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treatment information

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British Columbia Persons With AIDS Society

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

***living*⊕ editorial board**
Wayne Campbell – co-chair, Neil Self – co-chair, Michael Connidis, Sam Friedman, Rob Gair, Derek Thaczuk, Glyn Townson

Managing editor Jeff Rotin

Design / production Britt Permien

Copyediting Alexandra Wilson

Proofing Carl Bognar

Contributing writers
Michele Blanchet, Jennifer Chung, Melissa Davis, Glen Doupe, Jari Dvorak, Dr. Mark Gilbert, Robert Hogg, Sean Hosein, R. Paul Kerston, Carole Lunny, Jane Talbot, Carley Taylor, Soni Thindal, Katolen Yardley

Photography Britt Permien

Acting director of communications & education
Julia Smith

Director of treatment information & advocacy
Adriaan de Vries

Treatment informationcCoordinator
Zoran Stjepanovic

Director of positive prevention
Elgin Lim

Subscriptions / distribution
Ryan Kyle, Joe LeBlanc, Martin Davies

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living⊕ magazine
1107 Seymour St., 2nd Floor
Vancouver BC V6B 5S8
TEL 604.893.2206 **FAX** 604.893.2251

EMAIL living@bcpwa.org
BCPWA ONLINE www.bcpwa.org

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opinion & editorial . . .

A cross-cultural information exchange

by Glyn Townson

At the BCPWA Society, we've identified a need to learn more about providing services to the growing number of African immigrants. British Columbia has the third largest number of African immigrants in Canada. Many settled in BC's Lower Mainland and access important services through our agency, such as advocacy resources and crisis grants for food, clothing, and shelter.

In order to help address this growing trend, BCPWA submitted a funding application to the Federal Initiative to Address HIV/AIDS in Canada's HIV/AIDS Global Engagement Grants Program. The project would be an information exchange between BCPWA and the Lagos State AIDS Control Agency (LSACA) in Nigeria.

Most African refugee claimants who come to Canada are from Nigeria. Many of them face challenges such as risk of deportation based on their HIV status, racism, HIV stigma, and culture shock. The delegates visiting from Nigeria could inform BCPWA about some of the issues facing new immigrants and how best to engage and provide services for them. We are sure that BCPWA would benefit greatly from the cross-cultural exchange.

The visiting delegation would be from Lagos, the commercial centre of Nigeria. Lagos has the second largest population of HIV-positive people after South Africa. In Nigeria, HIV/AIDS service agencies face huge challenges in engaging and providing services for marginalized populations such as men who have sex with men (MSM) and injection drug users (IDUs). Although the bulk of infections are through heterosexual contact, LSACA specifically requested to learn best practice methods to engage and provide services for IDUs and MSM, two groups with rapidly increasing rates of HIV infection.

If the project is funded, the proposed date for this project would be in the last half of November of this year, before World AIDS Day. The visiting delegation would hold workshops with BCPWA and other AIDS service organization. Special activities would focus on sharing experiences and exchanging ideas on how to best empower ourselves in both Lagos and Vancouver. The legacy of the grant would be a simplified and effective website that could be maintained by volunteers. ⊕

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

New BCPWA executive

At its first regular meeting following the Annual General Meeting at which new directors were elected, the BCPWA Board of Directors determined the new composition of its Executive Committee. The Executive Committee members are: Glyn Townson, chair; Paul Lewand, vice-chair; Keith Morris, treasurer; and Ken Buchanan, secretary.

Nelfinavir advisory

Nelfinavir is a protease inhibitor that is no longer commonly used in Canada. In North America, nelfinavir is manufactured by Pfizer, Inc. In the European Union (EU), it is made by Hoffmann-La Roche.

Last June, Roche informed the European Medicines Agency that some batches of nelfinavir in the EU had become contaminated with unexpectedly high levels of a harmful substance called ethyl methanesulfonate (EMS). As a result, Roche recalled all packages of nelfinavir.

Pfizer then tested supplies of nelfinavir used in the US and Canada and found that they also contained EMS, but the levels were about 200 times less than what was found in the EU.

Health Canada has therefore recommended that, in general, people with HIV/AIDS—in particular pregnant women and children—who are using nelfinavir should be switched to another anti-HIV medication. PWAs should not stop taking it without first consulting their physician.

Source: CATIE

Government gives another extension for Insite

Ottawa's six-month reprieve for Vancouver's safe injection site simply allows the government to shelve the issue until after a possible fall election, leaving a suffering community in limbo, say supporters of the site.

Though they applauded the announcement from the federal government that Insite can remain open until June 2008, doctors, community activists, and opposition politicians said they are frustrated that a health issue has become a political football.

Health Canada announced it would extend the exemption from Canada's drug laws that allows Insite to operate. The exemption was set to run out at the end of the year.

A spokeswoman for Health Canada said the exemption will allow further research. However, reams of research have been done on Insite since it opened in 2003. The studies have included results showing drug addicts who used the program were more likely to enrol in detox programs, and more likely to start methadone replacement programs and reduce their number of monthly visits to shoot up.

Source: The Canadian Press

Roche abandons Biojector 2000 for T-20

Drug company Roche has withdrawn its application to US regulatory authorities for approval of a needle-free way of administering their fusion inhibitor enfuvirtide (T-20, Fuzeon).

T-20 is the only antiretroviral drug that needs to be injected. It has a relatively benign side-effects profile, but twice-daily injecting of the drug leads to the development of injection site reactions in 98 percent of patients.

Clinical trials had shown that the Biojector 2000 (B2000) was a generally safe and acceptable method of T-20 administration. Rather than using needles, the B2000 uses high pressure to force T-20 below the skin. Although the B2000 reduced the incidence of injection site reactions in T-20-treated patients, earlier this year the US Food and Drug Administration updated the product labelling for the B2000 after it was found to cause long-lasting nerve pain in some patients.

Source: Aidsmap

New national anti-drug strategy a step backward

The new National Anti-Drug Strategy recently unveiled by federal Health Minister Tony Clement is a huge step backward for Canada's response to HIV/AIDS, says the Canadian HIV/AIDS Legal Network.

The new strategy funds law enforcement, prevention, and treatment programs—three of the four so-called pillars common in many drug strategies. But the fourth pillar, harm reduction—which includes needle exchanges, methadone clinics, and safe-injection facilities—has been eliminated.

"The federal government is ignoring widely published scientific evidence on the value of investing in harm reduction programs," said Richard Elliott, executive director.

continued on next page

The new drug strategy apes the failed US approach of treating drug addiction primarily as a criminal matter, rather than a matter of public health. But despite spending billions of dollars on its "war on drugs," not a dent has been made in reducing either drug supply or drug consumption in the US.

Source: www.newswire.ca

Acetyl-L-carnitine promising for neuropathy

In a recent article in the journal *CNS Drugs*, Michael Youle, MD, a noted HIV specialist at London's Royal Free Hospital, claims that acetyl-L-carnitine (ALC), an over-the-counter amino acid supplement, is a promising treatment for peripheral neuropathy.

Characterized by alternating numbness, tingling, and pain in the feet, legs, hands, and arms, peripheral neuropathy can result from the use of certain antiretroviral medications, predominantly didanosine (Videx) and stavudine (Zerit). There are currently few treatments for neuropathy, and none is highly effective.

In the article, Dr. Youle reviews several small studies that have explored whether taking ALC can protect people from developing neuropathy or treat people who have already developed it. One early study found that people who took 1500 mg of ALC twice a day showed evidence of both nerve regeneration and a reduction in painful symptoms. A somewhat larger study found that ALC was significantly better able than a placebo to alleviate neuropathy symptoms.

Source: www.poz.com

New protease inhibitor for hepatitis C

Telaprevir is a protease inhibitor specific for hepatitis C. It is currently being fast-tracked for approval in the US by Vertex Pharmaceuticals.

Preliminary data from an ongoing study in people with type 1 hepatitis C virus who had no previous treatment showed that adding telaprevir to standard interferon and ribavirin dramatically increased treatment success. Approximately 79 percent of people who received standard treatment plus telaprevir had undetectable hepatitis C virus after four weeks, compared to only 11 percent of people getting interferon/ribavirin with no telaprevir. A new study is currently underway to evaluate how the drug performs in people who have previously failed interferon and ribavirin. So far, there are no studies in people who are co-infected with hepatitis C and HIV.

If approved, the drug will probably be marketed by Tibotec Pharmaceuticals.

Rob Gair

Source: Medscape

Calling all community advocates

The Canadian Treatment Action Council (CTAC) serves the needs of PWAs by securing treatment access, advising public policy, and promoting public awareness. In BC, CTAC has 52 members, each possessing lived experiences, knowledge, and skills that represent an enormous untapped resource to be organized into a powerful community advocacy group.

Sam Friedman, recently elected as CTAC's BC representative, is initiating a pilot research study titled: Data Mining the Gold from BC's CTAC Members and BC's Community Advocates. If you're a BC CTAC member or community advocate, your participation is critical. Absolute discretion and confidentiality are assured. No personally identifiable data will be collected. Research assistants are also required.

To participate or for more information, contact Sam at 778.737.8830, noon to 5pm (collect calls accepted) or email scfman1@hotmail.com or britishcolumbia@ctac.ca.

New social group for young, gay PWAs

Being young, gay, and HIV-positive today has so many challenges, and creating a space where none of those things defines you can be even more challenging. With this in mind, YouthCO AIDS Society (www.youthco.org) and Gayway (www.gayway.ca) have come together to host a monthly social group for young gay men, between 19 and 35, who are living with HIV.

The group will be held in a relaxed environment, with good food, fun activities, and no expectations other than to come enjoy and hopefully connect with a group of peers.

The group will meet the first Thursday of every month, starting December 6 at Gayway's new offices at 900 Helmcken Street in downtown Vancouver.

For further information, suggestions, or just to connect, contact YouthCO at tel: 604.688.1441, or e-mail: waygay@youthco.org. ⊕

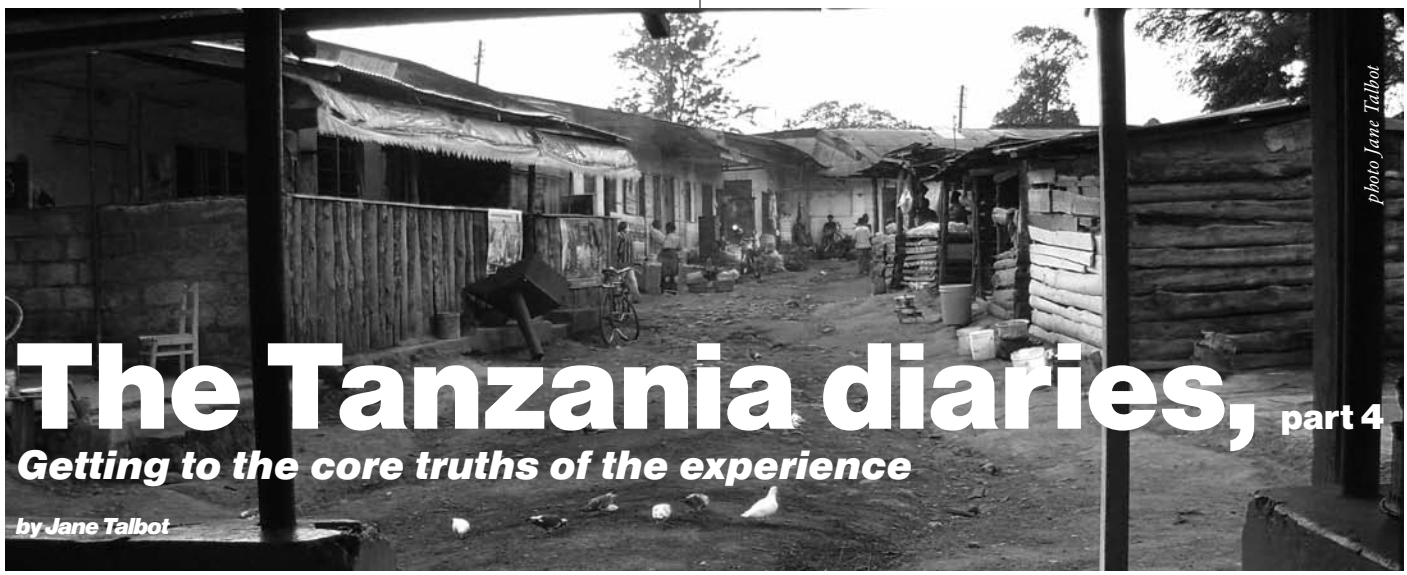


photo Jane Talbot

The Tanzania diaries, part 4

Getting to the core truths of the experience

by Jane Talbot

It's been almost a year since I left for Tanzania and even though the trip is behind me, the experience has always felt as though it lacked a conclusion. I couldn't find the words to properly express my thoughts and feelings. I finally realized that the ending had been written—not by me, but by a stranger.

On my last day in Arusha, I was sitting in a café feeling exhausted and sick, questioning whether my time in Tanzania had mattered in any way. I was beyond filthy. All I wanted to do was to take a hot shower in a western bathroom where I could wash my hair and clean the African dirt from my fingernails for the last time. I just wanted to go home.

As I was about to leave the café, a gentleman who I had seen a number of times asked if we could talk. I gestured for him to sit down. After a few moments of polite chitchat, he looked directly into my eyes and asked, "What will you tell the people back home about your time here?"

Before I could answer, he lowered his voice. "Please tell them this: Tell them to stop sending money to Africa. Tell them that their donations are not reaching the people in need and are serving mostly to make a few people very wealthy. Tell them about the new mansions outside of town and about the poverty, sickness, and death that you must step over every day on your way to this café. Tell them about the homeless children begging on the streets, about the people who cannot get medications or medical help, and tell them about the crime.

"Tell them that their money is creating wealthy people who use it to build beautiful homes, to buy SUVs, and overseas education for their children. Tell them that if they really want to help, they must send their money to an organization in North America or Europe that works to make real change or to find a cure. Tell them that a cure is the only thing that will help or save us.

"Promise me you will tell them this."

I nodded a slow confirmation and he left.

I have since formed a few loose conclusions: it is irrelevant whether my personal work helped in any meaningful way—meaning is subjective and no person can begin to crack the enormous crisis that now attacks Africa and may soon move on to other parts of the world. Also, I used to think that my work at BCPWA was important but "the real work" could only be done on the "front line" of the actual epidemic. I was wrong. Everywhere there is HIV, there is a potential epidemic. Even with the latest drugs, viruses will eventually mutate in a primal instinct to survive.

The truth may be that unless you live in the thick of a rampant AIDS epidemic, you cannot comprehend the gravity and enormity of the problem. Yes, holding an innocent African baby who was born infected may evoke a sense of heartbreak or nihilism, but the baby will die and will no longer suffer.

The experience has always felt as though it lacked a conclusion. I finally realized that the ending had been written—not by me, but by a stranger.

There are countless babies yet to be born and they need a cure. The Western world has the resources and facilities to discover a cure and the effort must be led from here. It's too late to be proactive, but we cannot be moved by urgency and fear when our statistics begin to climb and the "wrong people" begin to suffer. Inevitably, this will occur at some point unless the collective, ultimate objective is a cure.

Finally, I am keeping a promise to one Tanzanian man and I write his words—from his perspective, from his soul. I once believed that "if I could help just one person," somehow that would make a difference. That was naïve. If I help one person, three others die. Nonetheless, I am now seeking to help one person by conveying his words.

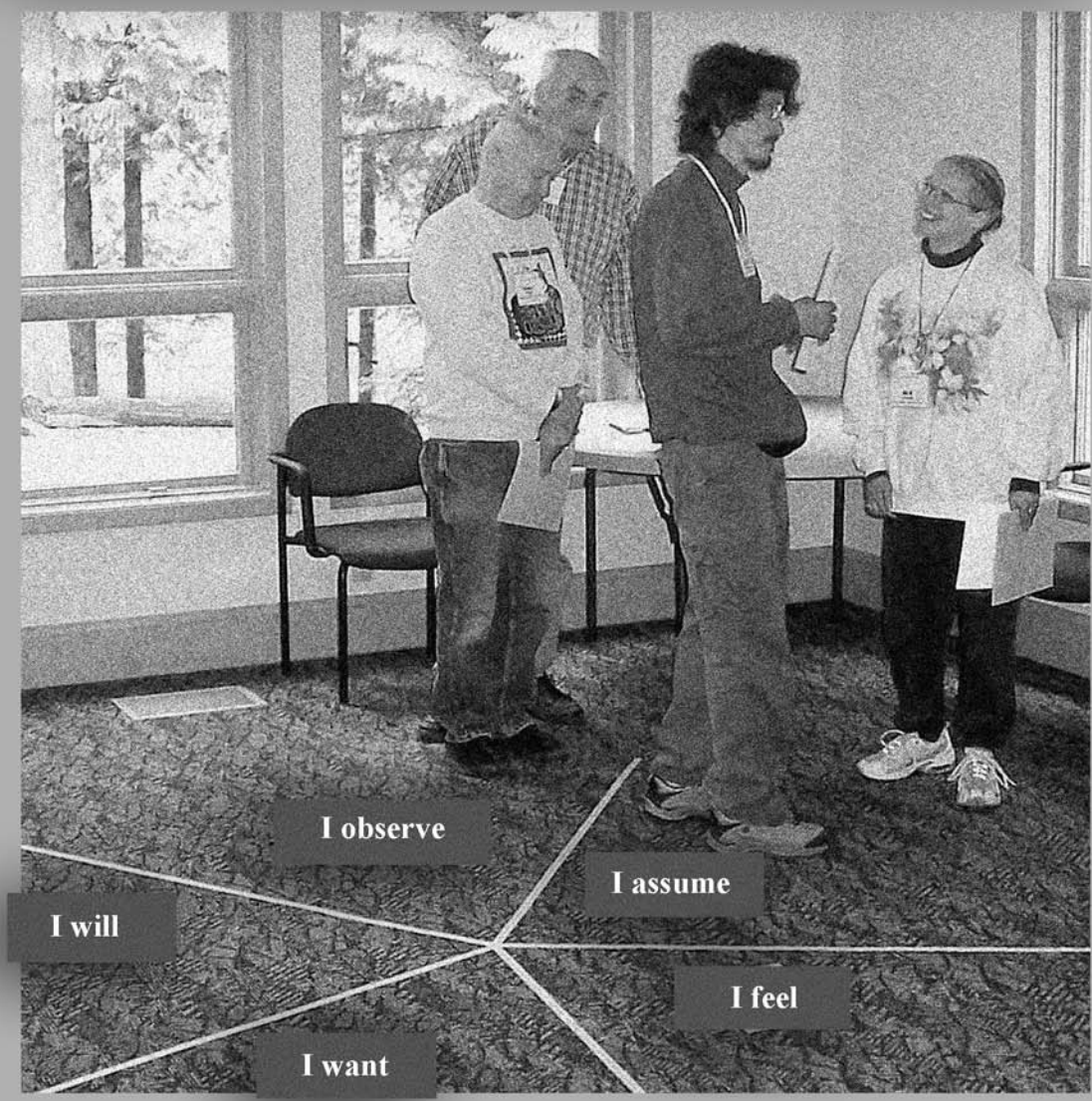
Giving that man's words a voice may be the one truly authentic action of my African experience. ⊕

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

Strengthening the bond

BCPWA's serodiscordant couples retreat was a big success

by Neil Self



In spring of this year, BCPWA's Support and Prevention Departments collaborated and delivered the second successful couples' workshop retreat. Eight serodiscordant couples (one is HIV-positive, the other is HIV-negative) attended a three-night, four-day workshop.

The concept of a serodiscordant couples' workshop came about for two key reasons: the BCPWA strategic plan called for the development of a new population- or issue-specific retreat, plus the 2002 Sex Now Survey revealed that half of all HIV-positive people in relationships, were in relationships with HIV-negative partners.

Helping couples help themselves

In developing the couples' workshop, the retreat team took its direction from serodiscordant couples themselves. While core programming was borrowed from the healing retreat model of small group sessions, much of the programming was researched and proposed by the retreat team, and then confirmed by 20 serodiscordant couples in an orientation and information session held in 2005. Past participants were also included in the retreat team.

The programming is designed to strengthen, affirm, and enhance the couples' relationships. Workshops included such topics as understanding

their partner's personality type, how to communicate, couple visioning, and planning a future together. The objective of the sessions was to help the couples develop and utilize their own tools to tackle their own relationship challenges. Newer couples may be discovering and using these tools for the first time, while more experienced couples may simply need a primer, reminder, or a reason to reengage those tools.

More experienced couples can share their wisdom and experience with the newer couples and the newer couples may bring different perspectives to the discussion. And for all couples, the objective is empowerment—in keeping with our Society's mandate.

Teaching old dogs new prevention tricks

As for HIV prevention, serodiscordant couples have successfully navigated the prevention minefield by virtue of their serodiscordant relationship. So prevention should be a non-issue, right? Wrong! Research on serodiscordant couples suggests that, over time, serodiscordant relationship members can take on more increasingly sexually risky behaviour within their relationship, in an effort to increase intimacy or as a 'test of their relationship." This poses a different type of challenge to the traditional prevention approaches.

This situation requires a more holistic approach to prevention and programming must be designed to address the issue from multiple angles. First, it needs to build on the successful past—and current—prevention within the relationship. It must acknowledge and celebrate the fact that the relationship has stayed serodiscordant. The lack of programs and services for serodiscordant couples suggests that most current prevention approaches take serodiscordant couples' prevention efforts for granted.

Prevention approaches also require a focus on communication skills between the couples. Most effective interventions in any couples-focused programming supports continued dialogue between the couple. Couples must continually discuss and evaluate their feelings, assumptions, challenges, and behaviour.

Serodiscordant couples should also be given the opportunity to expand their social network and share and learn from other serodiscordant couples. This reduces isolation and provides a safe environment for couples to talk and learn from other couples. Meeting other serodiscordant couples can inspire couples and provide positive role models.

Serodiscordant couples have successfully navigated the prevention minefield by virtue of their serodiscordant relationship. So HIV prevention should be a non-issue, right? Wrong!

The complexity of HIV requires that both PWAs and their non-positive partners need to be continually educated in the latest on treatment and prevention.

The couple that plays together stays together

While the workshop is packed full of educational and skills building sessions, it's also important to provide a fun and comforting environment that will allow the couples to relax, open up, and build on their relationship. The retreat team takes on the role of "social director" and encourages couples to partake in the social and recreational activities. Couples can spend time canoeing in or walking around Loon Lake. They can attend a seated massage workshop and learn how to massage each other. They can also participate in games that occur in the evenings or simply sit around the fireplace and chat.

All couples who attended the two couples' workshop retreats have completed extensive evaluations. The evaluations from the 2007 Couples Workshop Retreat were overwhelmingly positive and some valuable critical input has been received in a continual effort to improve the programs and services.

Two areas received unprecedented perfect scores from all of the couples: the food and the efforts of the retreat team. On the retreat team efforts, one participant wrote: "[They were] bloody amazing. Every member of the retreat team brought their compassion, insight, and professionalism to the retreat while checking their baggage at the door. BCPWA has set the platinum standard for peer involvement. Thank you."

The couples expressed enthusiasm about the programs. One participant wrote, "The skills that I learned from [them] were eye-opening. I felt I grasped the communication wheel the best. The couple visioning was inspiring."

The small group work was also well received. One HIV-negative partner wrote, "As one of the negative partners, it was excellent to be able to talk to others in the same situation, share our experiences, and make it a little less scary." Another participant wrote that the couples group was "one of the most powerful experiences of the weekend."

Of the social and recreational activities, one participant wrote that "all the games were very fun, the [final evening social event] had so much detail and work put into them. I felt cared for and special. And it was very cool to see the facilitators so into the events, too!"

With respect to the overall workshop retreat experience, a participant noted, "I didn't think this was for me as I had some uncertainty about it. I didn't realize how much I actually needed this retreat. I thought I was one of very few in this situation but now know different. I got exactly what I needed." Another participant wrote that the overall retreat experience was "one of the best experiences in my 17 years of being positive. Thank you for helping me realize the 'normalcy' of my relationship."

A third couples' workshop retreat is planned for 2008 or 2009. ⊕

***Neil Self** is a social worker, a BCPWA retreat member and a BCPWA board member.*

Telling it like it is

A report on the results of BCPWA's End HIV Stigma campaign

by Melissa Davis

In February 2006, the BCPWA Society received the 2006 – 2007 BC Association of Broadcasters' Humanity Award, based on an earlier proposal to launch an advertising and awareness campaign to expose the issue of HIV stigma. The award consisted of widespread broadcast media exposure, with a commercial value of $3 million. Cossette Communications, in conjunction with local production company Steam Films, agreed to produce, pro bono, a series of radio and television commercials for the campaign.

BCPWA's provincial campaign to end HIV stigma ran from July 1, 2006 – June 30, 2007 and included two TV and radio commercials; a website, www.endHIVstigma.ca; and a toll-free phone line for British Columbians seeking additional information, support, and referrals. A series of four issue-related fact sheets were also developed and distributed.

Throughout the campaign, BCPWA received considerable praise from the AIDS community, public health organizations, advocacy groups, PWAs, and many other citizens for our bold response to a 25-year social problem. We also received some critical feedback for the provocative approach and language used in our campaign advertisements.

At the conclusion of the campaign, a detailed report was prepared, analyzing community response and feedback received through email communications, online feedback surveys, and telephone calls.

Over the year, BCPWA received 43 emails in response to the campaign. Email respondents were roughly evenly divided in their impressions. Nineteen emails clearly endorsed the campaign. Another 17 emails criticized the creative approach used. And a further seven emails could not be classified as either positive or negative; most of these communications sought additional information about HIV, the campaign, or requests for print materials.

The End HIV Stigma website received 9,168 unique visits along with 97 online feedback surveys completed. Among online survey respondents, the overall approval rating for both commercials was 53 percent. A smaller proportion (42 percent) of individuals expressed disapproval, while 3 percent and 2 percent of respondents respectively indicated a neutral opinion or didn't answer the question. Interestingly, 70 percent of survey respondents indicated that the website was a very effective informational resource.

Both original and edited versions of the campaign commercials were uploaded to YouTube. Although the ads registered only a modest number of views (4,600 – 6,700), all four versions received scores of 4½ stars out of 5—an approval rating of 90 percent.

Out of 36 calls received to the toll-free campaign phone line, response was mixed. While no calls specifically registered praise for the advertisements, 12 callers phoned for further information, referrals, support, and DVD copies of the commercials for educational purposes. Fourteen callers registered complaints about the ads. An additional 10 calls were chronic or problem callers.

We did something especially powerful: we got under people's skin. We exposed them, repeatedly over the year, to a depiction of unsavoury and offensive behaviour.

Were our efforts ultimately successful? We think so. The strong reactions—positive and critical—from the campaign advertisements attracted media attention, spurred dialogue in communities and among families, and drew nearly 10,000 new people to our campaign website. And we did something else, something especially powerful: we got under people's skin. We exposed them, repeatedly over the year, to a depiction of unsavoury and offensive behaviour.

We didn't paint a pretty picture. We reminded some people of others. We reminded some of themselves. We demonstrated—unapologetically—the indisputable ugliness of stigma, prejudice, and discrimination. And we made people reflect: *It's time to change the way we think about HIV and AIDS.*

A copy of the complete campaign report is located on BCPWA's website. ⊕

***Melissa Davis** was BCPWA's acting director of communications from April 2006 – July 2007.*

Anxiety in overdrive

When the merry-go-round of fear won't stop

by Michael Connidis

Whether you have HIV, care for someone who's HIV-positive, or do what you can to protect yourself and others from the virus, HIV is a loaded reality that can rattle your cage. The attendant issues can, at times, increase your heart rate, preoccupy your thoughts, and deprive you of sleep. When these or other physical and emotional responses become extreme or prolonged and interfere with your ability to carry out routine activities, you could be dealing with clinical anxiety.

Take Phil (not his real name), a BCPWA member. He vividly remembers the moment it happened to him:

"It was 1993 and I was on AZT monotherapy; no antiretroviral cocktails then. At home alone, I was sorting through photos at my workbench. My thoughts had drifted off into the future when suddenly my heart started beating rapidly. I couldn't breathe and started gasping for air. I began to feel lightheaded. I thought I was having a heart attack. A wave of fear washed over me. My legs began to buckle."

continued on next page

"The next thing I knew, I had collapsed on the floor. I curled up on my side, crippled by feelings of dread and sadness, and waited for the end. After what seemed like hours my heartbeat began to slow and my breathing became more even. I burst into tears and lay there crying. Afterwards I felt shaken and afraid. I didn't know what had happened to me."

Your brain as a monitoring system

Even in the absence of disease, your body must remain alert and responsive to the world around you. Your senses are picking up information about your environment at all times. As you walk along the street, sit in a café sipping a coffee, or even flake out on the couch, your brain is receiving signals from all your sensory organs and directing your body to respond accordingly. This constant monitoring keeps you in a state of readiness to take appropriate action.

This monitoring system can trigger two extremes in the spectrum of responses. At one end, when everything is calm and there's no cause for concern, your brain tells your body that it's a good time to "rest, relax, and digest." Your heart rate slows, you breathe easy, your muscles relax, and your body draws nourishment from your digestive system. You're at ease and can sleep well.

It's not just what's going on around you that can bring about anxiety. Your thoughts, worries, and fears are part of an internal world that can trigger a shift in your psycho-emotional equilibrium.

At the other end, when something or someone threatening is present, your brain puts your body on red alert, shifting it into a "fight, flight, or freeze" mode. Your heart begins to beat faster, pumping more blood to your muscles. You breathe rapidly, even to the point of panting, drawing more oxygen into your body. The flow of blood to your digestive system is reduced. In extreme situations, you might vomit or be incontinent. Your senses are heightened and you're acutely aware and alert. You're prepared to take physical action.

It's not just what's going on around you, the external world, that can bring about the "relax, rest, and digest" or the "fight, flight, or freeze" responses. Your thoughts, worries, and fears are part of an internal world that can trigger a shift in your psycho-emotional equilibrium. Conscious thoughts and feelings can bring on the same defensive responses as external realities. Unconscious thought can have an equally powerful impact on your well-being.

The mechanics of anxiety

Most of the time, you move through your daily routines in a balanced state, aware yet at ease. To function effectively and be healthy, your body's response to your internal and external worlds must be regulated and balanced. Your body has a feedback mechanism that does this. Once a threat has passed or disturbing thoughts have been rationalized, your body switches off its defense mode and moves towards a more relaxed state. On the flip side, when you're relaxed and need to move from couch potato to action hero, your defenses gear up and prepare you for whatever may come along.

For some of us, this balanced state can suddenly and unexpectedly be disrupted. For others, the shift into the "fight, flight, or freeze" mode may be too strong and last too long relative to what's going on. Rather than prepare and protect us, the defense responses disorientate us, exhaust us, and put us at risk. A rapid heart rate, shallow breathing, weakening or stiffening in the arms and legs, along with feelings of intense fear or even terror may overcome you—and it may seem out of the blue. These are some of the symptoms of a common form of clinical anxiety, the panic attack.

"I kept having these spells, feeling paralyzed by this sense of impending doom," says Craig (not his real name), another BCPWA member. "It was awful and frightening. I never knew when it was going to come on. I felt like I was losing my mind and things were going out of control. Finally I told my doctor about it."

Specific vs. non-specific anxiety

While the physical, mental, and emotional experiences of clinical anxiety may be similar, what brings on the extreme and debilitating reactions can be very different for each person. There are two main categories of anxiety, specific and non-specific.

Specific anxieties are associated with perceived threats and involve an over-reaction to minor problems or even real dangers. There can be an historical component to this type of anxiety, as in post-traumatic stress syndrome. Certain situations, such as parties or meetings, cause sufferers of social phobias great anxiety. Different triggers that set off the exaggerated defense response are associated with these and other types of specific anxiety.

Non-specific anxieties aren't connected to a particular situation, person, or thing. People with non-specific anxieties react in situations that are neither dangerous nor threatening. Also referred to as free-floating anxiety, it's more difficult to treat. It may have a biological basis, such as a genetic predisposition

to worry. It can also be symptomatic of underlying neurological or mental health problems. Substance abuse, such as crystal meth use, can also cause free-floating anxiety. Some medications, such as efavirenz (Sustiva), have been implicated in this form of anxiety.

There's also a sub-category of clinical anxiety, anticipatory anxiety, which many people living with HIV are familiar with. It's an ongoing fear of possible future events and conditions that are seen as threats to one's health and well-being. Thus, your mind can be the primary source of stress, generating thoughts and visualizing possible realities that evoke an intense fear of the future. For example, medical appointments or shifting government policies that affect your housing or disability income can cause you to dread what may lie ahead. Most often, anticipatory anxiety is driven by both how you direct your thoughts and how you manage external events and situations.

Treating with medication, counselling, and therapy

Clinical anxiety can be treated and resolved. Medication is often the first line of treatment. Medications can help you gain mental and emotional stability and ease your physical discomfort so you can focus on what may be at the heart of your anxiety.

There are several classes of medications. Antidepressants, like Wellbutrin or Zoloft, are usually the first-line drugs and aren't addictive. Anxiolytic medications such as Xanax and Valium have the potential for abuse and dependence. Noradrenergic drugs, which are either alpha or beta blockers, are primarily used for treating post-traumatic stress disorder or performance anxiety.

Once the overpowering effect of the anxiety has been reduced with the help of appropriate medication, counselling or psychotherapy can help you sort out the thoughts and experiences associated with the debilitating feelings of fear. This sorting out is a key part of treatment. In many cases of clinical anxiety, once you understand what triggers your anxiety, you can then relearn more effective and balanced responses.

Shame is an insidious feeling that can induce as well as aggravate clinical anxiety. There's still an enormous stigma associated with HIV. If you're at all inclined to be embarrassed, to feel self-conscious, or have low self-esteem, it doesn't take much to push you towards feeling humiliated, remorseful, worthless, and ultimately ashamed. Unchecked, this progression to shame can become pathological and lead to self-hatred, raging at yourself, and mortification.

Shame can also be treated. The goal is to learn to forgive yourself, to accept your humanity, and to become resilient in the face of those who would judge you. Psychotherapy, counselling, the support of peers, the love of friends and family, can all help you achieve this goal. Remember, those who would judge you may do so out of ignorance and fear.

"As soon as I described what was happening to me, my doctor had the answer: panic attacks," says Craig. "It was such a relief to find out what was going on. I was prescribed lorazepam. It's a tiny pill that I put under my tongue and in minutes, the panic subsides. I also started to see a psychiatrist, to whom I am forever grateful."

The importance of getting help

If fear and anxiety are overwhelming you, talk with your doctor or primary healthcare provider. Anxiety is not only stressful and upsetting, it can also suppress your immune system. Treatment varies by individual: while some people benefit from medications alone and others may prefer counselling or psychotherapy, most will find a combination of both approaches works best.

Group therapy can also help you cope with your anxiety. In fact, group therapy has been shown to increase the life spans of people with serious illnesses. There are many traditional and non-traditional activities that help ease anxiety by inducing a relaxed state, including sweat lodges, meditation, yoga, tai chi, and exercise. Again, treatment is individual; it must consider all aspects of your life, and address issues affecting your mind, body, and spirit.

From the moment HIV was uncovered as the cause of AIDS, the virus has taken us on a merry-go-round of anxiety-inducing fear: The fear of becoming infected, and then the fear of being infected. The fear of rejection fed into the angst of choosing between disclosure and the isolation of silence. Declines in health brought on fears about the future. The double-edged sword of antiretroviral therapy began sparing lives while wasting bodies. Daily we remember to take the drugs while wondering how long they will remain effective. So, it comes as no surprise that many people with HIV will at some time suffer from clinical anxiety. It can be treated; reach out for help and you'll find the ups and downs of living with HIV easier to cope with. ⊕

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

For information and support

For further information and references on anxiety, visit www.thebody.com, and search for "Conquering Anxiety," by Joni Lavick and Gaetano Vaccaro, Winter 2007.

For peer support and information, contact the BCPWA Treatment Information Program at 604.893.2243, toll-free at 1.800.994.2437, and email at treatment@bcpwa.org.

For natural remedies to treat anxiety and stress, see page 19.

Broken promises

A recent campaign drew attention to the federal government's failure to follow through with funding

by R. Paul Kerston and Julia Smith

How would you feel if you were paid a low salary and your employer suggested he'd double it, but never did? Though your paycheque never increases, you're told to ask for specific money for needed items. Unfortunately, you realize that the money won't come in time to buy the basic things you need to do a good job. Finally, you learn that you might not be paid at all.

Welcome to the world of Canadian HIV/AIDS funding. The federal government is failing to follow through on its promise to increase funding to provide direct services to people living with HIV/AIDS and specific populations infected and affected by HIV/AIDS. As a result, many AIDS service organizations (ASOs) and community-based organizations (CBOs) with already-planned programs are being forced to make cuts. And if funds aren't delivered soon, BCPWA might have to join the trend. That's why BCPWA recently participated in the National Days of Action Campaign, organized by the Canadian AIDS Society.

HIV/AIDS funding in Canada hasn't kept up with established needs. In June 2004, an all-party House of Commons Standing Committee on Health recommended an increase in federal funding for domestic HIV/AIDS programs, from $42.2 million to $100 million per year. This figure was calculated after an extensive cross-Canada consultation.

Less than one year later, the government increased funding to $84.4 million, leaving a $15 million shortfall from the recommendation. Later that year, the Federal Initiative to Address HIV/AIDS produced a revamped funding program to which ASOs could apply. Part of that initiative, the Specific Population Fund, was meant for projects beginning in 2004. That money still hasn't been allocated–almost three years later. Similarly, the Knowledge Exchange Fund hasn't distributed any funding.

The promised increase in federal funding has actually resulted in decreased program funding for many ASOs, forcing them to cut programs that not only provide direct services to people living with HIV/AIDS, but also prevent the spread of the epidemic among at-risk populations.

Not willing to see a decline in service to people living with HIV/AIDS, BCPWA and other organizations decided to take their case to Members of Parliament. As part of the National Days of Action Campaign, held in September, BCPWA contacted a large number of BC MPs in an attempt to remind them of the desperate state of HIV/AIDS funding in Canada.

Most urgently, as of this writing, the AIDS Community Action Program (ACAP) funding appears threatened. BCPWA's departments of Advocacy, Prison Outreach, Positive Prevention, and the Positive Gathering operate with these funds. Unless this funding is secured, these programs may be cut.

While the National Days of Action Campaign flurry has passed, the promised federal money has still not arrived, and the expected upcoming elections may not arrive anytime soon. If you're worried about this lack of government delivery on commitment, now is the time to write your MPs and remind them of the government promise to deliver. It's a free letter–no stamp required! ⊕

***R. Paul Kerston** (l) is BCPWA's treatment outreach coordinator and community representation and engagement (CRE) coordinator. **Julia Smith** (r) is BCPWA's acting director of communications and education.*

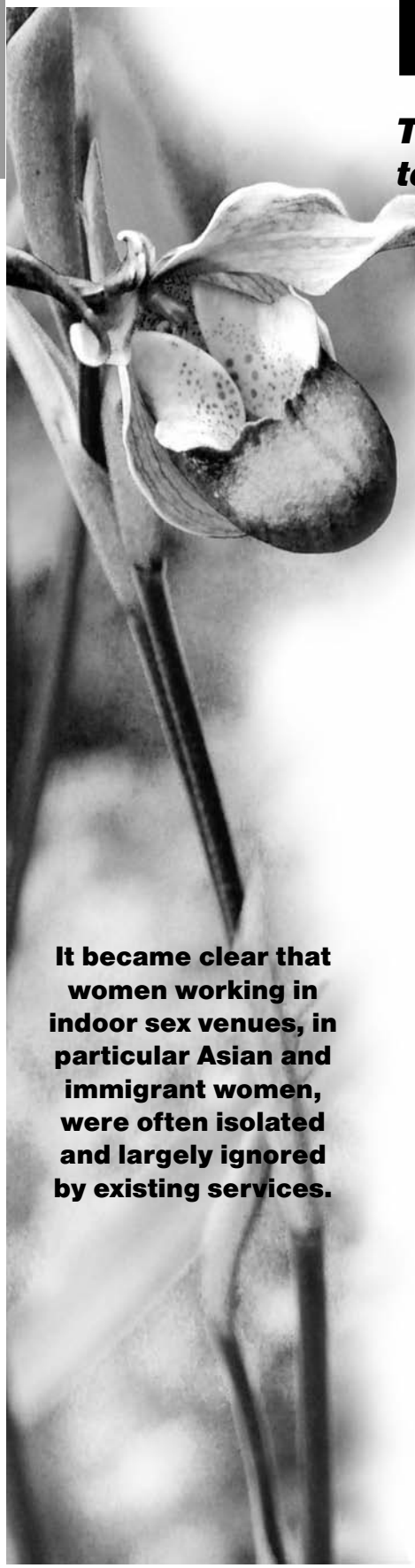
Write your MP!
The mailing address for Members of Parliament is:
House of Commons
Ottawa ON K1A 0A2

Postage to that address is free.
To find the name of your MP,
visit www.canada.gc.ca/directories/direct_e.html.

Reaching out

The ORCHID Project provides important services to female indoor sex workers

by Soni Thindal



It became clear that women working in indoor sex venues, in particular Asian and immigrant women, were often isolated and largely ignored by existing services.

In the media, you often hear about the conditions of street-based sex workers in Vancouver. Statistics suggest that outdoor sex work in Canada makes up 20 percent of all sex work activity. So where does the other 80 percent of sex work occur? Vancouver has a very active indoor sex trade that happens in a variety of indoor establishments, such as massage parlours, escort agencies, and micro-brothels.

After conducting preliminary research and focus groups with women working in the indoor and outdoor sex trade, it became clear that women working in indoor sex venues, in particular Asian and immigrant women, were often isolated and largely ignored by existing services. Something needed to happen to allow women to access services in their own environment.

The Outreach and Research in Community Health Initiatives and Development (ORCHID) Project was born out of partnership between the Asian Society for the Intervention of AIDS (ASIA) and researchers for the BC Centre for Disease Control (BCCDC) to address the needs of indoor sex workers. The project has two parts, service delivery and research. The service delivery is operated by ASIA and the research arm is operated through the BCCDC.

ASIA's work with peers is an intrinsic part of the ORCHID Project. In Vancouver, there is a large Asian and immigrant population and this is reflected by women working in indoor sex establishments. Therefore, language capacity was a crucial component in the creation of the outreach project.

The outreach program provides culture and language-specific HIV and sexually transmitted infection (STI) education, safer sex supplies, referrals, and support services. The outreach teams regularly visit over 31 indoor sex venues within the Lower Mainland, including Vancouver, Burnaby, New Westminster, and Richmond. To gain access to these venues and build a relationship with the owners, managers, and staff is something that takes time and patience. Although ORCHID functions as an outreach program, women can choose to meet with the outreach team outside of their place of work or visit the ASIA office.

The outreach teams are comprised of peers—women with experience in sex work—and volunteers, with at least one person on the team being able to speak an Asian language. The teams are provided with initial and ongoing training as well as monthly team meetings where they can debrief about outreach together as a group. There are also several team-building activities throughout the year to foster greater relationships between the volunteers, peers, and project coordinator.

Notably, many peers consider ORCHID to be their first "straight job." The project provides a stepping stone for them to gain new skills and confidence that can be transferred to new opportunities such as education or other employment. So far, two peers have pursued new opportunities while maintaining a commitment to outreach.

Over the last three years, the project has grown and provided valuable opportunities for peers and volunteers as well as much needed support for indoor sex workers. As an expansion of the existing services ORCHID provides, ASIA has received a grant from the Law Foundation of BC to work in partnership with PIVOT Legal Society to produce legal rights workshops and information cards for indoor sex workers. After receiving initial input from sex workers, the workshops and cards are now in development.

It's an exciting time for the project to be expanding in ways that are directed by the needs of women working in the sex trade indoors. ⊕

***Soni Thindal** is the program coordinator for the ORCHID Project.*

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On the rise

Thirty percent of all new syphilis cases in BC are among HIV–positive men who have sex with men

by Glenn Doupe and Dr. Mark Gilbert

In the past five years, there has been a steady rise in syphilis cases among gay and bisexual men in British Columbia. Last year, 155 cases of new infectious syphilis were reported in gay and bisexual men—47 percent of all syphilis cases.

Many of those cases were in HIV-positive men, with the greatest number between the ages of 30 and 59 years. Of those, 65 percent of cases were gay and bisexual men. That translates to a whopping 30 percent of all new syphilis cases. Other North American cities have reported similar trends. While the reason for this is unknown, one possible explanation is that serosorting among HIV-positive men—that is, seeking out other HIV-positive men for unprotected sex as an HIV prevention strategy—is a factor.

Syphilis is a sexually transmitted infection (STI) caused by the *Treponema pallidum* bacteria, and is transmitted through vaginal, anal, and oral sex. Symptoms come in stages, which can vary in severity from person to person. Symptoms in the later stages of syphilis can mimic many other diseases. Because of this, it's often misdiagnosed. Syphilis can also occur without symptoms, so you and your sex partners can have syphilis without knowing it.

Symptoms sometimes go unnoticed

The earliest symptom of syphilis, during the primary stage, is a painless, open sore called a chancre. It's usually the size of a dime with hard raised edges, and it oozes clear fluid, which contains the syphilis bacteria. It's infectious to touch. A chancre can appear anywhere your body touches someone else's chancre, though it usually appears on the genitals, in the anus, or in the mouth. Because it's painless, it's often unnoticed, and many people who are diagnosed with syphilis don't recall having a chancre.

The chancre will go away without treatment after about a month. Then you'll enter a secondary stage, where the most common symptom is a rash covering a large portion of your body. This rash can sometimes appear on the palms of your hands or soles of your feet. The rash isn't itchy or infectious. There can also be ulcerations around your genitals during the secondary stage. These ulcers are infectious in a similar way that a chancre is.

Untreated syphilis can lead to deep bone pain, permanent vision or hearing loss, and neurologic problems such as stroke, which can happen quite early or late in the course of the infection. However, the disease is easily treated with antibiotics once identified.

Syphilis seems to progress faster in people who are HIV-positive. PWAs tend to exhibit symptoms in later stages of the disease, compared to people who are HIV-negative.

If you're HIV-positive, untreated syphilis will increase your viral load, making it easier to transmit HIV. And if you're HIV-negative, having syphilis can increase your risk of HIV. This occurs for two reasons: Firstly, mucous membranes that normally protect you from HIV become damaged because of a chancre. Secondly, many white blood cells gather at the infection site (the syphilis chancre)

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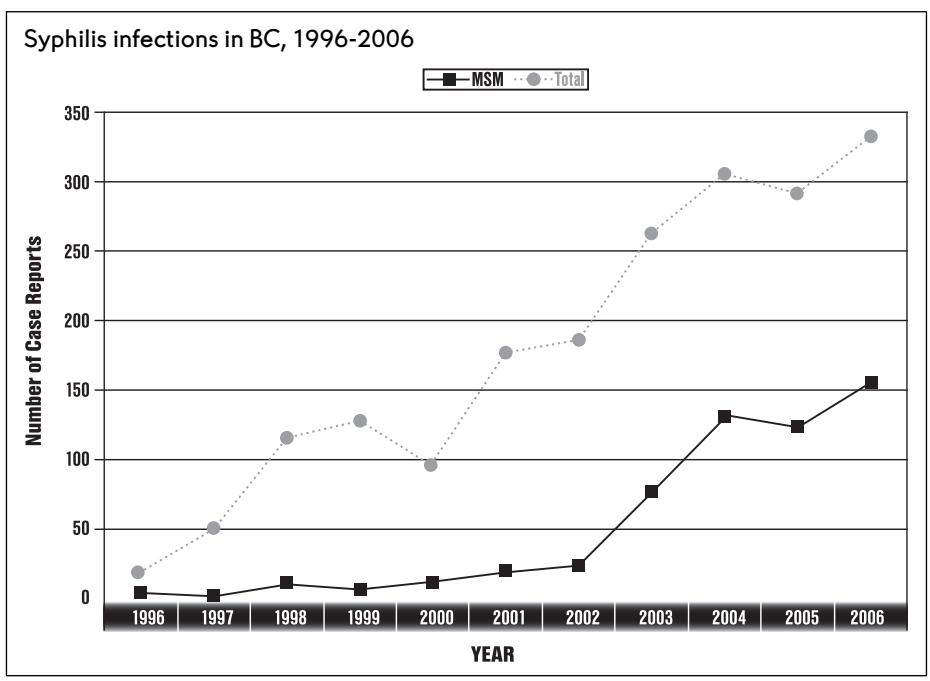


and HIV likes to attach itself to these cells. It's not uncommon to give someone an HIV diagnoses and a syphilis diagnosis at the same time.

Protecting yourself—and others

A specific syphilis blood test at your family physician's office, community health centre, or STI clinic will determine if you have syphilis. Syphilis will take time to show up in your blood after you've been infected. The shortest time this could take is nine days, and the longest time is three months; it varies with each individual. Occasionally, the syphilis bacteria can be seen with a microscope in a sample of fluid taken from a chancre.

Syphilis seems to progress faster in people who are HIV-positive. PWAs tend to exhibit symptoms in later stages of the disease, compared to people who are HIV-negative.

Condom use can reduce your risk of becoming infected with syphilis. Syphilis can also spread through oral sex—as the giver or receiver. If you think you might be at risk of syphilis infection, the best way to find out is to get tested, and to test frequently if you have an active sex life. In addition to getting treated faster, this will also help prevent you from passing syphilis to your sex partners and avoid complications. ⊕

Glenn Doupe *is clinical team leader for the BC Centre for Disease Control's HIV/STI Outreach Nursing Program, which operates the Bute Street Clinic.*

Dr. Mark Gilbert *is a physician epidemiologist with the Division of STI/HIV Prevention and Control at the BC Centre for Disease Control.*

Get more details, get tested

For more information about syphilis, visit www.stiresource.com. In Vancouver, to get tested, drop by the Bute Street Clinic at 1170 Bute Street, tel: 604.660.7949.

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.

The disease can be as hard to diagnose as it is to pronounce. Fortunately, it's rare. And improving immune function through highly active antiretroviral therapy (HAART) has significantly improved survival rates.

Progressive multifocal leukoencephalopathy (PML) is an infection of the brain caused by the JC virus. Although the majority of adults have been exposed to the JC virus, it's harmless—except among people with a compromised immune system, particularly those living with HIV/AIDS. PML usually occurs in people with very low T-cell counts (less than 100), but it's also been seen in HIV-positive people with as many as 500 T-cells.

In people infected with PML, the JC virus infects the brain and begins to rapidly form lesions that affect various body functions controlled by the nervous system. The symptoms of PML are diverse and there's no typical course of the disease. That's because the symptoms are related to the location and amount of damage in the brain. Early symptoms of PML may include weakness in one side of the body or limbs, blurred or loss of vision (possibly on one side), fatigue, memory loss, confusion, disorientation, and loss of balance. More advanced symptoms include paralysis and coma. The symptoms of PML are similar to other HIV-related conditions that affect the brain, so it's important to consult with a specialist when these symptoms occur to assure the correct diagnosis.

The prevalence of PML in adults living with HIV/AIDS is between one and ten percent. HIV-associated PML can also occur

continued on next page

during immune recovery following the introduction to HAART. This paradoxical response occurs in about 20 percent of people infected with HIV-associated PML. The outcome is more variable than PML that occurs in the end stage of AIDS.

Early symptoms of PML may include weakness in one side of the body or limbs, blurred or loss of vision (possibly on one side), fatigue, memory loss, confusion, disorientation, and loss of balance.

Because PML is rare and the symptoms are similar to several HIV-related conditions, PML is hard to diagnose. The most definitive way to diagnose it is through a brain biopsy. This involves the removal of a small piece of brain tissue that is sent to a lab for analysis. However, a brain biopsy is a very invasive procedure that can be risky and can cause significant discomfort. The main benefit of a brain biopsy is to rule out other possible brain diseases that may be more readily treatable. A diagnosis can also be made by combining an observation of the progressive course of the disease, the detection of white matter lesions on an MRI, and/or the detection of the JC virus through a spinal tap.

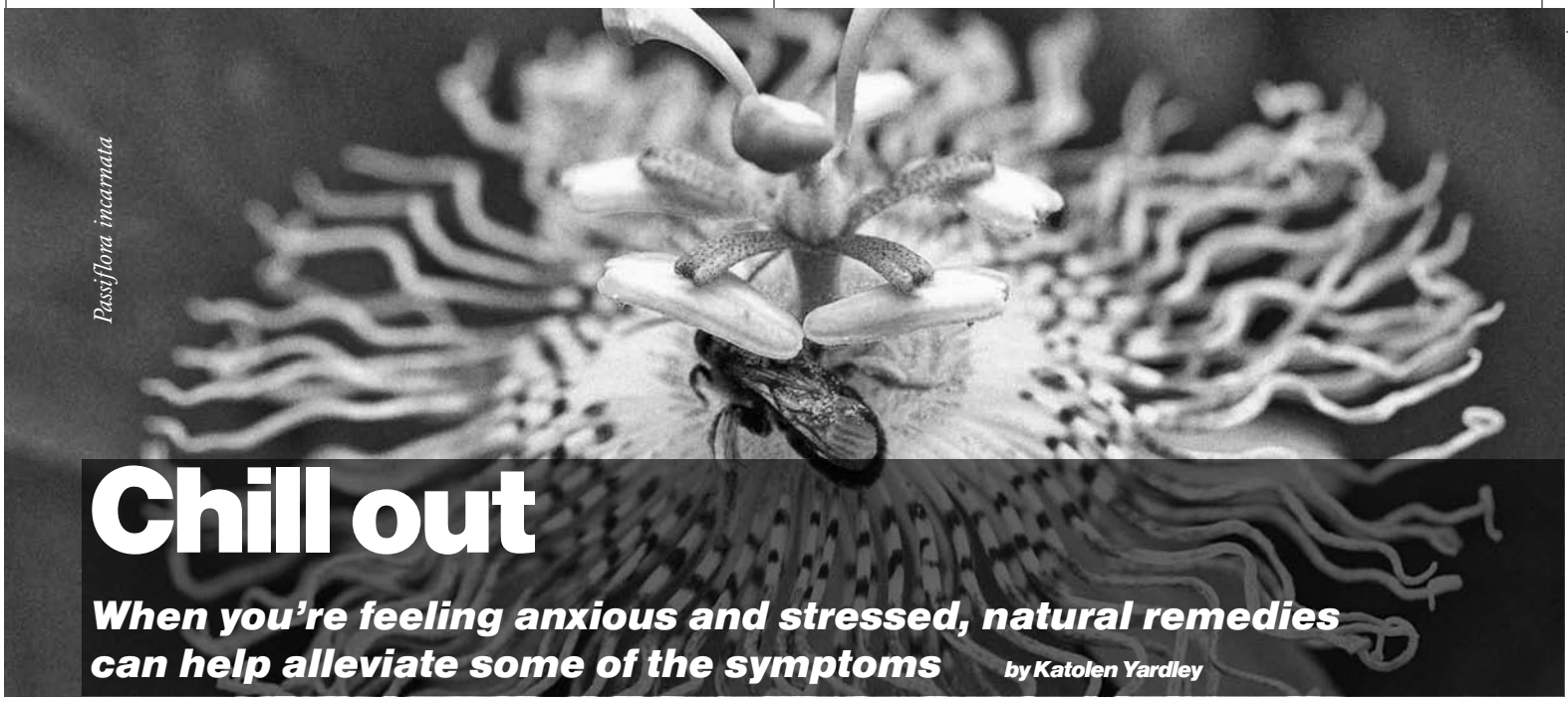
Before the introduction of HAART, PML was almost always progressive and fatal. Unfortunately, there's still no known cure or effective treatments. That said, increased immune function with HAART has had a profound effect on treating PML. Although successful treatment usually means only stabilizing or partly resolving symptoms, death rates for people with HIV-related PML have fallen dramatically, from approximately 90 percent to around 50 percent. Survival rates of 10 years and up have been reported.

Factors associated with increased survival include using an antiretroviral regime with a protease inhibitor and changing to a new regime after a PML diagnosis. A more recent study shows extremely encouraging results with a six-month survival rate of 75 percent upon introducing enfuvirtide (Fuzeon) to a traditional regime with protease inhibitors. The trend suggests this survival rate may hold to one year and beyond.

Spontaneous recovery has occurred in approximately eight percent of people living with PML. Spontaneous recovery is most likely to occur in people with CD4 counts above 200.

The bottom line is, if you experience any of the symptoms of PML, consult a specialist and get a correct diagnosis. ⊕

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



Chill out

When you're feeling anxious and stressed, natural remedies can help alleviate some of the symptoms

by Katolen Yardley

If you're feeling anxious or stressed, there are a number of natural remedies—in addition to the treatment options suggested in our cover story on page 9.

Calcium and magnesium citrate, for example, can help relieve muscular spasms and tics, and help promote a restful sleep when taken at night. Calcium and magnesium deficiencies are seen in frequent waking and difficulties in falling asleep. Supplements of these minerals can help calm tense muscles and relieve anxiety. Calcium citrate is one of the most absorbable forms of calcium on the market.

Among other supplements, tyrosine, is an amino acid that helps decrease the effects of stress in the body while enhancing clarity and mental focus. Don't use it when taking MAO inhibitors or experiencing an overactive/hyperactive thyroid. B vitamin complex provides nervous system support, decreases anxiety, improves endurance, helps balance brain chemicals, and can help you cope with stress. S-adenoslmethionine (SAME), a natural antidepressant, also has a calming effect on the body. Don't use it if you're taking antidepressants or you're diagnosed with bipolar disorder.

Herbal medicine can help support your nervous system. Passionflower (*Passiflora incarnata*) is a nervine used to quiet the mind from constant mental thoughts and over-excitability. Skullcap (*Scutellaria lateriflora*) is a nervous system restorative and relaxant herb used for stress, headache, anxiety, and insomnia.

Adaptogens—herbs that contain balancing, regulative, and tonic properties—essentially help to restore harmony to the whole body. The term "adaptogen" is a Russian concept based on the daily use of herbs to prevent disease and enhance an individual's current state of health. Adaptogens are particularly helpful for supporting the health of people with HIV/AIDS, cancer, autoimmune disorders, and other chronic illnesses. Adaptogen herbs are used to increase physical and mental endurance, enhance vitality, and help your body cope with stress. They also improve resistance to infection and help maintain optimal organ function. Used in conjunction with allopathic (Western) medicine, adaptogens can often minimize the side effects caused by many drugs.

Adaptogens include Siberian ginseng (*Eleutherococcus senticosis*). Known as an antistress herb, it helps the body to cope with external stress, enhances immune system function, and helps resist viruses, if you're suffering from depression or overwork. Ashwagandha (*Withania somnifera*) is an ayurvedic East Indian herbal medicine, for building endurance and stamina, used daily as a tonic for conditions of depletion and exhaustion.

Try aromatherapy to soothe your nerves. Lavender essential oil is a balancing oil used for lack of energy during the day and to promote sleep at night. Add 5 – 6 drops to a hot bath at night to promote sleep. Rosemary and basil essential oils are gentle stimulant oils that can help promote clarity and energy throughout the day or in the morning. Use in a candle diffuser.

Your diet can also make a big difference. If you're feeling stressed, avoid all processed foods and refined sugars, artificial sweeteners, carbonated soft drinks, tobacco, and alcohol. Caffeine can trigger an attack, so take steps to avoid all stimulants, including tea, coffee, and chocolate. Hypoglycemia—or low blood sugar levels—can also trigger stress in the body. Therefore, focus on consuming small frequent meals throughout the day to help keep your blood sugar levels constant. Also eat mineral-rich foods, such as whole grains, brown rice, raw (unsalted and unroasted) nuts, fresh vegetables, and fish.

Finally, get regular exercise and practice deep breathing. One breathing exercise for alleviating anxiety: inhale through your nose to the count of four, hold your breath for four counts, then exhale to a count of six. Hold your breath for four counts, then inhale again. ⊕

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

Conference reports

News tidbits from three recent AIDS conferences

by Sean Hosein

While you may have heard a lot about new medications, here are some other bits of news from AIDS conferences over this past summer and early fall. Those conferences include: the 9th International Workshop on Adverse Drug Reactions and Lipodystrophy in HIV from July 19 – 21 in Sydney, Australia; the 4th International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention, from July 22 – 25 in Sydney, Australia; and the 47th Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC) from September 17 – 20 in Chicago.

Treatments for drug-resistant HIV in Canada

In high-income countries, many treatments for HIV are usually available. Despite this bounty of options, once HIV develops the ability to resist one or more treatments, future options become limited. This limitation arises because resistance to one drug in a class of anti-HIV medications often confers a degree of resistance to other members of that class.

People with HIV/AIDS may acquire drug-resistant HIV at the time of their infection. However, in the average treatment-experienced person, HIV gradually and over many years acquires the ability to resist the effect of therapy, becoming, in some cases, multi-drug resistant. This type of highly-resistant HIV is difficult to treat.

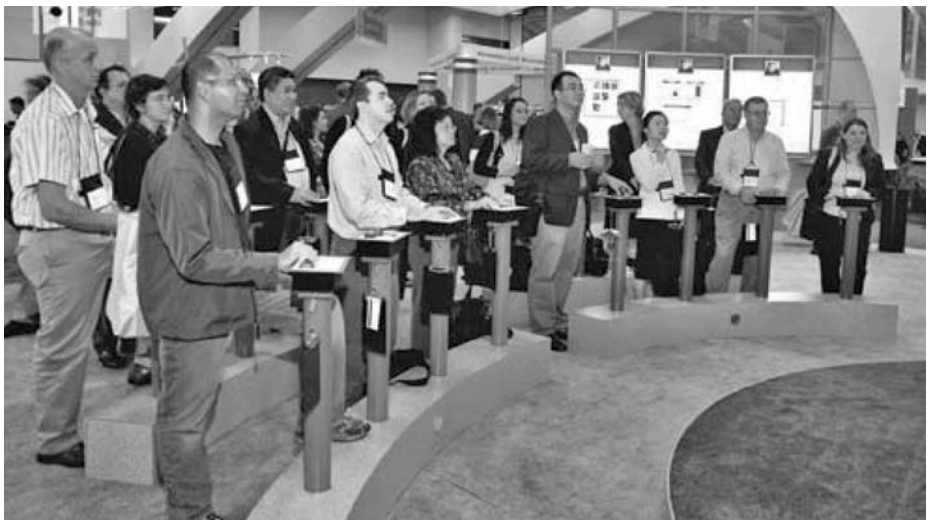
There are several ways to try to deal with drug-resistant HIV. One is to design new drugs that can work against resistant virus. Another is to develop entirely new classes of anti-HIV agents.

In high-income countries, PWAs benefit from converging research and development programs that have led to new treatment options. Here are some of them. All of the medications listed below may provide some benefit to treatment-experienced PWAs:

Entry inhibitors. These drugs work by blocking a co-receptor called CCR5, which HIV uses to infect cells of the immune system. The entry inhibitor that is currently being released in Canada through an expanded access program is called maraviroc (Celsentri).

Among two oral sessions on maraviroc at the ICAAC conference in Chicago, "Efficacy and safety of maraviroc in antiretroviral experienced patients infected with CCR5-tropic HIV-1: 48-week results of Motivate 1" showed that viral suppression is still being maintained in the majority of participants taking maraviroc. The presentation "Changes in HIV-1 co-receptor tropism for patients participating in the maraviroc Motivate 1 and Motivate 2 clinical trials" indicated that people with CXCR4-tropic or dual/ mixed-tropic HIV experience earlier treatment failure on maraviroc than people with CCR5-tropic virus.

Integrase inhibitors. These drugs work by interfering with an enzyme called integrase, which is needed to help HIV take over an infected cell. Two integrase inhibitors are in advanced stages of testing in people: raltegravir and elvitegravir. The integrase inhibitor now being released in Canada



Educational games played by visitors of the 47th Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC).

through an expanded access program is raltegravir (Isentress, formerly known as MK-0518).

An oral session entitled "Forty-eight week efficacy and safety of MK-0518, a novel HIV-1 integrase inhibitor, in patients with triple class resistant virus" was presented at the ICAAC conference. Lead investigator Beatriz Grinsztejn presented updated data indicating that raltegravir continues to be well tolerated and generally effective among PWAs who have drug-resistant HIV.

Protease inhibitors. Protease inhibitors (PIs) work by interfering with the protease enzyme, also needed by HIV-infected cells to produce copies of HIV. Darunavir (Prezista, or TMC114) is designed to be effective against strains of HIV that are resistant to other PIs. Most PIs are taken with a small dose of a boosting agent called ritonavir (Norvir). This drug, also a PI, helps to raise and maintain levels of the PI that needs boosting. Darunavir is a new PI approved for use in Canada.

At the IAS Conference in Sydney, Dr. Jose Valdez-Madruga, director of clinical trials for the Sao Paulo AIDS Program in Brazil, presented findings from the TITAN trial ("Comparison of 48-week efficacy and safety of darunavir/ritonavir (DRV/r) with lopinavir/ritonavir (LPV/r) in LPV/r-naïve, treatment-experienced patients: a randomised, controlled phase III trial (TITAN)"). He said that after 48 weeks of treatment, 71 percent of participants who were taking darunavir/ritonavir had undetectable viral loads, compared to 60 percent of participants on lopinavir/ritonavir.

Non-nucleoside reverse transcriptase inhibitors. "Non-nukes" (NNRTIs) work by impairing the activity of another enzyme needed by HIV called reverse transcriptase. New NNRTIs at an advanced stage of testing in people include TMC125 (etravirine) and TMC278 (rilpivirine).

At the IAS Conference, Dr. Anthony Mills, lead investigator in the DUET-1 study, indicated that significantly more patients (56 percent) taking etravirine/Prezista group had undetectable viral loads compared with those in the placebo/Prezista group (39 percent). His presentation was entitled, "DUET-1: 24 week results of a phase III randomised double-blind trial to evaluate the efficacy and safety of TMC125 versus placebo in 612 treatment-experienced HIV-1 infected patients."

Taking PEP to prevent HIV infection

Taking highly active antiretroviral therapy (HAART) soon after accidental exposure to HIV may help prevent this virus from infecting and spreading throughout the body. Using HAART to prevent infection is called post-exposure prophylaxis (PEP). PEP is meant to be taken for 28 days or four weeks. In Denmark, Dr Suzanne Lunding and other researchers collected information on the use of PEP—such as who used it and why—and its outcomes between 1998 and 2006. They presented their findings in the form of a poster at the IAS Conference.

In Denmark, PEP can only be provided by specialists working in infectious disease clinics. Before 2004, the recommended regimen for PEP was indinavir (Crixivan), zidovudine (AZT, Retrovir) and lamivudine (3TC, Epivir). In 2004, the PEP regimen was changed to lopinavir/ritonavir (Kaletra), zidovudine, and lamivudine.

For their report, the researchers analyzed their database of information collected from surveys and laboratory test results on 632 people. A total of 374 people received PEP after a potential sexual exposure to HIV. Unprotected anal sex—both insertive and receptive intercourse—accounted for nearly 60 percent of exposures. Twenty-two percent were female and seventy-eight percent were male; fifty-seven percent of the men were bisexual or gay. They all started PEP about 11 hours after the potential exposure.

The remaining 258 people received PEP following exposure to potentially infectious fluids through needlestick injuries, cuts, or spills. These people were largely health care workers; 65 percent were female, and 35 percent were male. This group started on average two hours after exposure.

Exposure to HIV in a healthcare setting ranged from between 20 and 40 cases each year. By contrast, with sexual exposure the number of cases rose steadily year after year, with more than 80 cases occurring in 2006. PEP was prescribed more than once for 23 people. And in 2006, nine people who had received PEP in the past did so again. Six of these nine were gay or bisexual men.

In one of those nine men, HIV exposure led to infection. The research

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team noted that this man had repeated bouts of unsafe sex before, during, and after his use of PEP, which may have accounted for the failure of his regimen. This last point also highlights that there are limits to the effectiveness of PEP.

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

The use of HIV medications usually involves taking several pills once or twice daily. For people who aren't used to this, such regimens can be difficult. HAART also has short-term side effects that can include headache, nausea, vomiting, and diarrhea. Among people exposed to HIV through a sexual encounter, 62 percent completed their regimen. Among those experiencing occupational exposure to HIV, only 46 percent completed their regimen.

The most common reason for discontinuing PEP prematurely was that doctors found out that the potential source of exposure was HIV-negative. Another reason was the tolerability of HIV medications.

Overall, the Danish report suggests that PEP is easily available in Denmark, and repeated use of PEP by the same person is uncommon.

It's difficult to assess the effectiveness of PEP based on the type of study design used by the Danish researchers. However, very few cases of HIV infection following exposure and PEP seem to have occurred. The Danish team noted that, "PEP can only be prescribed by a small number of infectious disease clinics with HIV treatment experience. This ensures a qualified risk assessment [following potential exposure] and a uniform and rational use of PEP."

Yoga for heart disease?

As HAART users age, their risk for cardiovascular disease increases. Although many medications are available to lower cholesterol levels and blood pressure, potential therapies that don't involve medications to achieve a similar effect are understudied. Because yoga is generally safe and may help reduce stress and anxiety, it's possible that this form of therapy could help reduce blood pressure. Some researchers in the United States have been interested in a particular form of yoga called Ashtanga yoga because it's much more strenuous than other forms of yoga. Engaging in Ashtanga yoga will likely cause people to burn more calories and strengthen muscles, perhaps faster than other forms of yoga.

Dr. Kevin Yarasheski, is a researcher at Washington University in St. Louis, Missouri, whose laboratory conducts many studies trying to understand the changes that occur in HIV infection as well as in HAART users. One of his most recent experiments focused on Ashtanga yoga, which was presented as a poster at the International Workshop on Adverse Drug Reactions and Lipodystrophy in HIV.

The study team enrolled 41 PWAs (25 percent women, 75 percent men), all of whom were taking HAART and who had at least one risk factor for cardiovascular disease. On average, they had been HIV-positive for 11 years and had a CD4 count of 507. Eighty-nine percent of participants had a viral load below 50.

All participants received monthly nutritional counselling from a research dietitian. They were randomly assigned to either a yoga group, which entailed five months of individual and a group instruction for Ashtanga yoga two to three times weekly from a certified instructor, or a standard of care group that entailed HAART, and no additional therapy.

During the study, blood samples were regularly collected and assessments of body composition and blood pressure were performed. Only 17 yoga participants and 10 standard of care participants had completed the study at the time of preliminary data analysis.

Among the standard of care group, there were no significant changes in any of the factors measured. However, among the yoga group, researchers found a small but statistically significant reduction in total cholesterol, triglycerides, and blood pressure.

No significant changes in CD4 counts, viral load, or blood sugar were detected between the two groups over the course of the study. Analysis of the participants' diets suggested that they were similar.

In summary, the preliminary analysis of the study suggests that a simple and relatively inexpensive intervention—Ashtanga yoga—is safe and associated with modest improvement in some factors that affect the risk for cardiovascular disease in PWAs. ⊕

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

Conference websites

- The 9th International Workshop on Adverse Drug Reactions and Lipodystrophy in HIV: **www.intmedpress.com/lipodystrophy**
- The 4th International AIDS Society (IAS) Conference on HIV Pathogenesis, Treatment and Prevention: **www.ias2007.org**
- The 47th Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC) from September 17 – 20 in Chicago: **www.icaac.org**

Still going strong

An update on the five dying men who gained special access to TMC114 and TMC125

In 2005, the BC Centre for Excellence in HIV/AIDS (BCCfE) identified six HIV-positive men who had become resistant to all conventional anti-HIV drug treatments (see "Fighting for Life," *living* ⊕, March/April 2006). Their situations were life threatening, and the experimental drugs TMC125 and TMC114 were considered their only hope. However, Health Canada hadn't yet approved the drugs.

By November 2006, four of them had reached a viral load below 50, which for some of them was the first time they reached that low a threshold in many years.

TMC125 and TMC114 are antiretrovirals manufactured by Belgian drug company Tibotec. TMC125, also known as etravirine, is a non-nucleoside reverse transcriptase inhibitor (NNRTI) overcomes resistance to the standard NNRTIs such as nevirapine (Viramune) and efavirenz (Sustiva). TMC114, also known as darunavir (Prezista), is a protease inhibitor (PI) overcomes resistance to standard PIs, including lopinavir/ritonavir (Kaletra) and atazanavir (Reyataz). Like most PIs, TMC114 needs to be taken with a small dose of ritonavir (Norvir) in order to achieve high enough levels in the blood to be active.

In April 2005, the BCCfE applied to Health Canada's Special Access Program (SAP) to gain authorization to prescribe the drugs to the six men. SAP is specifically designed for patients with serious or life-threatening conditions who require "emergency" and/or "compassionate access" to drugs that aren't authorized for sale in Canada. Doctors submitting to SAP on behalf of patients are required to provide data about the "use, safety and efficacy" of the drug.

The Centre's initial application to SAP was denied, and Health Canada cited "lack of sufficient data" to support the use of the two drugs in combination. In response, some of the men contacted media to tell their story and highlight that data relating to experimental drugs, or drug combinations that are in early stages of development, can't meet the appropriate scientific standards required to constitute evidence for "use, safety, and efficacy"; essentially, if sufficient data existed, the SAP wouldn't be necessary.

Subsequently, Health Canada reversed its decision, deeming the situation a special clinical trial under the Compassionate Use Protocol. Sadly, one of the six men died before the ministry granted access to the drugs.

By November 2006, the five men on the experimental drugs were seeing improvements in their health. All were reportedly doing well, with no serious side effects. Four of them had reached a viral load below 50, which for some of them was the first time they reached that low a threshold in many years. One of the men saw an improvement in his CD4 cell count, from 100 to 260, only six months after starting the new drugs.

Today, all five men are still on TMC114 and TMC125 and they've all achieved undetectable viral loads. All have gained weight, one person as much as ten kilograms.

Since the men were put on the drugs, Health Canada has approved TMC114, and it's expected to be available in Canada before the end of this year. TMC125 is available on expanded access and it's expected that Health Canada will approve the drug sometime next year. ⊕

This article was provided by the BC Centre for Excellence in HIV.

Less guesswork

Qualifying tests you'll need to take before starting certain drugs

by Zoran Stjepanovic

Qualifying tests are taking a bit of the guesswork out of whether two antiretroviral drugs, maraviroc (Celsentri) and abacavir (Ziagen), can work you.

Tropism testing for maraviroc

In the last issue of *living* ⊕ magazine, we talked about a new entry inhibitor, maraviroc, and how results from clinical trials showed its effectiveness. There's one catch, though: before you're even considered for this drug, you have to take a specialized test, called a tropism test, to see if maraviroc is an option for you.

Monograph Biosciences has developed a blood test called Trofile, which is used to determine if you have a CCR5-type virus or CCR4-type virus. As we've mentioned in past issues of this magazine, when HIV attaches itself to a CD4 receptor, it needs a co-receptor for the virus to enter the CD4 cell and start reproducing. This co-receptor can be a CCR5 or a CXCR4. If you're HIV-positive, you can have either co-receptor; however, maraviroc will only work for those with the CCR5 receptor.

If you live in BC and take the test, your blood work has to be sent to California, since Monograph Biosciences doesn't yet perform the test in Canada. You'll get your results within a month. This raises some concerns about the security of your personal information, since the US still bans HIV-positive people from entering the country.

Under the Expanded Access Program, the drug manufacturer will cover the costs of having this test done. However, once maraviroc is fully available in BC, it will raise the question of whether tropism testing will be covered through the BC Medical Services Plan.

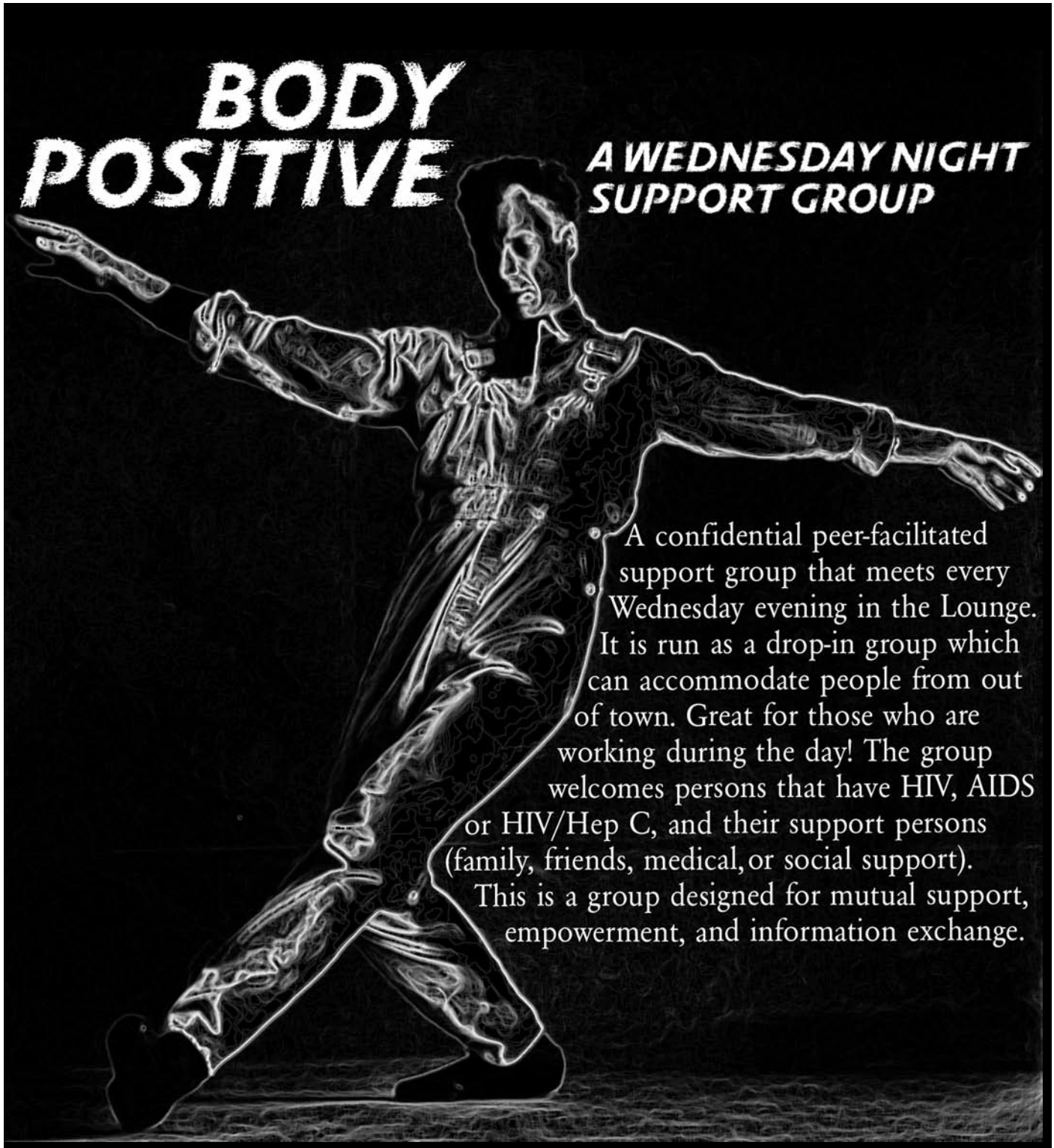
Hypersensitivity testing for abacavir

Abacavir is a nucleoside reverse transcriptase inhibitor (NRTI). The abacavir hypersensitivity screening test helps identify those persons with HIV who may be at a high risk for a serious adverse reaction to abacavir or drugs containing abacavir—namely Kivexa (abacavir/ lamivudine) and Trizivir (abacavir/ zidovudine/ lamivudine).

Up to eight percent of people with HIV might develop quite a severe reaction to abacavir. This reaction can include fever, rash, gastrointestinal symptoms (nausea, vomiting, diarrhea, and stomach pain), respiratory symptoms (cough, shortness of breath, sore throat) and other symptoms such as unexpected lack of energy, and muscle and bone pain. Usually, this type of severe reaction occurs within the first six weeks of starting abacavir and you need to see your doctor right away. You'll have to stop taking abacavir, and can never take it again because you could have a fatal reaction if you do.

Fortunately, now there's a test to see if you're likely to have a reaction to abacavir. A blood test checks for the presence of specific genetic material called HLA-B*5701. If the test result reveals that you have this genetic material, you have a high risk of developing a hypersensitivity reaction and you shouldn't use abacavir or any drug containing it. If the test shows up negative, this means there is a less than one percent chance that you'll develop the hypersensitivity reaction—although it can still occur, so you need to monitor how you're feeling. The hypersensitivity test is available in Canada. ⊕

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



Date: Every Wednesday evening
Time: 7:00PM – 9:00PM
Location: The Lounge (2nd Floor, 1107 Seymour Street, Vancouver)
Contact: Aaron @ wayoverhere@hotmail.com or
Jackie at 604.893.2259 and jackieh@bcpwa.org

British Columbia Persons With AIDS Society

Going to pot

The medical marijuana laws are getting more restrictive, making criminals out of PWAs who need it

by Michael Connidis

Law-abiding citizens who want to legally possess and use marijuana for therapeutic purposes continue to be denied their right to do so by a recalcitrant government. The legal and social demonizing of marijuana has transformed this medicinal plant into the devil's weed, and that has hindered the development of effective policies and programs.

Even though there's overwhelming evidence in support of the medical benefits of marijuana, some Canadian politicians and government bureaucrats remain negative towards any use of this herb. And despite repeated directives by the courts compelling Health Canada to rectify the situation, people continue to put themselves at risk in order to obtain medical marijuana.

The criminalization of marijuana remains a major stumbling block on the road to a workable medical marijuana program. Since 1973, when the Le Dain Commission's report on the inquiry into the non-medical use of drugs was made public, there has been support within government to change the laws regarding marijuana. Among the early pro-decriminalization politicians were Pierre Trudeau and Joe Clark, both Prime Ministers of our country. In 2002, the Senate Special Committee on Illegal Drug Use, which had studied the cannabis issue extensively, was unanimous in its recommendation that cannabis be legalized in a regulatory framework similar to alcohol.

An onerous licensing system

Even if possession and use of marijuana is no longer considered a criminal act, some still view it as socially and morally reprehensible. There have been repeated efforts to make possession of marijuana a ticketed offence punished only by a fine. The most recent attempt was in April of this year when MP Keith

Martin, (Esquimalt-Juan de Fuca) tabled his Private Members Bill C-431 in the House of Commons.

Paul Lewand, then chair of BCPWA, wrote to Mr. Martin asking him to withdraw his bill. Lewand argued that since about 30 percent of people living with HIV/AIDS in North America use medicinal marijuana, many BCPWA members were at risk of penalties for possessing one of the most commonly used forms of alternative and complementary therapies in BC.

Health Canada, under the Marihuana Medical Access Regulations, (MMAR), has developed a licensing program that on paper allows those who apply and qualify to grow and/or use marijuana for medical purposes. Yet many people have found obtaining a license difficult and have not done so.

You require two licenses if you plan to grow your own crop. The first is a license to possess marijuana for medical purposes, which must be endorsed by a medical practitioner. But if your doctor is unwilling to sign the required forms, what's your recourse?

The second license is to grow your own marijuana or have a designated grower. You must provide consent from the owner of the property on which you intend to grow your crop as well as details of the location and security of your crop. This can be problematic if you're renting. You must also apply for the government issued seeds from which you must grow your marijuana. Once you've obtained your licenses, you must adhere to excessively restrictive rules and regulations. You have to re-apply for your licenses annually.

The government's substandard supply

If you aren't going to grow your own or have someone else grow for you, the only legal supplier of marijuana you can use is the government. In addition to getting a license to possess, you must complete and submit an application to obtain dried marijuana. The marijuana provided by the government has been criticized for its poor quality; their supply of seeds and dried marijuana comes from only one strain of the cannabis plant. This falls far short of the variety of strains available through compassion clubs, where users can choose the type that will give them the best symptom relief.

The effect of this onerous licensing program is that people still don't have legal access to medical marijuana for a variety of reasons. Unless they have the required licenses and comply with MMAR rules, they risk encounters with law enforcement agencies. Growers could have their homes and other assets seized. And not everyone has the green thumb required to produce a healthy crop of herb, let alone the space and equipment.

Many people don't have the financial resources to either cultivate their own plants or pay for their supply from the government. For people living on disability incomes and those on income assistance, the cost of this medicine can be equal to over 80 percent of their monthly income. Consequently, they run up thousands of dollars of debt.

People are being cut off from their only legal supply of marijuana and being pursued by collection agencies. Last August, Lewand wrote to Justice Minister Robert Nicholson and Health Minister Tony Clement insisting that the issue of cost be addressed.

Changing rules are like moving targets

Changes to the regulations are making the licensing process more difficult, rather than helping it. One BCPWA member got an unpleasant surprise when she reapplied for her license to produce marijuana through a designated grower for the fourth consecutive year. In previous years, the designated grower's crop had to be within 25 kilometres of her home. This year, the distance was reduced to one kilometre. Finding a secure setting to grow a crop of marijuana within such close proximity of her home in a suburban neighbourhood has proved difficult.

This woman is now trying to argue her case with Health Canada, but she's already looking at the very real possibility that she may be denied her license. Without a license, she'll have no choice of access to effective therapy for the side effects of her anti-HIV drugs. She can't afford to buy from the government, nor would she want to. The only option she has is to break the law and risk the consequences.

People living with HIV/AIDS and those suffering from other chronic and life-threatening health problems are enduring unnecessary stress and anxiety in their efforts to get relief and treatment. The entire medical marijuana program is dysfunctional, and it's failing to provide access to a medicine that could be readily available at very low cost.

Health Canada is phasing out MMR

Yet Health Canada continues to take regressive steps in dealing with this issue. It has been working towards phasing out licenses to grow and planning to terminate the program in 2008. This will mean that all licensed users will have only one choice for a legal supply of marijuana: the government.

In July 2005, BCPWA launched an advocacy alert, urging members and friends to send letters to the then Health Minister, Ujjal Dosanjh. The letter stated that, "The current regulatory environment, including the MMAR, is still unduly restrictive and hinders access to a safe, affordable, varied, and reliable supply of cannabis for therapeutic purposes without fear of prosecution or discrimination for those who use it therapeutically."

Two years later under a new government, the situation has only deteriorated. Clearly there are serious flaws in the current system and many people are calling for changes. It's time for a complete reworking of the medical marijuana program and the laws that affect it. ⊕

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

Highs and lows

Reflections on the current state of cannabinoid research

by Jari Dvorak

Pharmaceutical companies realize the medical power of cannabis and are extremely eager to exploit it commercially. Research is constantly coming up with new breakthroughs. Certain cannabinoids might even prevent the onset of Alzheimer's disease and shrink cancer tumours. When it comes to pain control, cannabinoids are expected to be better than opiates such as morphine, codeine, and heroin. The human body has ten times more cannabinoid receptors than opiate receptors. That opens the door to the formulation of new, extremely powerful, possibly non-addictive painkillers.

All this adds up to a seemingly difficult question: With marijuana still illegal, how do the pharmaceutical companies produce enough cannabinoids for research and production?

The industry gets what it needs from hemp. Hemp is very easy to work with, it's legal in most countries, and it contains all the cannabinoids that marijuana does. The proportions are a bit different, but that's no problem for modern chemistry. Nifty machines extract the resin from hemp, split it into individual cannabinoids, and package them in bottles. Researchers can mix and match them in different ways, feed them to rats, and study them in clinical trials.

The research is still at the early stage. The first wave of research focused on examining the effect of each cannabinoid separately. Synthetic cannabinoids came to the scene. That gave us Marinol, the appetite stimulant pill. Sativex is a product of the next-generation research: two cannabinoids acting together. Manufactured by GW Pharmaceuticals, it's approved in Canada and distributed to pharmacies by Bayer HealthCare AG.

When it comes to pain control, cannabinoids are expected to be better than opiates such as morphine, codeine, and heroin. That opens the door to the formulation of new, extremely powerful, possibly non-addictive painkillers.

Cannasat Therapeutics, a Toronto-based pharmaceutical company, is reportedly testing an even more complex product. More cannabinoid medications, from hemp and other sources, are on their way.

Most of the large pharmaceutical companies don't want anything to do with marijuana's euphoric high. To marijuana users, this might seem strange. Nevertheless, it makes a lot of sense. Cannabinoid medications will help many people who normally wouldn't go near marijuana. Many pain sufferers—possibly most of them—dislike being high. They just want to get rid of their pain and stay sober.

On the surface, Sativex might be giving the drug czars another excuse to keep medical marijuana illegal. Recently, Health Canada cancelled the Canadian Medical Marijuana Research Fund. The Minister of Health, Tony Clement, took the opportunity to explain the government's reasons for the cut: "Clinical research regarding the use of marijuana for therapeutic purposes and the development of marijuana-based products is best undertaken and funded by the pharmaceutical industry."

His statement rings false. In reality, the pharmaceutical industry has no inducement to research marijuana. They have easier options, such as hemp extracts and synthetics. Does it mean that Sativex-like medications can adequately replace the medical marijuana programs? Not at all! None of them comes even close to the interplay of the 60 cannabinoids that users of medical marijuana find so helpful. For pharmacological research, the interaction of so many ingredients is impossible to study. It's well beyond the current research capability. For most medical marijuana users, cannabinoid-based medicine will offer no solution.

In the end, we patients know that the evidence for medical marijuana is overwhelming. For us, marijuana is an effective medicine with minimal side effects. If you don't mind the euphoria, that is. ⊕

***Jari Dvorak** is an AIDS activist from Toronto.*

Munchies with merit

Dump the potato chips and satisfy your urges with nutritious snacks. Your body will appreciate it

by Michele Blanchet

Let's face it; junk food is convenient, tasty, and addictive. While appealing, the consequences of overindulging in it are serious and can make you sick. Junk foods laden with high sugar, fat, salt, and preservatives are high in calories and low in nutrients. They decrease your appetite for regular meals, cause swings in energy levels, and leave you feeling blah.

Junk foods laden with high sugar, fat, salt, and preservatives cause swings in energy levels and leave you feeling blah.

It's well know that individuals with HIV need to optimize their nutritional intake, stay within a healthy weight range, and be proactive with their general overall health. Being overweight increases your risk for health problems such as heart disease, stroke, and diabetes. Snacks that are abundant in vitamins and minerals can fill in your nutritional gaps, help you maintain a healthy body weight, preserve lean body mass, and optimize your nutritional health status. The added bonus: it gives you a boost of energy, combats fatigue, tension, and mood swings, and helps prevent hunger and cravings for junk food.

Set yourself up for success

In order to keep on track with healthy snacking, plan ahead:

- Add healthy snacks to your grocery list.
- Plan for healthy snacks during the day; you're less likely to overeat at meals and reach for something that isn't healthy.
- Designate a highly visible location in your kitchen for healthy ready-to-eat snacks. Don't let the vegetables rot. When you buy them, wash and cut them, then store them in a Tupperware container in your fridge for easy access.
- Make sure healthy foods are available wherever you are. Keep snacks like nuts and dried fruits, whole grain cereal, and V8 juice, in your desk, locker, bag, or car.
- Drink water for thirst. If you reach for a Coke, the calories and sugar add up. A ten-ounce can of pop contains on average nine teaspoons of sugar; juice the same. As an alternative, choose fruit juices diluted with water or soda water. Carry a water bottle.

Try something new

Make sure your snacks are interesting and add variety to your enjoyment of eating. When you go shopping, purchase exotic and seasonal fruits, different types of nuts, a variety of dried fruits such as apple rings and apricots, or pickles and olives.

Craving something crunchy? Try Corn Thins, pretzels, Japanese rice crackers, Quaker Corn Bran Squares cereal, or graham crackers. Try mixing different flavours and textures: hummus and juicy red pepper strips, antipasto and rice crackers, apple slices and almond butter, or your favourite yoghurt sprinkled with Post Grape Nuts cereal.

Read the label

A healthy choice should be:

- Low in fat. Choose snack items that have 3 grams of fat or less per serving, and avoid trans fat.
- Low in sugar. Glucose, sucrose, fructose, dextrose, and corn syrup all fit into this category.
- Rich in fibre. Choose foods that have at least 2 grams or fibre or more per serving.
- Low in sodium. Processed foods are high in salt; choose foods with 140 mg or less of sodium.

Watch your serving size. If you eat twice as much, then you need to double the amounts that the nutrition information label indicates for calories, fat and sugar. Never eat from the box. Try to add a source of protein such as a glass of milk, slice of cheese, or a few nuts; that helps to keep you full longer, as well maintain your blood sugars.

Don't eat for the sake of eating when bored or stressed. When you're hungry, make sure you have a snack that satisfies your body. When you are full, stop eating.

Happy munching! ⊕

***Michele Blanchet** is a registered dietitian at Gilwest Clinic in Richmond and counsels individuals with HIV and hepatitis C.*

Hot flash

An update on menopause and HIV—and what you can do to ease the symptoms

by Carole Lunny

Menopause is a natural change in a woman's life. That said, it can be a challenging time for some women, especially those living with HIV: HIV-positive women sometimes experience earlier menopause, more severe symptoms, and higher risks of certain diseases. But if you're an HIV-positive woman, there are natural remedies you can try to ease some of the symptoms.

Women typically experience menopause between the ages of 48 and 55 years; for non-smokers, the average age is 51. Women reach menopause when they don't have their period for 12 consecutive months. In the two to eight years before menopause—called perimenopause—estrogen and progesterone levels drop because the ovaries slowly stop producing eggs. The most common symptom of menopause is hot flashes, affecting 60 to 85 percent of all menopausal women. Hot flashes involve a sensation of heat throughout the body. Women also experience night sweats, palpitations, dizziness, skin crawling sensations, depression, vaginal dryness, hair loss, and headaches.

Some studies report that HIV-positive women have more menopause symptoms than HIV-negative women. One New York study reported that symptoms were less frequent in women with more advanced HIV disease. Depressive symptoms, joint pain, hot flashes, and night sweats were the most common symptoms. However, every woman is different and will experience menopause in her own unique way.

Premature menopause, before the age of 40, occurs in less than one percent of women in the general population. However, cigarette smokers and women with chronic illnesses tend to experience menopause at an earlier age. Other studies show that HIV-positive women are more likely to reach early menopause when their CD4 counts are less than 200. Women with low levels of physical activity were also at risk for earlier onset of menopause.

Researchers also report that HIV-positive women who use drugs reach menopause sooner than women who don't. In one study of 120 HIV-positive drug-using women between 40 and 57 years of age, methadone use within the past 6 months was associated with early menopause.

The importance of maintaining bone density

Estrogen inhibits overall bone loss. Menopausal women can lose up to four to five percent of their bone density annually due to the loss of estrogen. HIV-positive women have a higher risk of osteopenia (early onset of osteoperosis) than their HIV-negative counterparts. HIV-positive women who have reached menopause need to take calcium, vitamin D, and magnesium daily.

Other options that help to maintain bone mass include weight-bearing exercise as well as eating fruits and vegetables. Soy products containing isoflavones—such as soy milk, tofu, soy beans, soy burgers, and soy cheese—are also a good alternative to pills, which may actually be harmful. Women should also reduce alcohol, salt, smoking, and caffeine alone (coffee with milk reverses the bad effects), as these promote bone loss.

Heart disease is also a concern. Certain antiretroviral drugs, such as protease inhibitors, can increase the level of low-density lipoprotein (LDL, or "bad") cholesterol and triglycerides over time, and thus the risk of heart disease. HIV-positive women with diabetes are also at increased risk of heart disease. Heart disease can be prevented through exercise, eating a low-fat diet, and quitting smoking. Statin medications reduce LDL cholesterol and triglyceride levels and can help lower the risk of heart disease.

The risks of hormone replacement therapy

Hormone replacement therapy (HRT) is often prescribed to treat symptoms of menopause, however it carries some risks. In the US, two Women's Health Initiative trials were discontinued in the interest of safety: the Estrogen-Plus-Progestin Study was discontinued after it revealed an increased risk of heart disease, stroke, blood clots, breast cancer, and dementia with long-term use. And women in the Estrogen-Alone Study who had hysterectomies had a slightly increase risk of stroke. Many women are therefore cautious about taking HRT.

Short-term HRT (less than two years) doesn't seem to be harmful and has been shown to alleviate hot flashes by 70 to 80 percent. HRT also improves vaginal dryness, anxiety, irritability, and depression associated with menopause, and prevents osteoporosis. Before undertaking any treatments for menopause symptoms, consult your healthcare providers; therapies should be individually tailored to your lifestyle, medical history, and current medication regime.

Alternative treatments for menopausal symptoms

Approximately 30 percent of women seek complementary and alternative medicines to treat menopausal symptoms. Many of the studies report high rates of placebo effect, which confound the overall findings. In general, studies of these alternative treatments need to be longer in duration and more randomized-controlled trials are needed.

Black cohosh is approved by the German Medicine Control Agency for six months to treat hot flashes, night sweats, insomnia, and anxiety. A 2006 randomized trial gave 301 women either a combination of St. John's wort (for depression) and black cohosh (for menopause symptoms) or a placebo for four months. Menopause symptoms decreased significantly by 50 percent and depressive symptoms by 41.8 percent in the women taking the combination therapy.

Another randomized trial had women taking a product called Phyto-Female Complex (ingredients: black cohosh, *dong quai,* milk thistle, red clover, American ginseng, chaste-tree berry). Participant's hot flashes decreased by 73 percent, night sweats by 69 percent, and sleep quality improved. A review of these types of studies suggest that benefits are only seen after three months or more of continuous use.

St. John's wort is efficacious in mild to moderate depression in perimenopausal women. St John's wort interferes with the metabolic pathway of the cytochrome P450 system and therefore interacts with various drugs including protease inhibitors and non-nucleoside reverse transcriptase inhibitors, warfarin (an anticoagulant drug), paroxetine (an SSRI), and the oral contraceptive pill. Women should not be taking these drugs in combination with St. John's wort.

Hot flashes were reduced in women taking red clover extract in two randomized studies. As well, a recent meta-analysis revealed a small reduction in the frequency of hot flashes in women receiving red clover compared to those receiving placebo.

Asian populations consuming a diet high in soy appear to have lower rates of menopausal symptoms, heart disease, osteoporosis, as well as breast, colon, endometrial, and ovarian cancers. One study of 102 women treated for 12 weeks with a diet high in soy showed a 45 percent reduction in hot flashes in comparison to a 30 percent reduction in the placebo group. A more recent trial of 75 women showed a 61 percent reduction in symptoms for those taking soy products compared to 21 percent of those taking a placebo.

Studies show that HIV-positive women are more likely to reach early menopause when their CD4 counts are less than 200.

A healthy lifestyle can help, too

Other strategies to reduce menopause symptoms don't require oral treatment. Reducing hot flashes can be as easy as keeping your body temperature as cool as possible. Exercise can also help some women with symptoms of hot flashes. In one study, women who did regular aerobic exercise (swimming, running) had 50 percent fewer hot flashes than women who were sedentary. Deep breathing can also lower the number of hot flashes by approximately 50 percent.

In general, a healthy lifestyle—eating whole fruits, vegetables, and soy products, regular aerobic and weight-bearing exercise, not smoking, and reducing substance use—can help reduce the severity of menopause symptoms. There are many treatment options for women entering menopause including HRT and serotonin reuptake inhibitors (SSRIs), as well as a range of complementary and alternative therapies. Talk to your doctor or nurse before starting any new treatments because they may interact with oral contraceptives or antiretroviral drugs. Each woman is individual, therefore it's up to you and your doctor to decide which menopause treatment is best for you. ⊕

***Carole Lunny** is currently settled in Glasgow, Scotland and is working remotely for the Canadian National Centre for Infectious Diseases.*

Further reading on treatments for menopause

The Society of Obstetricians and Gynaecologists of Canada has published recent clinical treatment guidelines for menopausal symptoms. You can find it online at **www.sogc.org/jogc/abstracts/200602_SOGCClinicalPracticeGuidelines_1.pdf.**

You can also visit the American Academy of Family Physicians at **www.aafp.org/afp/20060201/457.html** for a good review of non-hormonal therapies.

Depression and non-adherence can be deadly

by Dr. Robert Hogg

Living with HIV can be a day-to-day struggle between the infected person and the virus, which often inflicts mental and physical harm. Therefore, it isn't surprising that depression is common among people living with HIV. In fact, studies have shown that up to 34 percent of people living with HIV have symptoms of depression—more than twice as many as among the general population. It's also been demonstrated that an HIV-positive person who is depressed is more likely to develop AIDS or die, than one who isn't depressed.

The mechanism by which depression affects HIV disease progression isn't clear, but may have something to do with the immune system or to health-related behaviours. What is known is that depression plays an important role in the way people with HIV adhere to their antiretroviral medications—how well they take their medications on time as prescribed. A depressed person may not adhere to his or her antiretroviral medication regimen, and poor adherence is associated with disease progression and death.

How depression affects survival, and what role adherence to antiretrovirals plays in this effect, have not previously been studied. But in a new study published in the journal *AIDS*, Dr. Viviane Lima and colleagues from the BC Centre for Excellence in HIV/AIDS tried to answer this question by studying 563 people who initiated highly active antiretroviral therapy (HAART) between August 1996 and June 2002 in BC. Participants completed a short questionnaire before starting HAART that included questions on depression. HAART in this paper refers to people starting anti-HIV therapy with either a protease inhibitor (PI) or a non-nucleoside reverse transcriptase inhibitor (NNRTI) and two nucleoside reverse transcriptase inhibitors (NRTIs, or nukes).

Of the 563 people starting on HAART and eligible for this study, 51 percent had symptoms of depression at baseline, and 23 percent were imperfectly (less than 95 percent) adherent during the first year. Depressive symptoms were more common in women, people less adherent to medication in the first year, those with a history of injection drug use, and those with an income of less than $10,000 per year. No association was observed between depression and age, previous AIDS diagnosis, First Nations status, CD4 cell count, or plasma HIV viral load.

Ten percent of the people in the study group died over an average follow-up period of four years. Older age, lower CD4 cell count, less education, lower income, history of injection drug use, First Nations status, lower adherence to therapy in the first year, and depression were associated with a higher risk of death.

When the interaction between adherence and depression was examined further and other factors associated with risk of death were adjusted for in analysis, the investigators found that adherence and depression influenced risk of death as a gradient. Compared to adherent individuals with no depressive symptoms, non-adherent individuals with depressive symptoms were nearly six times more likely to die, followed by non-adherent individuals without depressive symptoms, who were four and half times more likely to die. No increased risk of death was observed among those who were adherent but depressed.

The results of this study demonstrate that both depression and low adherence increase the risk of death in persons taking HAART for the first time. Given the high level of depression among HIV-positive people in this study and its strong association with poor adherence, persons living with HIV should be encouraged to seek treatment or counselling for their depression prior to or at the time of starting HAART. ⊕

***Robert Hogg** is a professor in the Faculty of Health Sciences at Simon Fraser University in Burnaby and the director of the Drug Treatment Program at the BC Centre for Excellence in HIV/AIDS.*

A new face in HIV

by Jennifer Chung

They have passed on more lucrative areas of medicine to devote their energy to clinical research. The Canadian HIV Trials Network's (CTN) latest postdoctoral fellows not only represent a new wave of HIV investigators, they are also reinvigorating the field in BC, across Canada and globally.

Take Dr. Mark Hull—an infectious diseases specialist—who is currently completing his CTN fellowship at St. Paul's Hospital in Vancouver. Hull is among a growing group of researchers who are zeroing in on the issue of simplifying anti-HIV regimens and lowering the risk of drug interactions in treatment-experienced people.

"We want to focus on how we can suppress HIV and make sure we can address some of the consequences of being on antiretroviral therapy," says Hull. "We need to look at options to lower pill burden and achieve a better metabolic profile for people now and in the future."

According to Hull, a pared down regimen will allow people to take fewer pills and may help decrease the risk for metabolic complications such as high cholesterol, as well as the risk of adverse drug interactions, which can arise when taking two protease inhibitors.

When he isn't seeing patients in the 10 C ward at St. Paul's, which provides in-patient care for people living with HIV, Hull devotes much of his time to his latest research project. Working alongside his mentor Dr. Julio Montaner, national co-director of the CTN and director of the BC Centre for Excellence in HIV/AIDS, Hull is examining the efficacy of ritonavir-boosted darunavir in treatment-experienced people who are currently on double-boosted protease inhibitors.

As HIV becomes increasingly viewed as a chronic disease in North America, Hull believes that the next frontier of research will centre on the development of new drugs that can improve the quality of life for people living with the illness. "In Canada and the US, I think the aim is simplifying treatments, addressing metabolic concerns, and developing new drugs for treatment-experienced patients who need new types of salvage regimens," he says.

The quest for new treatments means there is still a need for clinical trials—and participants. Hull says that while advancements have been made in HIV care, the road to developing more streamlined anti-HIV regimens is one that researchers need to continue exploring.

"Volunteering in a clinical trial is not an easy thing to do because it's a lot of work, but it's still very worthwhile for people to participate," Hull says. "By taking part in a trial, not only are people contributing knowledge to their particular treatment, they are also helping thousands of others who will benefit from the results of those trials."

Since 1992, the CTN Postdoctoral Fellowships have been providing career support to promising clinical scientists. To date, more than 50 fellowships have been awarded to 38 individuals, many of whom have emerged as Canada's leading HIV clinical investigators. ⊕

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

Trials enrolling in BC

CTN 194 — Peg-Interferon and Citalopram in Co-infection (PICCO)
BC sites: Downtown Infectious Diseases Clinic (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.

A new twist

Does barebacking put you at risk of hepatitis C?

by Rob Gair

In recent years, there's been a disturbing trend: significant numbers of HIV-positive gay men are acquiring hepatitis C through sex. But people don't usually get hepatitis C from sexual activity. The virus, which causes chronic liver disease in humans, is usually passed from person to person through direct blood contact. In developing countries, people get hepatitis C from blood transfusions and by sharing needles when injecting drugs. In developed regions such as North America, where the blood supply is relatively safe, the most vulnerable population is injection drug users (IDUs).

Viral hepatitis was around for hundreds of years without causing a significant impact on human health. In the last century, however, widespread use of blood transfusions led to a mysterious "post-transfusion hepatitis" in many people. For decades, the exact cause of the hepatitis was unknown, although an infectious agent was suspected. In the 1960s and 70s, scientists identified hepatitis A and B viruses; eventually screening methods for blood were introduced, as well as effective vaccines. Another virus, first called "Non-A, Non-B," was also known to cause post-transfusion hepatitis but its exact identity eluded scientists until after the HIV outbreak.

Scientists formally isolated hepatitis C in 1989. By this time, its clinical course was well-recognized as different from other types of viral hepatitis. Hepatitis A & B produce an acute illness early after infection, usually characterized by fatigue and jaundice. Most people clear the virus on their own within a few weeks.

Because hepatitis C produces little in the way of symptoms during the early stages of infection, it was first thought to be a milder form of hepatitis. However, it quickly became apparent that most people aren't able to clear the virus on their own. This usually leads to serious liver disease, typically years after the initial infection. Researchers also found that hepatitis C has a high rate of mutation as it reproduces in the body, precluding development of an effective vaccine.

A "viral time bomb"

Hepatitis C has been called a "viral time bomb." Today, approximately three percent of the world's population–180 million people–is infected, and there are an estimated three to four million new infections every year. People from developing countries are especially vulnerable because of poor blood screening.

Without treatment, about 70 percent of people with hepatitis C usually go on to develop chronic hepatitis and liver cirrhosis. In Canada, approximately 300,000 people have hepatitis C (one percent of the population); in BC, the rate is higher, at about 1.5 percent. In the years to come, the disease is expected to cause a considerable burden to health systems

around the world as chronically infected individuals advance to serious liver disease.

Hepatitis C and HIV are similar in many ways. Both are highly mutating blood-borne viruses, neither cause significant illness during the early stage of infection, and both are highly stigmatized. Because they're spread in a similar fashion, perhaps it isn't surprising that many people are co-infected. In the US, approximately 20 percent of people with HIV also have hepatitis C. In Canada, the average rate of co-infection is 7.8 percent. For IDUs who are HIV-positive, the co-infection rate approaches 90 percent.

Treatment for hepatitis C is available, but it's expensive and lengthy, side effects are grueling, and there's no guarantee that it will cure the illness. HIV-positive people who acquire hepatitis C often experience accelerated liver disease compared to those who aren't co-infected, and they're less likely to see successful results from treatment.

Taking a closer look at sexual risk factors

Despite similarities between HIV and hepatitis C, there's one important difference. Although it's well established that HIV is sexually transmitted, this hasn't been the case for hepatitis C. For the most part, the risk of hepatitis C from sex was considered low, because studies in hepatitis C serodiscordant heterosexual couples (one's hep C-positive, the other isn't) and HIV-negative gay men failed to show a clear link between sex and the transfer of the virus.

Data in HIV-positive gay men have been comparatively confusing. As far back as ten years ago, studies reported increased incidence of hepatitis C in men who have unprotected anal sex, multiple sex partners, rough sex, and those co-infected with HIV or other sexually transmitted infections (STIs). However, these results were largely overlooked because the risk activities failed to show statistical significance or because many of the study participants also reported injection drug use.

In recent years, though, a more definite pattern of hepatitis C infection in HIV-positive gay men (who deny IV drug use) has forced public health officials to take a closer look at sexual risk factors in this group. The result is alarming new information that is shedding light on previously observed trends.

Research reveals sexual risk factors

A recently published study from Amsterdam pulled data from a group of over 1,800 HIV-positive and negative gay men who were tracked since 1984. It showed that, after the year 2000, the rate of hepatitis C infection in the HIV-positive men increased tenfold and that many were infected with similar strains that are different from those commonly acquired by IDUs. This suggests that a core group of HIV-positive gay men were getting hepatitis C from sex and then passing it around. Significant risk factors included presence of other STIs and rough sex. HIV-negative men in the study were virtually unaffected by hepatitis C.

More information on risk factors was revealed at the recent International AIDS Society conference in Australia, where a German group presented results from a small study looking at HIV-positive gay men who had acquired hepatitis C from sex (with no history of IDU). Risk factors included greater than five episodes of unprotected sex in the last year, cocaine or amphetamine use, group sex, bleeding injuries from anal sex, fisting, and the use of Viagra or similar drugs.

The authors conclude that unprotected sex by itself doesn't explain hepatitis C transmission among HIV-positive gay men. Instead, it appears to be a complex interaction between barebacking, drug use, and the type of sex that occurs under these conditions.

Unfortunately, there are many unanswered questions about the exact mechanism of hepatitis C transmission in HIV-positive gay men. Nevertheless, it can no longer be denied that hepatitis C is emerging as a sexually transmitted disease in HIV-positive men who bareback.

What now?

While it's tempting to say that the problem of acquiring hepatitis C through sexual transmission begins and ends with barebacking, this is clearly an oversimplification. Undeniably, increased rates of hepatitis C infection have coincided with the recent popularity of barebacking, but blaming that activity won't solve the problem.

Barebacking is a symptom of a larger, more fundamental, issue for HIV-positive gay men—an issue that is rooted in loneliness, fear of rejection, and desire. Desire for good sex, desire for something intimate, and desire for empowerment over whom we choose for sex partners and what we do with them. Barebacking is a bold gesture of defiance against a disease that has taken so much from us. It's an attempt to stand up for ourselves in the face of rejection and shame, to be proud of who we are and to flaunt it.

The cruel irony is that boldness is fraught with risk, and there are more than a few of us who know this only too well. How we proceed from here will depend on many factors. The first is awareness. The rest is dependent on the community's response to this new health crisis.

Whatever happens, we're going to need strong leadership and candid public debate. As HIV-positive men, we need to support one another better. We need to stop being so afraid of rejection and more accepting of our fate. As individuals, we'll need to take a serious look at the state of our mental health and the health of our sex lives. This is not to advocate for a complete ban on barebacking, however for some of us, changes will be necessary. The oft-quoted words of W.H. Auden sum it up best: We must love one another or die. ⊕

***Rob Gair** is a contributing writer for* living ⊕ *magazine.*

For more information

For more information, visit the Treatment Action Group (TAG) HCV Co-infection Project website at **www.aidsinfonyc.org/tag/coinf/coinf.html**.

Simply Positive

living⊕ has a new feature - an easy-to-read page on HIV treatment and care.
At BCPWA we want to ensure that HIV related information is accessible to everyone, regardless of reading ability. So the easy-to-read page aims to explain HIV as simply as the ABCs.

British Columbia Persons With AIDS Society

Starting HIV Drugs & Side Effects

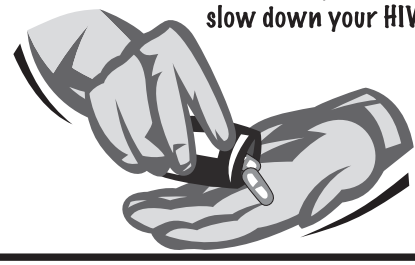
HIV damages your immune system. HIV drugs slow down HIV so it does less damage.

Starting HIV drugs is a big decision. You need to be ready. Talk with people who take HIV drugs to help you prepare.

Talk with you doctor about when you should start, which drugs you should take and how to take them.

Taking HIV drugs is long term. You must take them every day the way you have been told to and at the right times.

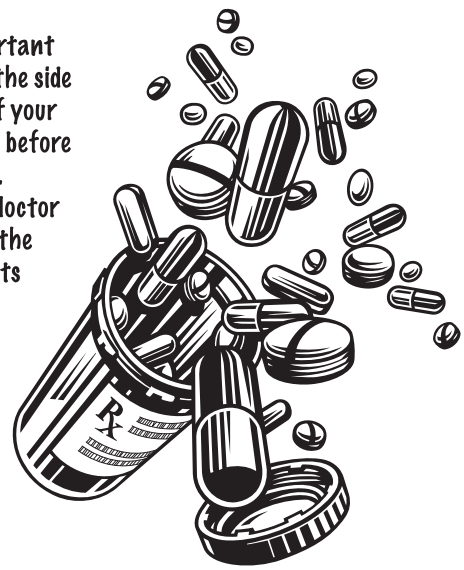
If you forget or decide not to take your HIV drugs they will lose their power to slow down your HIV.



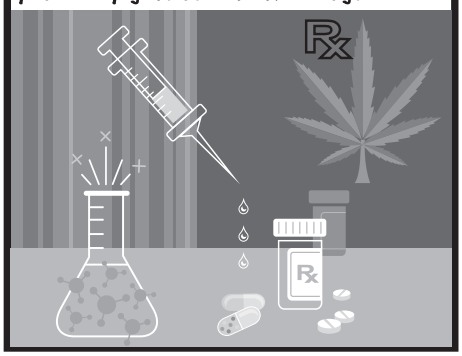
HIV drugs won't cure HIV but when you take them the way you are supposed to they can help you stay healthy and live longer.

When you first start taking HIV drugs you may have side effects that make you feel unwell.

It is important to know the side effects of your HIV drugs before you start. Tell your doctor about all the side effects you have.



Most side effects will get better or go away after a few weeks or months as your body gets used to the drugs.



You may have to live with some side effects if you want the drugs to help protect your body from the damage HIV does.

Talk with other people who take HIV drugs and find out how they deal with side effects.

Side effects can be managed so you can enjoy life while the drugs slow down your HIV.

Volunteering at BCPWA

Profile of a volunteer: Trevor Sinclair

"Trevor has been a long-time retreat volunteer who we can always rely upon, and he's been cutting his hair shorter through the years to look more like me!"

Mike Verburgt,
Coordinator of
member services

Volunteer history

I started as an active leader in the counselling program, and spent time as a relief lounge security person. I have been a core volunteer with the retreat team and have never missed a retreat in all my years here. Because of my dedication, I have been jokingly nicknamed "Ironman."

Started at BCPWA

August 2000

Why pick BCPWA?

I have personally known people who have benefited from BCPWA and so the choice was easy.

Strongest point

The retreat program is incredible and I am proud to be a volunteer with it.

Favorite memory

Seeing the great look on a person's face after they've finished rappelling down a cliff during the outdoor activities at a retreat.

Future vision of BCPWA?

I enjoy volunteering and see myself doing so for many years. Life is great!

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
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
December 19, 2007	1:00	Board Room	Standing Committees / Financial Statements — October Director of Development
January 2, 2008	1:00	Board Room	Written Executive Director Report
January 16, 2008	1:00	Board Room	Executive Committee / Financial Statements — November Director of TIAD

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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Phone _____ E-mail _____

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please send _____ subscription(s)

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

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

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

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

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

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

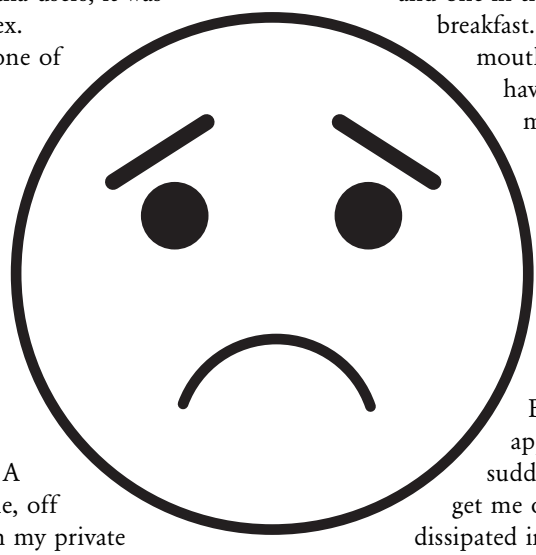
A wasted trial

One person's disappointing experience with a new cannabis-based prescription drug

by Jari Dvorak

"Marijuana-derived drug approved for cancer pain," read a recent and very attention-grabbing headline. For medical marijuana users, it was hard to miss the media interest in Sativex.

Sativex, by GW Pharmaceuticals, is one of the new prescription medications with active ingredients derived from the cannabis plant. Sativex is packaged in a tiny brown bottle with a spray pump. You don't inhale the medication–you spray the contents below your tongue or inside your cheeks.



I was curious about how Sativex stacks up against marijuana. Would it help me with my appetite? At the time, I was experiencing some flu-like symptoms, so I decided to take a break from marijuana. It made sense to try Sativex. A doctor agreed to prescribe me one bottle, off label. The bottle costs about $165. With my private insurance reimbursing most of it, I still paid $33.

First I read the product information sheet. Sativex contains two cannabinoids, tetrahydrocannabinol and cannabidiol. Only two? I found that slightly disappointing. That didn't even come close to the healing interplay of the 60 cannabinoids in medical marijuana. However, the information sheet did list a range of possible intoxication-type reactions.

The sheet also stated that both of Sativex's cannabinoids are from cannabis extract. Yet when I checked the manufacturer's website, it stated that their product has nothing to do with "crude herbal cannabis or marijuana." This was puzzling: If the extract wasn't from marijuana, how did GW Pharmaceuticals produce the cannabis extract?

At first, I couldn't find a straightforward answer. It took several sources to piece it all together. In the end, the answer was simpler than I thought. The cannabis extract is likely from hemp, the other cannabis plant. Hemp contains all the cannabinoids that marijuana does. The proportions are a bit different, but that's no problem for modern chemistry.

Having clarified that issue, it was time to give it a try. The instructions on the label were to take one squirt in the morning and one in the evening. I gave it one squirt before breakfast. A bitter mint taste exploded in my mouth. There was a burning sensation like having a shot of vodka. Five minutes later, my appetite still hadn't improved. I ate what I could. Ditto at dinnertime.

The next day at breakfast, my stomach felt queasy. Again, one squirt didn't help. That was very different from marijuana, which only requires a couple of tokes to calm my tummy.

I gave it a couple more squirts to see what that would do. Still nothing. But later on, while biking to a doctor's appointment, a kind of disorientation suddenly washed over me. It was enough to get me off my bike for a moment. The feeling dissipated in a minute and I continued on my way.

After a few days of experimentation, my sinuses began acting up. The sinus pain made me feel miserable. My roasted chicken dinner didn't look appetizing. I decided to give Sativex another try. I squirted until the bottle was completely empty. Ten squirts! For a moment, the bitter taste felt like a hint of munchies. But it wasn't to be. Ten minutes later, I still didn't feel like eating. By 20 minutes, I was weak and lethargic, watching TV. The pain from my sinuses had disappeared, but my appetite still hadn't improved.

At some point, I realized that I had been sitting in front of the television, zonked like a zombie, for three hours. Unexpectedly, I began having an anxiety attack. I went to bed but the anxiety made it difficult to sleep. I woke up bleary eyed.

It was a disappointing ending to my Sativex trial. It did help with my sinuses, though. ⊕

***Jari Dvorak** is an AIDS activist from Toronto .*