A natural approach to neuropathy

by Jennifer Chung

Relief could be on the way for sufferers of neuropathy. A new study from the Canadian HIV Trials Network (CTN) aims to combat painful HIV-related neuropathy in the feet with an ingredient commonly found in the kitchen pantry.

Neuropathy is a painful and debilitating condition that can affect people with advanced HIV. Symptoms range from mild tingling to severe and excruciating pain in the feet and sometimes in the hands. HIV-related neuropathy is due to nerve damage caused by the virus and can be a side effect of certain anti-HIV drugs.

Led by Dr. John Gill of the Southern Alberta HIV Clinic in Calgary, CTN 221 is testing NGX-4010, a once-daily dermal patch that could help ease the pain and discomfort caused by HIV-related neuropathy. The patch contains a high concentration of trans-capsaicin, a synthetic form of capsaicin—the ingredient that makes chili peppers hot. Researchers believe that capsaicin has the ability to make sensory nerves less sensitive to pain when applied directly to the skin.

"The dermal patch with capsaicin is a natural health product and our hope is that this treatment could provide an alternative to medication for people suffering from HIV-related neuropathy," says Curtis Sikora, the national research coordinator for CTN 221.

While there are other topical products with a low concentration of capsaicin available to treat chronic pain conditions like neuropathy, many of them require repeated applications to affected areas. This can lead to missed doses and overall problems with adherence. The hope is that a once-daily patch with a high concentration of capsaicin could potentially provide similar or better pain relief.

During the three-month study, participants will receive treatment for affected areas in the feet where they will receive either an active NGX-4010 patch or low concentration patches for 30 or 60 minutes. Pain will be measured according to the numeric pain rating scale from one to ten, and participants will be required to keep a diary describing their pain each evening following treatment.

This study is looking to recruit 480 participants at sites worldwide, including the Downtown Infectious Diseases Clinic (DIDC) in Vancouver. According to Dr. Brian Conway, director of the DIDC, this study will benefit people in BC and across Canada because NGX-4010 offers an advantage over other types of therapy for HIV-associated neuropathy.

"Patients with this condition are often treated with toxic systemic therapies, which may include narcotics with a significant risk of addiction," says Conway. "NGX-4010 may provide an effective, non-systemic approach to this very serious problem."

For more information about CTN 221, visit www.hivnet.ubc.ca. ⊕

__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
CTN 222 —	Canadian Co-infection Cohort *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.

Step up to the plate

How the larger community can take responsibility to address the problem

by Sarah Fielden

Food insecurity and hunger are common in people living with HIV in BC. A 2005 publication by the BC Centre for Excellence in HIV/AIDS showed that food insecurity was five times higher for HIV-positive people compared to the general Canadian population. In particular, women, Aboriginal people, people living with children, as well as those with less education, a history of substance use, or unstable housing situations, were more likely to experience food insecurity than other HIV-positive people.

In 2001, the Food and Agriculture Organization of the United Nations defined food security as “a situation that exists when all people, at all times, have physical, social, and economic access to sufficient, safe, and nutritious food that meets their dietary needs and food preferences for an active and healthy life.” (See also “Dual crises” in the March/April 2007 issue of *living* ⊕.)

Hunger is the most extreme form of food insecurity. You don’t need to go far in Vancouver or elsewhere in BC to find people struggling to access and afford nutritious foods for themselves and their families.

Living isn’t cheap in Vancouver

For many people experiencing unstable housing or homelessness, getting three balanced meals in a day is nearly impossible due to low incomes, limited access to social programs such as food banks, and other social and economic barriers. Social assistance shelter allowance in BC is $375 per month for a single “expected to work” person, increased since April 1, 2007 from $325 per month. Food costs are included in a “support” allowance (that is, for all other expenses), increased from $185 to $235.

Despite these raised assistance rates, few people on welfare can find affordable housing or consume balanced, safe, and nutritious meals. In an urban centre like Vancouver, a single person is unlikely to find adequate and safe housing for a single person for less than $600 per month. Subsidized housing exists, but it’s difficult to access, with long waiting lists for accommodations like BC Housing.

There’s little housing dedicated to people living with HIV on limited or no incomes. Many HIV-positive people struggling with poverty live in areas like Vancouver’s Downtown Eastside (DTES) in small one-room units or single room occupancy units, with shared cooking facilities—or no cooking facilities at all. Some residents will have small fridges or a hot plate as appliances in their rooms, but many have no means of safely storing and cooking food. Food in shared kitchens is often stolen.

The difficulty of maintaining hygienic food conditions

Poor housing conditions make it difficult for poor people with HIV to follow guidelines around food safety that are essential to their health. This includes being able to wash hands, foods, and utensils, accessing purified water, and safely storing some perishable foods below freezing temperature. Pests may also make it difficult to store dry items.

Also, people who work with residents in areas like the DTES still report cases of discrimination against people with HIV when trying to access housing. Just last week, a housing manager told a case worker that she was concerned about housing a client because of shared bathroom facilities in the building.

Despite the economic advantages to the taxpayer of improving the housing situation in Vancouver, the decreasing availability of low-income housing in Vancouver has been widely discussed in recent years, with limited impact. In PIVOT Legal Society’s 2006 report “Cracks in the Foundation,” homeless participants from the DTES talked about housing barriers such as limited affordable housing vacancies, insufficient shelter beds and facilities, limited washroom facilities, limited social assistance, insufficient access to drug treatment, lost/stolen ID, physical disability, and insufficient access to mental health support workers. All of these issues will impact a person’s ability to access and prepare quality food items and have good overall nutrition and health.

> **For many people experiencing unstable housing or homelessness, getting three balanced meals in a day is nearly impossible.**

Advocating a community approach to food security

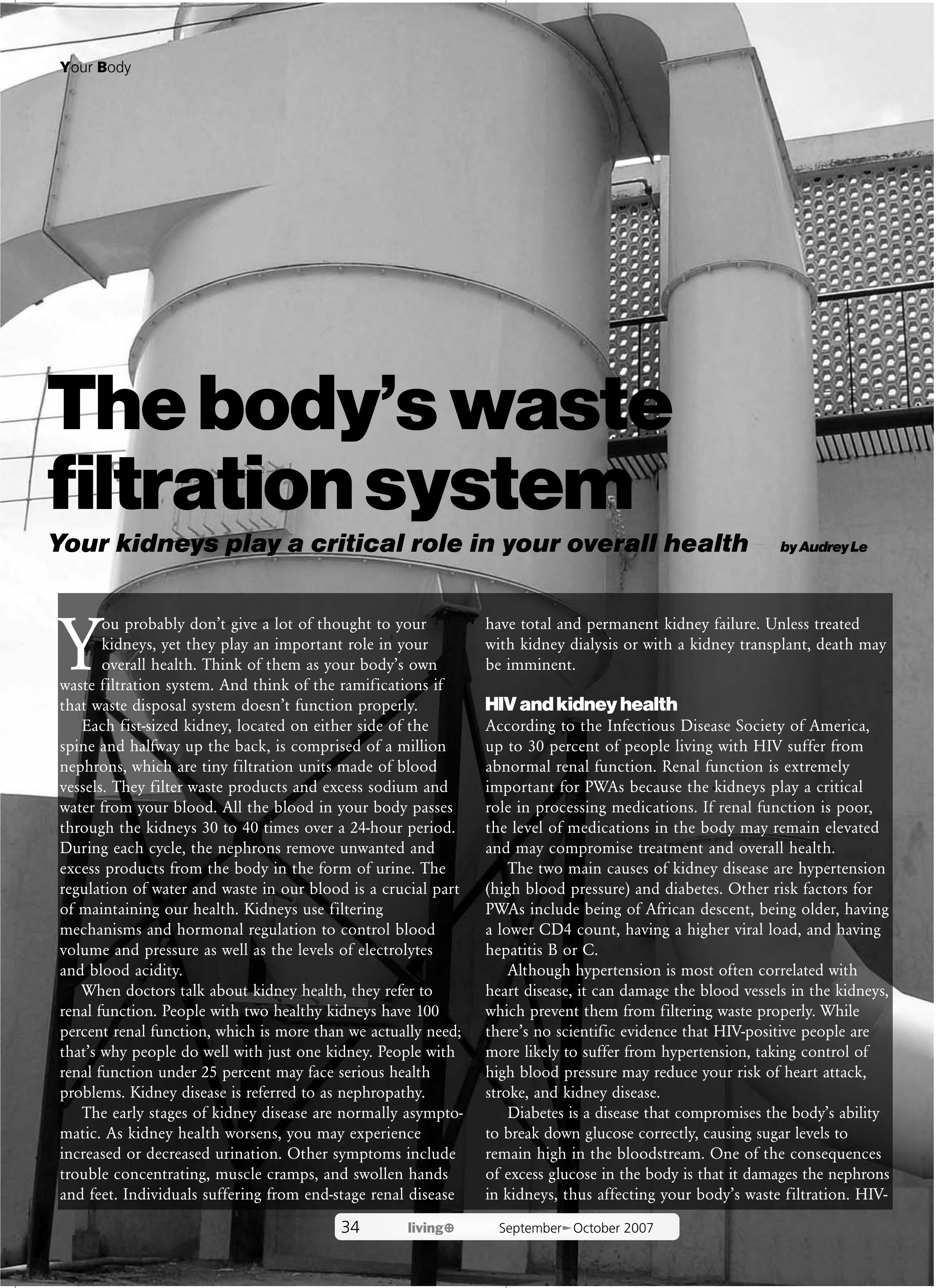
While most food security research and initiatives have operated at the level of the individual, community food security is a fairly new concept described in a recently published position paper from the Dietitians of Canada. According to this paper, community food security “exists when all community residents obtain a safe, personally acceptable, nutritious diet through a sustainable food system that maximizes healthy choices, community self reliance, and equal access for everyone." This approach combines environmental health, economic vitality, social equity and human health to obtain sustainable access to quality food and nutrition.

This perspective calls for innovative community strategies to involve different parts of the food production, supply, and distribution systems to support healthy eating and broader health outcomes like environmental sustainability and local economy. Strategies for people and groups may include:

- Advocating for increases to social assistance rates and the supply of affordable housing
- Advocating for adequate food budgets in facilities/institutions that provide care (such as long-term care facilities)
- Advocating for policy changes to reduce HIV discrimination and other forms of marginalization
- Supporting women and families in their choice to breastfeed infants by creating breastfeeding-friendly environments (such as in hospitals, restaurants, and public spaces)
- Providing tax incentives to attract local food business to low-income neighbourhoods
- Creating broader access to farmers' markets, community shared agriculture, and local food producers, especially for people living on lower incomes
- Encouraging and supporting the development of community kitchens, community gardens, and food box programs in neighbourhoods, especially for people living on lower incomes
- Influencing local food policy such as advocating for school or work policies around prioritizing local food producers and nutritious low-cost menus

Approaching food and nutrition from the level of society and social responsibility can help to improve the food supply and promote health and well-being–broadly and across communities. ⊕

__Sarah Fielden__ is member of Vancouver's Dietitians in AIDS Care, and an interdisciplinary PhD student in Health Promotion at the University of British Columbia.



The body's waste filtration system

Your kidneys play a critical role in your overall health

by Audrey Le

You probably don't give a lot of thought to your kidneys, yet they play an important role in your overall health. Think of them as your body's own waste filtration system. And think of the ramifications if that waste disposal system doesn't function properly.

Each fist-sized kidney, located on either side of the spine and halfway up the back, is comprised of a million nephrons, which are tiny filtration units made of blood vessels. They filter waste products and excess sodium and water from your blood. All the blood in your body passes through the kidneys 30 to 40 times over a 24-hour period. During each cycle, the nephrons remove unwanted and excess products from the body in the form of urine. The regulation of water and waste in our blood is a crucial part of maintaining our health. Kidneys use filtering mechanisms and hormonal regulation to control blood volume and pressure as well as the levels of electrolytes and blood acidity.

When doctors talk about kidney health, they refer to renal function. People with two healthy kidneys have 100 percent renal function, which is more than we actually need; that's why people do well with just one kidney. People with renal function under 25 percent may face serious health problems. Kidney disease is referred to as nephropathy.

The early stages of kidney disease are normally asymptomatic. As kidney health worsens, you may experience increased or decreased urination. Other symptoms include trouble concentrating, muscle cramps, and swollen hands and feet. Individuals suffering from end-stage renal disease have total and permanent kidney failure. Unless treated with kidney dialysis or with a kidney transplant, death may be imminent.

HIV and kidney health

According to the Infectious Disease Society of America, up to 30 percent of people living with HIV suffer from abnormal renal function. Renal function is extremely important for PWAs because the kidneys play a critical role in processing medications. If renal function is poor, the level of medications in the body may remain elevated and may compromise treatment and overall health.

The two main causes of kidney disease are hypertension (high blood pressure) and diabetes. Other risk factors for PWAs include being of African descent, being older, having a lower CD4 count, having a higher viral load, and having hepatitis B or C.

Although hypertension is most often correlated with heart disease, it can damage the blood vessels in the kidneys, which prevent them from filtering waste properly. While there's no scientific evidence that HIV-positive people are more likely to suffer from hypertension, taking control of high blood pressure may reduce your risk of heart attack, stroke, and kidney disease.

Diabetes is a disease that compromises the body's ability to break down glucose correctly, causing sugar levels to remain high in the bloodstream. One of the consequences of excess glucose in the body is that it damages the nephrons in kidneys, thus affecting your body's waste filtration. HIV-positive people, especially those on protease inhibitor therapy, are at an elevated risk for glucose-related problems. According to research, you can reduce your likelihood of developing kidney disease by 50 percent by maintaining tight control of your glucose levels. Your doctor can help you regulate your blood pressure and glucose levels.

Get screened right away

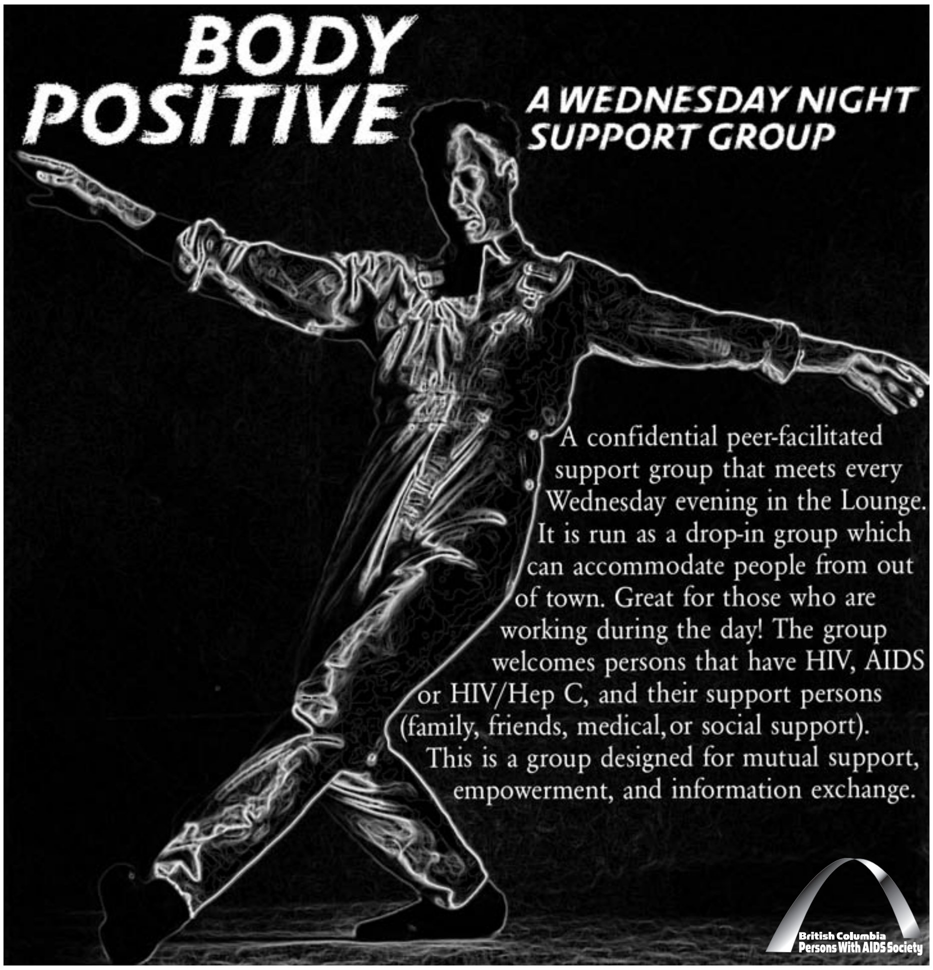
To address kidney health and to maximize your HIV treatment, experts recommend that you get screened for kidney disease soon after being diagnosed with HIV. HIV-associated nephropathy (HIVAN) occurs when HIV enters the kidneys, multiplies, and then wears away and damages the nephrons. Of all the diseases that attack the nephrons, HIVAN is believed to be the most serious. If left untreated, kidney failure can occur within six to 12 months.

Although scientists don't know exactly how many HIV-positive people have HIVAN, research shows that HIVAN is more prevalent among men, people of African descent, and those with a history of intravenous drug use. Low CD4 counts and hereditary renal disease also place people at a heightened risk for developing HIVAN.

> **According to the Infectious Disease Society of America, up to 30 percent of people living with HIV suffer from abnormal renal function.**

The bottom line is that HIV infection can cause kidney problems, which can become serious. Since kidney problems may be asymptomatic, get your urine checked regularly for any signs of trouble. Also, if you have kidney problems, you may need to lower the amount of some antiretrovirals you're taking. With early screening and the aid of your doctor, you can maintain your kidney health. ⊕

***Audrey Le** is a researcher/writer for BCPWA.*



A confidential peer-facilitated support group that meets every Wednesday evening in the Lounge. It is run as a drop-in group which can accommodate people from out of town. Great for those who are working during the day! The group welcomes persons that have HIV, AIDS or HIV/Hep C, and their support persons (family, friends, medical, or social support). This is a group designed for mutual support, empowerment, and information exchange.

Antiretroviral update

Two promising new drugs on the horizon

by Zoran Stjepanovic

On May 30, the BC Centre for Excellence in HIV/AIDS presented an antiretroviral therapy update. One of the sessions focused on new antiretrovirals. There are some exciting new drug developments in the works.

Raltegravir

Dr. Julio Montaner presented information on a new drug called raltegravir (Isentress), by Merck & Company. This drug comes from a new class of antiretrovirals called integrase inhibitors. HIV uses the integrase enzyme to get its viral genetic material into the genetic material of the CD4 cell. Integrase inhibitors prevent this from happening.

There were two identical studies (Benchmark 1 & 2) in phase III ongoing clinical trials that looked at the effectiveness of raltegravir. Benchmark 1 studies took place in Europe, Asia-Pacific and Peru, while Benchmark 2 studies took place in North and South America. HIV-positive individuals who had documented resistance to at least more than one drug in each of the three current drug classes and a viral load of more than 1000 copies/ml of blood were allowed to participate in this study. Participants were randomized and either received raltegravir at 400 mg twice a day along with other antiretrovirals, or they were placed in a placebo group (not receiving the drug).

Participants on raltegravir performed much better, with increases on average of 80 extra CD4 cells while the placebo group gained only 30 additional CD4 cells. After 24 weeks, 60 percent of those using raltegravir achieved viral suppression (viral load below 50), while about 30 percent of placebo group had their viral loads fall below 50. When additional HIV medications were added to raltegravir—either enfuvirtide (Fuzeon) or darunavir (Prezista)—this combination was even more effective.

Early data shows that this drug appears to be well tolerated, with some participants reporting fatigue. As this is a new drug, it's still too early to tell what long-term side effects will be like.

Maraviroc

Maraviroc (Celsentri), by Pfizer Pharmaceutical, is a new entry inhibitor that works to prevent HIV from attaching to the CD4 cell. A CD4 cell has receptors known as CCR5 (R5) or CXCR4 (R4), to which the virus attaches. An individual can have either receptor or both (known as dual or mixed tropism). In the early stages of HIV infection, most viruses seem to prefer the CCR5 co-receptors; over time, this can change to the R4 co-receptors. Maraviroc works only against HIV that prefers to use the CCR5. Before considering maraviroc, individuals will have to have a blood test to see what type of receptor they have.

Motivate 1 and 2 studies examined the effectiveness of maraviroc. Those who participated in the study had to have the R5 receptor, a viral load greater than 5,000 copies/ml of blood, and evidence of drug resistance. Participants were randomly assigned to maraviroc 150 mg once daily, 150 mg twice daily, or a placebo.

The results of this study showed that 45 percent of participants taking maraviroc were able to get their viral load below 50 copies, while only 23 percent of those taking a placebo were able to get their viral load below 50 copies. Participants taking maraviroc saw a higher increase in CD4 cells: on average, they experiences an increase of 106 extra CD4 cells with maraviroc once daily, and 111 extra CD4 cells with maraviroc twice daily. By contrast, participants taking a placebo only gained, on average, 52 extra CD4 cells. The most common side effects reported included diarrhea, fatigue, headache, and nausea. The long-term side effects are still unknown.

Expect to hear more about raltegravir and maraviroc in the future. ⊕

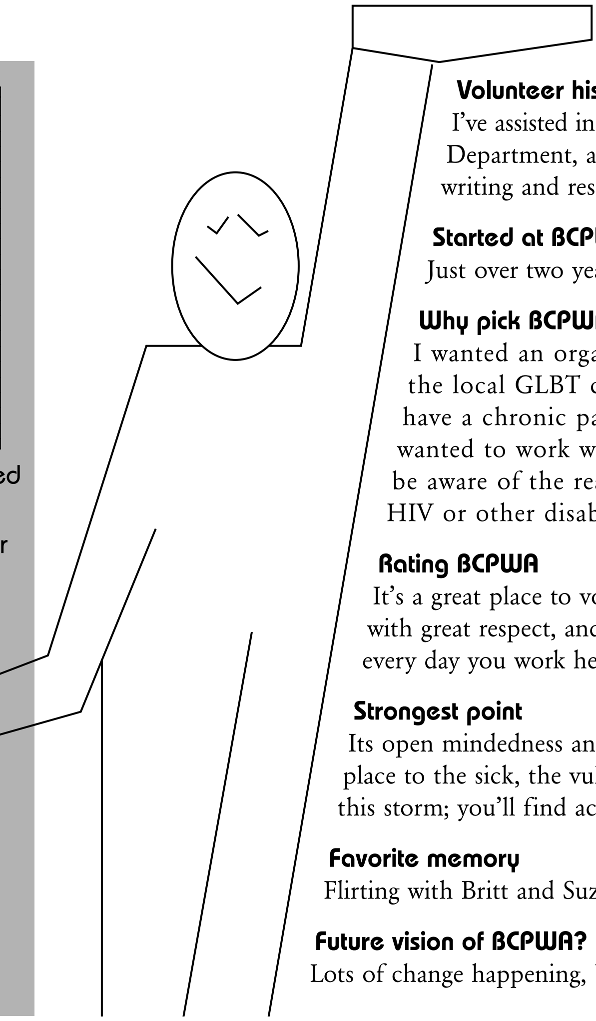
***Zoran Stjepanovic** is BCPWA's treatment information coordinator.*

Volunteering at BCPWA

Profile of a volunteer: Taz Fletcher

Taz is a valued and respected member of our Advocacy team. Always looking out for the underdog, she is a true activist at heart and always has the best interest of our members in mind. I feel fortunate to have worked with her.

Jane Talbot, *former director of treatment information and advocacy*



Volunteer history

I've assisted in Positive Prevention and the Communications Department, and now work in the Advocacy Program, writing and researching.

Started at BCPWA

Just over two years ago

Why pick BCPWA?

I wanted an organization that was historically based in the local GLBT community and gay friendly. As well, as I have a chronic pain disorder and other disabilities, I wanted to work with an organization where people would be aware of the realities we face as PWDs, whether with HIV or other disabilities.

Rating BCPWA

It's a great place to volunteer. Volunteers are valued and treated with great respect, and you can feel that from staff and members every day you work here.

Strongest point

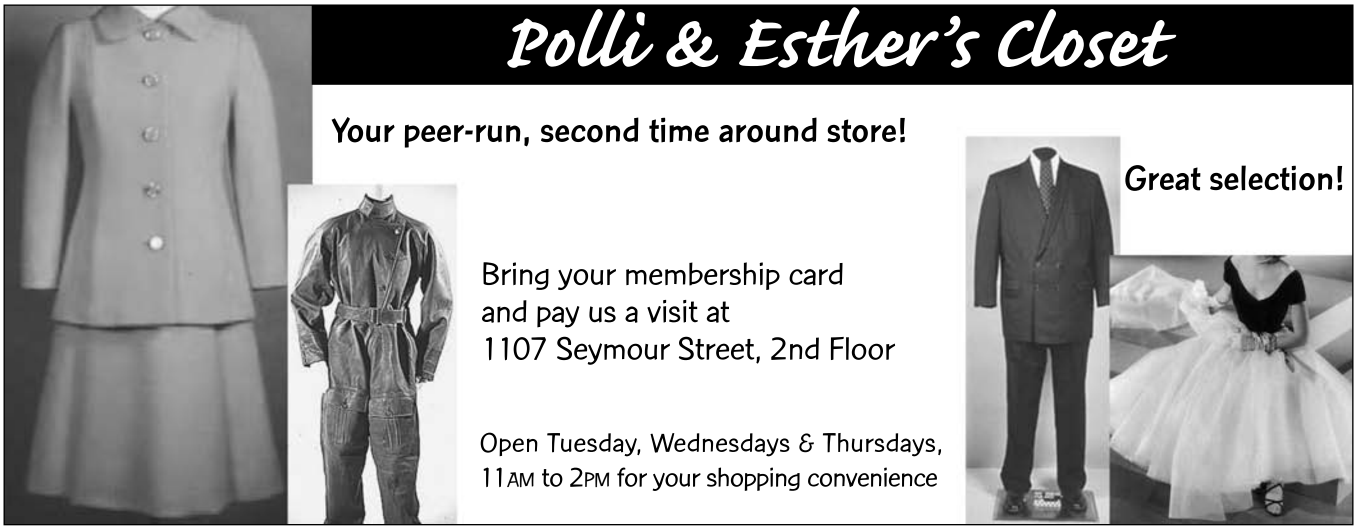
Its open mindedness and compassion. The world is not a friendly place to the sick, the vulnerable. BCPWA is like a sanctuary from this storm; you'll find acceptance and flexibility, not judgment.

Favorite memory

Flirting with Britt and Suzan! And marching in the Pride Parade.

Future vision of BCPWA?

Lots of change happening, but good things I'm sure!



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 or 1.800.665.2437
e info@avi.org ***www***.avi.org
AIDS Vancouver Island
(Cowichan Valley Mobile Needle Exchange)
t 250.701.3667
AIDS Vancouver Island (Campbell River)
t 250.830.0787 or 1.877.650.8787
AIDS Vancouver Island (Port Hardy)
t 250.949.0432
AIDS Vancouver Island (Nanaimo)
t 250.753.2437
AIDS Vancouver Island (Courtenay)
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 info@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 info@oaas.ca ***www***.oaas.ca

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

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

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

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

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

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

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

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

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

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

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

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

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

Upcoming BCPWA Society Board Meetings:

Date	Time	Location	Reports to be presented
September 12, 2007	1:00	Board Room	Executive Committee / Written Executive Director Report Financial Statements — July / Director of TIAD
September 26, 2007	1:00	Board Room	Standing Committees
October 10, 2007	1:00	Board Room	Written Executive Director Report / Financial Statements — August Director of Communications
October 24, 2007	1:00	Board Room	Executive Committee
November 7, 2007	1:00	Board Room	Written Executive Director Report /Standing Committees
November 21, 2007	1:00	Board Room	Financial Statements — September / Director of Support
December 5, 2007	1:00	Board Room	Written Executive Director Report / Executive Committee Quarterly Department Reports — 2nd Quarter

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: Marc Seguin
t 604.893.2298 e marcs@bcpwa.org

Community Representation & Engagement
Contact: Paul Kerston
t 604.646.5309 e paulk@bcpwa.org

Education & Communications
Contact: Julia Smith
t 604.893.2209 e julias@bcpwa.org

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

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

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

Prevention
Contact: Elgin Lim
t 604.893.2225 e elginl@bcpwa.org

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

Treatment Information & Advocacy
Contact: Adriaan de Vries
t 604.893.2284 e adriaand@bcpwa.org

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

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www.bcpwa.org
e-mail to living@bcpwa.org
or call 604.893.2206

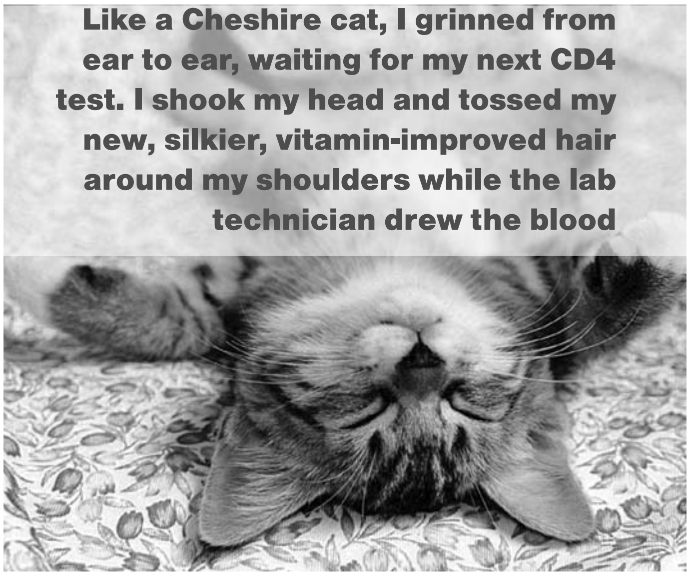
Thinking positive

Reaping the rewards of The Secret

by Denise Becker

A few years ago, my husband Lloyd and I were visiting his aunt, when she brought out a copy of the family tree. She proudly pointed to its most famous member, Andrew Carnegie. Andrew Carnegie came from humble beginnings in Scotland yet became the richest man in America and one of its greatest philanthropists. He's the Carnegie in Carnegie Hall and he gave millions to build libraries so that everyone had a chance to read for free and improve themselves.

Many people point to his steel business as the reason for his massive wealth but he knew that the small group of wealthiest people in America had something different about them. So he commissioned Napoleon Hill to write a book, *Think and Grow Rich*, which explained that "the secret" was in how the richest people thought.



Like a Cheshire cat, I grinned from ear to ear, waiting for my next CD4 test. I shook my head and tossed my new, silkier, vitamin-improved hair around my shoulders while the lab technician drew the blood

Unless you were at the North Pole or in a jungle for the last year, you'll surely be familiar with the best-selling book and movie, *The Secret.* (If this was an audio Last Blast, you would have just heard me whisper those last two words.) The Secret is about the law of attraction: how quantum physics gives us the power to attract the good–or the bad–to us. The movie puts it in simple terms: think about how bad life is and the bad will continue, think about how good things are and–presto!–good things will happen to you.

I was fascinated and convinced. Life changed for me the moment I saw the movie.

One interesting scene in the film is when a feng shui guru talks to a man about the negative paintings he has in his house. For me, that seemed to be a good place to start. My favourite piece that I had painted, "Ground Zero," was hanging in my kitchen. I love that painting, but it wasn't a good way to start in the morning, with the twin towers engulfed in fire. I had made too much burnt toast recently. It all made sense. The painting now hangs in a quiet corner of the living room.

I looked at my fridge magnet with the quote, "Be the change you want to see in the world," by Mahatma Gandhi. We were already saying "no more" to ridiculous prices for third-world HIV therapy. We were protesting needle exchange closures. Women were getting tested for HIV during pregnancy, resulting in far fewer babies born with the disease. I was beginning to feel like Bridget Jones, walking confidently. Life was good.

I went to the beach and picked out a gratitude rock. Each time I rubbed it I was going to be grateful for what I had. I wasn't going to wallow in a "poor me with HIV" attitude. I was going to concentrate on getting myself to a better place. I realized nothing would change without me making an effort.

Like a Cheshire cat, I grinned from ear to ear, waiting for my next CD4 test. I shook my head and tossed my new, silkier, vitamin-improved hair around my shoulders while the lab technician drew the blood. It didn't even hurt. Why would it? Nothing would bother me again.

A week later, there was no sign of my blood sample at the hospital, so I took another blood test. No big deal. I couldn't help jumping up and down when my blood came back 200 CD4 cells higher–the best ever! And all because I had stumbled on "The Secret."

Two days later, I got a call from my doctor's office saying they had found my original blood sample. It was 400 CD4 cells lower than the one taken on Friday. What? How could that be? Calm down, think positive, think positive, I kept telling myself. My overall percentage was excellent. Life is good. It's happening, and it's going to get better!

Sure, it can be incredibly challenging to think positive when the world around you sucks. But it's so much better for me to have hope than to be hopeless.

Live your best life and the world *will* make a shift for the better. ⊕

***Denise Becker** is the founder of the Hummingbird Kids Society. She lives in Kelowna.*