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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.

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think ⊕

opinion & editorial . . .

High time for a favourable court ruling

By Glyn Townson

The recent Federal Court ruling on medicinal marijuana is another indicator that it is time for the government to get out of the grow-op business and leave marijuana production to those who have the capability and skill.

Over the past few years, by establishing its own operations, the government has attempted to restrict access to medicinal marijuana by making itself the country's exclusive bulk supplier—with less than impressive results.

The British Columbia Persons With AIDS (BCPWA) Society continually receives complaints from our members about the poor quality and high cost of government grown medicinal marijuana. Add to this the inconvenient and restrictive approval process, compared to the ease—particularly for many British Columbians—of securing a quality local grower, and Health Canada's pot has very limited appeal. With the current framework, it is not surprising that many of our members continue to access medicinal marijuana illegally, placing themselves at risk both of criminal charges and of being targeted by criminals trying to control the trade.

Though medicinal marijuana users are able to obtain a license to grow cannabis plants for personal use, designated growers have only been authorized to supply one medical user at a time. This restriction has prevented efficient and cost effective production, further limiting access to this therapeutic drug.

BCPWA Society continues to monitor the medicinal marijuana situation closely. We encourage members who are eligible to obtain licenses to grow for personal use. We will also continue to lobby the government to remove restrictions so PWAs can access affordable, good quality medicinal marijuana.

There have been some positive changes. The recent ruling deems the current restrictions on supplying marijuana unconstitutional, making it now possible for users to choose their own supplier and for growers to supply to more than one user. This decision is another small gain for medical marijuana users, and another loss for the government's overly stringent policy on marijuana production.

It is expected that the government will appeal the court's decision. We can only speculate why they continue to fight this battle. To date they have lost every appeal.

In the meantime, we hope the recent ruling will benefit those BCPWA members who rely on medical marijuana as part of their HIV/AIDS therapeutic treatment. ⊕



Glyn Townson is the chair of the BCPWA Society.



Statement from Swiss federal commission for HIV/AIDS

Swiss HIV experts have produced the first-ever consensus statement to say that HIV-positive individuals on effective anti-retroviral therapy and without sexually transmitted infections (STIs) are sexually non-infectious. The statement was published in the *Bulletin of Swiss Medicine* [89 (5) 2008]. The statement also discusses implications for doctors; for HIV-positive people; for HIV prevention; and the legal system.

The statement's headline says that after review of the medical literature and extensive discussion, the Swiss Federal Commission for HIV/AIDS resolves that an HIV-infected person on antiretroviral therapy with completely suppressed viraemia (effective ART) is not sexually infectious, i.e. cannot transmit HIV through sexual contact. It goes on to say that this statement is valid as long as:

- ▷ the person adheres to antiretroviral therapy, the effects of which must be evaluated regularly by the treating physician, and
- ▷ the viral load has been suppressed (< 40 copies/ml) for at least six months, and
- ▷ there are no other sexually transmitted infections.

Source: www.aidsmap.com

The face of AIDS in America

The US Centers for Disease Control and Prevention (CDC) released a snapshot of HIV infection in the country on January 29. The report showed that about a half of one percent of adults ages 18 to 49 living in households are also living with HIV, putting the number of HIV-positive people in the US at about 600,000. The study excluded people who are incarcerated, homeless, and in institutions.

The study, which included 11,928 adults, confirms other research showing that black men are more likely than any other group of Americans to be HIV-positive. Black men aged 40 - 49 had the highest HIV infection rate, at close to 4 percent.

The full report is available online at: www.cdc.gov/nchs/data/databriefs/db04.pdf
Source: www.poz.com

Aboriginal IDUs more vulnerable to HIV infection

Startling new research reveals that aboriginal drug users living in Vancouver's Downtown Eastside are contracting HIV at twice the rate of non-aboriginal users.

Over the four-year study, 18.5 per cent of aboriginal men and women who injected such drugs as cocaine and heroin became HIV-positive, compared with 9.5 per cent of non-aboriginal intravenous drug users.

Dr. Evan Wood, the lead author of the research, said the higher rates of infection among native peoples are not due to biological factors but rather to patterns of social networking: The fact that aboriginal people interact principally with each other heightens their exposure and speeds the spread of HIV.

The study, published recently in the *American Journal of Public Health*, shows that aboriginal and non-aboriginal injection drug users have essentially the same risk factors and behaviours, such as needle sharing, selling sex, and practising unsafe sex.

However, Lucy Barney, a nurse-researcher at the Children's & Women's Health Centre of British Columbia and co-author of the paper, said the real explanation for the higher rates of HIV infection has its roots in poverty, unemployment, lack of housing, and dislocation that plague many aboriginal communities.

Source: *Globe and Mail*

Movement on microbicides

Pfizer announced today that it is offering the International Partnership for Microbicides (IPM) a royalty-free license to develop the antiretroviral drug Selzentry (maraviroc) as a microbicide to prevent HIV transmission.

Selzentry, an HIV entry inhibitor, is currently approved to treat HIV-positive people who have tried and failed other antiretroviral drugs.

Selzentry works by binding to the CCR5 receptors on a person's CD4 cells and thus blocks entry of the virus. Researchers hope that Selzentry may also work to stop transmission of HIV if used as a microbicide, which is typically a gel, film, or slow-release device that can be put into the vagina or anus before sex.

IPM has similar licensing agreements with a number of other pharmaceutical companies, which would allow them to develop other promising compounds as microbicides.

Source: www.poz.com

Vaccine research to fight growing AIDS epidemic in China

Scientists in Hong Kong and China are working on an AIDS vaccine to protect against three variants of HIV sweeping across south and west China, Hong Kong and Taiwan.

Chen Zhiwei, director of the new AIDS Institute in Hong Kong, said scientists have been using gene sequencing to track how HIV viruses in China are evolving, and their geographical spread.

Two closely-related HIV variants had spread through intravenous drug users (IDUs) from southwestern Yunnan province; one to as far as Xinjiang in the northwest, and the second to Guangdong in the south.

continued on next page



REALITYBITES

News from home & around the world



The third variant is in Yunnan and southern Guangxi province, which Chen said is passed mainly through heterosexual sex.

Chen said collaborating scientists in the US and China have designed a vaccine based on the two HIV variants spreading among IDUs and they hope to test it in animals by the end of this year.

Source: Reuters

Health Canada issues statement to clarify organ donation policy

Health Canada has clarified its latest policy on organ donations from sexually active gay men, injection drug users, and other

groups it considers high risk, saying that it does not ban the use of organs from these groups. Rather, their organs are “excluded” from consideration for transplant unless a potential recipient authorizes their use by signing an informed consent document.

“This requirement is related to the risk of the activity and not a person’s lifestyle or sexual orientation,” said Carole Saindon, a spokesperson for Health Canada, in a statement e-mailed to CBCNews.ca. “The organs can still be used provided the recipient is aware of the risk and gives consent.”

Saindon said the regulations on organ donation are based on risk factors for the

transmission of infectious disease. One of these risk factors pertains to a man who has had sex with another man within the past five years. Donors are also excluded if they have had a recent tattoo or piercing, are an inmate of a correctional facility, or have hemophilia and have received blood products.

Source: www.CBCNews.ca ☉

2008 CURRENT ANTIRETROVIRAL DRUGS IN BC

(as of 4 January 2008)

Protease Inhibitors (PIs)

- saquinavir (Invirase)
- ritonavir (Norvir)
- indinavir (Crixivan)
- fosamprenavir (Lexiva, Telzir)
- lopinavir (with ritonavir: Kaletra)
- atazanavir (Reyataz)
- tipranavir (Aptivus)
- TMC 114 (darunavir or Prezista)

Nucleoside Reverse Transcriptase Inhibitors (NRTIs)

- AZT (generic: zidovudine; brand: Retrovir)
- ddi (generic: didanosine; brand: Videx or Videx EC)
- abacavir (Ziagen)
- lamivudine (compound/chemical: 3TC; brand: Epivir)
- stavudine (compound/chemical: d4T; brand: Zerit)

Nucleotide Reverse Transcriptase Inhibitors (NRTIs)

- tenofovir (Viread)

Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs)

- nevirapine (Viramune)
- efavirenz (Sustiva)
- TMC 125 (Etravirine, Intelence) – (limited availability through federal Special Access Program (SAP))
- delavirdine (Rescriptor)

Newer Fixed-Dose Combinations (NRTIs and NNRTIs)

- AZT + 3TC (brand: Combivir; generic: lamivudine/zidovudine)
- AZT + 3TC + abacavir (brand: Trizivir; generic: abacavir/zidovudine/lamivudine combination)
- 3TC + abacavir (Kivexa)
- tenofovir + emtricitabine or FTC (Truvada)
- efavirenz/emtricitabine/tenofovir (Atripla)

Fusion Inhibitors

- enfuvirtide (Fuzeon)

Entry Inhibitor (CCR5 antagonist)

- maraviroc (Celsentri) – (limited availability through federal Special Access Program (SAP))

Integrase inhibitor

- raltegravir (Isentress; MK 0518)

Source: BCCfE bi-annual antiretroviral update, November 2007. See pg.17 of living ☉ for a report on this conference.

FIGHTING WORDS



(Almost) every vote counts

A step backwards for the federal electoral process

by Julia Smith

Many BCPWA Society members may not be eligible to vote in the next federal election.

In June 2007, Bill C-31 received Royal Assent from the House of Commons. This Bill changes voting laws and, according to the BC Public Interest Advocacy Center (BCPIA), has the potential to disenfranchise many First Nations people, seniors, as well as people who are homeless and/or living with disabilities.

The new law requires every voter to produce documentation that proves his or her identity and lists a residential address. While a provincial driver's licence would be considered suitable, neither a current passport nor a First Nations status card would be accepted since these pieces of identification do not provide address information.

Jim Quail, a lawyer with the BCPIA, says the new laws are discriminatory. "If you don't have the right documentation and you have limited mobility due to age or disability, you are likely to lose the right to vote. If you are homeless—and therefore have no home address recorded on a document—you can't vote. If you live in a rural area where homes are not assigned addresses, like many rural First Nations communities, you will not be able to vote."

On November 1, 2007 Quail and the BCPIA launched a Charter challenge, arguing that the new laws violate the Charter of Rights, which guarantees all Canadians the right to vote in federal elections. The challenge involves two individual voters who are homeless, along with three organizations: the BC Coalition of People with Disabilities, the Council of Senior Citizens' Organizations of BC, and the Tenant Resource and Advisory Centre.

BCPWA Society's Community Representation and Engagement Committee is closely monitoring this case, concerned that many HIV-positive members living with disabilities or without a permanent residential addresses may lose their right to vote.

Former Chief Electoral Officer Jean-Pierre Kingley predicts that over 700,000 voters may not be eligible to vote if Bill C-31 is ultimately proclaimed. The government argues the new laws will "preserve the integrity of our electoral process," but there is no evidence that the process is under any threat. In the last two decades, there have been only two documented cases of fraudulent voting.

So why impose these new regulations? "I suggest that if you want to undermine the integrity of our democratic electoral process, the best way to do that is to stop eligible citizens from casting their votes," says Quail.

The new measures will indeed prevent citizens from voting, especially specific groups who tend to be highly critical of government policies. For this reason, as Quail and his team fight the new law in the courts, the BCPWA Society wants to make sure our members and other concerned citizens are aware of the new rules so they have the proper documentation once an election is called.

Identification required to vote:

- ▶ Valid driver's licence
- ▶ Valid BC identification card
- ▶ Two piece of approved documentation listing your name, with one of these pieces also listing a residential address (i.e., birth certificate and utility bill; or passport and bank statement).
- ▶ If you have no such identification, a neighbour with the proper documentation can vouch for your identity one time only. ☺



Julia Smith is the acting director of communications with the BCPWA Society.



SCI-FI

BCPWA Volunteer Recognition Event

Stardate:

**Thursday May 1, 2008
5:30-9:00PM**

Where:

**Chateau Granville,
1100 Granville St @
Helmcken**

**FREE TO
OUR FABULOUS VOLUNTEERS**

"Friends of Volunteers" > \$25.00

**To buy tickets contact Marc at
604.893.2298 or
marcs@bcpwa.org**

**Prizes for
Best Costumes**

The Burma stories

The second installment in a series of personal accounts related by PWAs in Southeast Asia *by Thiha Maung Maung*

Thiha Maung Maung was a private doctor in Burma (now Myanmar), treating people living with HIV/AIDS. When he was exiled in early 2004, he fled to Thailand, where he continued to work as a doctor and trainer for PWAs. He is now a permanent resident in Canada. When he worked with PWAs in Burma as well as with illegal migrant workers in Thailand, he recorded their life experiences. In the next several issues of living⊕, we will publish some of those stories.

“I was so lucky to have a good husband. He was strong and a hard worker. He worked many jobs, including being a boat man for many years. He was quiet, but very accomplished and industrious.

A year after we were married, my husband began to suffer from fevers. He became weak and could no longer take on as much work. Eventually, we went to the local clinic. My husband was diagnosed with tuberculosis and given medications. He began to feel better and his fever subsided. Once again, I was happy and I returned to the factory. However, my husband remained too weak to work.

Two or three months later, the fevers returned accompanied by diarrhea. We went back to the clinic and the worker suggested a test for HIV. When we found out we were both HIV-positive, we were not concerned at first because we did not know anything about the infection. When the health worker explained its complications, we became very worried.

I continued to eat and work like other people. But my husband became thin and wasted and he always had fevers. My neighbours always asked what was wrong with him. I didn't know how to explain. One day, I told my best friend about our HIV infection. From that day on, no one would come to our home. We were ostracized from the entire community. I was upset, but I was able to care for my husband on my own.

In July 2004, my husband's fever was very high and he lost consciousness for one night and day. I tried my best to revive him but he never awoke. By the time I called the midwife the following evening, all she was able to do was certify his time of death. Later, I went from home to home, all over our neighbourhood, begging someone to spend the night with me so I would not have to sleep alone with a dead body. No one came.

I could not sleep that night, sitting by my husband's dead body. I cried and cried all night long. I sat, shaking my husband's body and asking him what to do.

Every funeral service in my village was organized by the community. But there was no one to help me with the funeral. The next morning, I did not know what to do. I had never organized a funeral before and I needed help. I went to the same friend who had ostracized us when my husband became ill. She offered some money.

One day, I told my best friend about our HIV infection. From that day on, no one would come to our home. We were ostracized from the entire community.

I could not carry my husband's body alone to the crematorium. I could not rent a car because it was too expensive; so I hired four drunken workers to carry his body instead.

We walked for two kilometres to the crematorium. I spent the entire journey wracked by thoughts of anger, confusion, and frustration. I asked myself: why wouldn't anyone help me? Why didn't my neighbours participate in the funeral? Why did everyone treat my husband as if he was a criminal? Was my husband a criminal?

After that day, I moved far away. I didn't tell my new neighbours about my HIV status, and they helped me find work as a betel nut vendor. Every day I sell my nuts and smile with my customers as if I am happy.

But my smile is only a mask. Each day I live with the knowledge of the cruelty that really drives human nature.” ⊕

Thiha Maung Maung is presently studying in the Faculty of Health Sciences at Simon Fraser University, and is also a volunteer with BCPWA Society's Treatment Information and Advocacy Department.

The most recent research project on this subject, undertaken through CWGHR, is entitled *Navigating the Maze*. Early work on this project has exposed how inflexible many of our safety networks have become, and how uneven the playing field is for persons living with episodic disabilities such as HIV. Our current system includes federal, provincial, and privately funded programs designed for people with permanent disabilities, but the various programs frequently conflict with one another. Some benefits layer—meaning that monies issued to the recipient from different sources can be added together—but more often the provincial programs and private disability insurers claw back any money received from other sources.

The ideal future state for persons living with episodic disabilities would be a minimum set standard of benefits. It is also crucial that such a system be structured to ensure that income and benefits would not be discontinued during periods when an individual is unable to work. In order for these ideas to become a reality, the episodic nature of many disabilities and the recognition that a person with a disability may be capable of participating in the labour force must be incorporated into the definition of disability.

By the year 2012, as the baby boom generation reaches retirement age, Canada will face an enormous worker shortage. Addressing this challenge, partly by re-evaluating disability legislation, programs, and benefits, is an effective way to retain qualified, experienced workers. First, it is in the country's best interest to address current disincentives in existing disability programs. Furthermore, by modifying policies and practices to remove barriers that exclude people with episodic disabilities from the workforce, employers will find an effective solution to this worker shortage. These modifications could include flexible scheduling practices, job sharing options, and mechanisms to bridge benefits during periods of ill health.

The obsolete paradigm of you are either fully able to work or you are disabled has to be discarded.

As we review and propose a restructuring of our current system as it relates to disability income, benefits, and employment options, it is of paramount importance to engage people living with episodic disabilities to share their experiences and their identified needs. Any programs that are developed must be designed to be flexible, address existing disincentives related to employment, and not penalize individuals for attempting to find ways to participate in volunteer and work opportunities.

To illustrate the range of experiences of people living with HIV with respect to employment options, we interviewed three HIV-positive individuals who have each been forced to weigh the benefits and disadvantages associated with paid work versus disability income. As their stories illustrate, their choices were based on a range of factors, including the state of their health, regulations associated with specific disability programs, the flexibility of the workplace environment, and the level of support received from employers.

Maintaining balance

Moffatt, a program consultant for the Public Health Agency of Canada, never considered leaving work. Even when suffering from severe hepatotoxicity—he once weighed merely 90 lbs., went to the bathroom hourly, and felt constantly nauseous—no one suggested that he consider applying for disability insurance.

“In hindsight, oddly enough, no one brought it up as an option,” he says.

Moffatt was diagnosed with HIV on April Fool's Day 1996 and has continued to work ever since. It helps that he has a generally supportive employer; in fact, he's never experienced any negativity at his workplace regarding his HIV status.

“I'm very lucky,” Moffatt says. “Not only do I enjoy good job security and benefits, there are a lot of options to accommodate people in our workplace.”

Opportunities to work from home or to take a self-funded leave of absence offer employees like Moffatt maximum flexibility. He also works in the HIV field, meaning he's often in the loop when it comes to the most current trends in treatment and support.

The obsolete paradigm of you are either fully able to work or you are disabled has to be discarded.

“Sometimes it feels like I can never escape from it,” he admits. “But it's also a blessing in disguise: I've gained a lot of contacts through my work.”

Some of those contacts are other public service employees living with HIV. They connect informally to share experiences and offer support—a key factor in ensuring that Moffatt's life remains stable and healthy.

“Living with HIV is like balancing on a three-legged chair: when the circumstances are good, the treatment is working, and the support systems are there, it's not hard,” says Moffatt. “But if just one thing goes awry, it takes a tremendous amount of effort to regain that balance.”

Though living with HIV has included its fair share of challenges, Moffatt says it has also given him a lot of “induced wisdom,” strength, and resilience he might not otherwise have gained.

“I used to think HIV would kill me and wondered when the time would come to apply for disability insurance, but given effective treatments and my ability to deal with it all, I've ruled that out as an option.”

Caught in the middle

After finding it difficult to sustain his energy level, health, and daily living routines, Robert decided to leave his job working with a community-based organization.

“I had difficulty finishing my work day without falling asleep, and if I did finish, I would fall asleep immediately when I got home,” he says, adding that antiretroviral medication was not yet available at the time. “I ended up missing meals and losing a lot of weight.”

Though his health improved after leaving work and finding a successful antiretroviral regimen, his financial situation proved to be a major struggle. He was on long-term disability (LTD) which provided him with a steady income, but limited his return-to-work options. Any other source of income, such as a part-time job, meant the amount of LTD he received each month would decrease.

“Even though I want to, there’s no financial incentive for me to return to work, and I know with my health, I can’t work full-time,” says Robert. “Meeting my daily living expenses is a huge challenge.”

I used to think HIV would kill me and wondered when the time would come to apply for disability insurance, but given effective treatments and my ability to deal with it all, I’ve ruled that out as an option.

Then there are the psychological effects. At first, Robert volunteered extensively; but after 15 years it stopped offering him the same degree of fulfilment, illustrating one of the problems of “retiring” early. When people retire at 65, he explained, they roughly plan the next 10 to 15 years, but that’s usually it.

“I’m 45 now and I often wonder what in the world I’m going to do for the next 25 to 30 years. I don’t have a career or kids. I don’t have future life markers that I can look forward to in order to get through today.”

If you’re thinking about leaving work and going on permanent LTD, figuring out what to replace work with has to be a major consideration, Robert says.

“For those of us who are healthy enough to know we’re not going to die, but are too sick to work full-time, there’s no middle ground. If you leave work, it may solve your immediate health problems but there are long-term psychological and financial challenges to think about.”

There and back

For someone who reintegrated back into the workforce, Garnet understands the pros and cons of both worlds.

Garnet was working in two different industries when he found out about his diagnosis—on his 30th birthday. He decided to stop working in order to consider his treatment options and adjust to the major lifestyle changes he had to make.

After a year, he began volunteering with an organization that strives to enhance the wellness of individuals with life-threatening illnesses.

“For the next ten years, I became what I like to call a ‘professional volunteer,’” says Garnet. He was volunteering around 40 hours a week when it occurred to him that he might as well try to earn an income for it.

“I was doing well, had good support in my life, developed an amazing skill set, and was really producing. I thought, why not transition it to paid work?”

He began applying for jobs and landed a full-time position at a not-for-profit organization.

“Transitioning back into the workforce is certainly a shift,” says Garnet. “I don’t have as much free time as I used to and my energy level isn’t the same, but I feel good and I’m enjoying it.”

Still, Garnet acknowledges that having HIV and working are accompanied by unique concerns not faced by the average worker.

“Life expectancy is always there at the back of your mind, especially when you have HIV. If you get a cold, you’re always going to wonder if it’s going to lead to something worse,” says Garnet. “But you still have to move ahead and seize life.”

For those debating whether to return to the workforce, Garnet suggests volunteering as a first step. Assessing how well you meet your commitments as a volunteer is a good indicator of your ability to perform in the workplace. But remember that returning to work may not be for everyone.

“It is an incredibly personal choice each individual must consider carefully and decide for themselves given their own circumstances,” Garnet emphasizes. “For me, I had to arrive at a place where I was ready to make that decision to return to work. I thought, if I was going to do it, I was going to do it now.” ⊕

Glyn Townson is the chair of BCPWA Society’s board of directors and Jennifer Tsui is a Vancouver-based freelance writer.





Working it out

HIV disclosure in the workplace

by Autumn Chilcote

Our personal health information is one of the most sensitive and private matters that we live with on a daily basis. For many people living with HIV/AIDS (PWAs), guarding our HIV status may be the only thing keeping us from suffering discrimination in the workplace or even losing our jobs. There are a number of issues to consider with respect to HIV disclosure in the workplace, from individual privacy rights for PWAs, to decisions about sharing personal health information with employers and/or colleagues.

The *Personal Information Protection and Electronic Documents Act* (PIPEDA) is an important piece of federal privacy legislation that limits your employer's collection of personal information, and mandates that the collection of such information is reasonable only as part of a *bona fide* employment circumstance.

PIPEDA also has strict rules about security of storage and use of your personal information, as well as your right to access this information to review and correct any inaccuracies.

The PIPEDA legislation is specific to federal employees; as a result, it applies to individuals working in the field of

telecommunications or broadcasting, and inter-provincial or international transportation, including trucking, shipping, rail, aviation, and maritime navigation. It also applies to employees in the banking industry, nuclear energy, and anyone working in the Yukon, Nunavut, or the Territories.

By disclosing your HIV status to work-related friends, you are building a network of support and actively reducing the sense of isolation that is often felt by concealing the truth.

Although BC does not have a specific provincial Act related to healthcare information or disclosure, many of these issues

are covered by the *Freedom of Information and Protection of Privacy Act* (FIPPA). This provincial legislation regulates the protection of personal information—including medical and health information—for individuals working in British Columbia that are not federal employees. FIPPA allows access to information held by public bodies (such as ministries, universities, and hospitals) and determines how public bodies may collect, use, and disclose personal information.

There are various employment-related circumstances where the issue of HIV disclosure has the potential to arise in the workplace, so it is important for both employers and employees to be aware of privacy rights and responsibilities.

Pre-employment medical exam. Your employer may only ask you to complete a physical exam before your job if doing so constitutes a “*bona fide* occupational requirement.”

Completing insurance forms and medical questionnaires. If the employer has no legitimate need to see your insurance form, you may send your forms directly to the insurance company, and keep your medical information private.

Providing a doctor’s note for health-related absences. If your employer requires a doctor’s note due to an extended period of absence, the letter need only state that you were seen by the doctor and that you were ill; it is optional for the doctor to list general symptoms of your illness. For the protection of the patient’s privacy, a doctor’s note should not identify a specific illness. Similarly, a doctor’s note should never be faxed to an employer, and an employer is not permitted to request this. As well, the details of the doctor’s note must not be shared with any other member of the business or workplace except the individual that requested it.

Requesting accommodation. An employer is required to make accommodations for employees with disabilities assuming that these accommodations do not cause “undue hardship” to the employer. So if, for example, you need to request different working hours due to side effects of your medication, there is no requirement that you need to share the type of medication or your specific diagnosis with your employer. Instead, your doctor need only supply information about your working limitations and requirements in order to allow your employer to make the necessary health-related accommodations.

You may have personal relationships with work colleagues, and might consider disclosing to them within a friendship context. By disclosing your HIV status to work-related friends, you are building a network of support and actively reducing the sense of isolation that is often felt by concealing the truth. Choosing the right time and place, as well as ensuring that your privacy at work is protected, is very important. You may feel vulnerable immediately after you disclose, and it is best to be prepared to receive both positive and negative reactions.

Selectively disclosing your HIV status to your employer and/or colleagues also means that you have less control over how that information is shared. Before deciding, consider what

would happen within your work environment if your other office-mates became aware of your status. Would your position or reputation in the workplace be threatened? This is a difficult question that must be considered from the standpoint of the organizational structure, culture, and values.

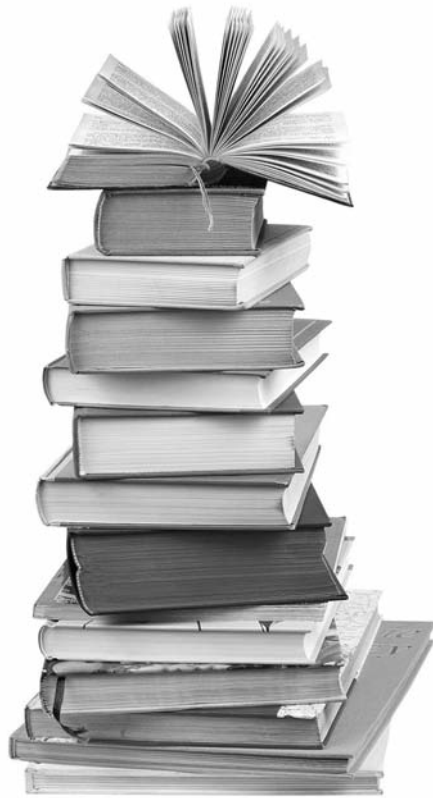
Thinking positive, living positive, and acting positive may help decrease stigma and discrimination associated with HIV disclosure at work.

An alternate viewpoint in favour of HIV disclosure in the workplace is the opportunity that presents itself in educating co-workers about AIDS and living with HIV. If you feel confident that you will not experience discrimination because of your serostatus, you may take it upon yourself to engage your workplace in education by demonstrating and expressing the realities of living with HIV. Perhaps you can enlist the support of your colleagues by coordinating volunteer opportunities with groups like BCPWA Society, AIDS Vancouver, or YouthCO, or organizing a company team for the AIDS Walk for Life.

Thinking positive, living positive, and acting positive may help decrease stigma and discrimination associated with HIV disclosure at work.

To stay healthy, we need access to employment that is both meaningful and feels safe. It is important that we feel we can control the information about our medical history within our workplace. More information about privacy can be found at the Office of the Information and Privacy Commission for British Columbia, www.oipcbc.org or Canadian HIV/AIDS Legal Network, www.aidslaw.ca. ☺

Autumn Chilcote is a volunteer in the Prevention Department of the BCPWA Society.



Hitting the books

Smart survival strategies for HIV-positive students

by Neil Self

Whether you have been diagnosed within the last ten years or you are a long-time survivor with HIV, pursuing your education—as a first time or returning student—may be something you are considering. For younger or newly diagnosed people living with HIV/AIDS (PWAs), this may involve coming to terms with your current health challenges, accessing and setting up educational supports, then continuing on with your original educational and career goals. But for long-time survivors, the issues may be more complicated. The decision to attend or return to school could involve dramatic lifestyle changes and might affect your current income support system (i.e., disability benefits or pension).

A good place to start if you are considering post-secondary studies, is meeting with an academic advisor at the school you wish to attend, as well as with a BCPWA advocate. These people can help you evaluate the demands of an academic program and schedule against your health issues and

practical requirements. It is helpful to be clear about all the factors surrounding your decision prior to applying for admission.

Do your homework

Before beginning or resuming your studies, consider what you want to do with your education. Do some research, find out about jobs that interest you, talk to people working in the field, and inquire about the positive and negative aspects of their jobs. Consider carefully how living with HIV would affect your ability to manage your studies or work.

There are a range of educational institutions to consider: technical schools, community colleges, public universities, and private colleges. And each post-secondary school offers an extensive array of programs (degrees, diplomas, and certificates) as well as individual courses. Most of these institutions have admission and program advisors who can discuss specific program requirements with you, and many also have

disability or access coordinators that offer assistance to people with disabilities, including HIV-positive students.

Investigate the reputation and academic approach at different schools. Talk to current and former students and, especially in the case of private institutions, research their employment placement track record. Also, check with the Better Business Bureau to ensure that no complaints or concerns have been registered against the school. Private post-secondary institutions should be accredited through the Private Career Training Institute Agency of BC.

PWAs who receive provincial Persons with Disabilities (PWD) assistance may be eligible for BC's Employment Program for Persons with Disabilities, a Ministry of Employment and Income Assistance (MEIA) program which includes vocational testing, career planning, and job-skill training. For PWAs not on provincial disability benefits,

other pre-education or vocational testing options may be available. Meet with an employment counsellor for details.

Dollars and sense

Financing your post-secondary education can be a challenge. Tuition, student fees, and books for an undergraduate degree at UBC average about \$6,500 a year. BCIT's trades and technical programs cost anywhere from \$700 to \$15,000 a year, excluding textbooks. And the Emily Carr Institute of Art + Design costs about \$1,700 a year, excluding textbooks and supplies.

Most public and many private school students can apply for BC and Canada student loans through StudentAID BC. PWAs living on PWD assistance can receive student loans while maintaining their disability benefits, provided the loans are restricted to educational expenses (i.e., tuition and books) and some other related costs (such as unsubsidized childcare) and not used towards rent, food, or other living expenses. PWAs living on regular Income Assistance will lose their benefits if they apply for full-time studies/student loans. Canada Pension Plan (CPP) disability recipients do not have any restrictions with respect to applying and receiving student loans; however, if CPP discovers that you are attending school, they may initiate a review of your disability status that could result in the loss of your pension. Those with private long-term disability benefits should carefully consult their policy, or meet with a BCPWA advocate, since many policies do not allow recipients to attend school.

Regardless of your income, there are many bursaries, grants, scholarships, and awards available to assist students in financing their education. Meet with a financial aid officer at the school(s) you wish to attend to find out more about the application criteria and process.

In the ivory tower

Living with HIV while going to school can present health challenges that other students typically do not face: managing fatigue, coping with gastrointestinal problems and medication side effects, and dealing with sudden and long-term illnesses.

Most public and many private institutions have a disability resource centre or access coordinator to facilitate the educational experience for students with disabilities. Initially, the disability office will require documentation confirming your disability, but once this paperwork is processed, these resource centers can be a great asset. HIV-positive students can receive assistance with course scheduling, exam accommodation, and extra time for course requirements and assignments due to illness.

PWAs living on disability benefits are also eligible to receive full student loan funding for a reduced course load. Ordinarily, students are required to maintain a minimum 60 percent course load to qualify for student loans; however, students with disabilities need only maintain a 40 percent course load. This is an important concession since many PWA students may prefer a reduced course load for a variety of health reasons.

PWAs may also apply for Canada Study Grants for additional or specialized educational assistance, including computers with adaptive technology, as well as Canada Access Grants, which provide up to \$2,000 per program year and help to reduce student loan amounts.

After school

Once your education is complete, there are several options to consider in entering the workforce and repaying student loans. Use the employment and placement programs that many schools offer; these programs are often the best way to secure employment in your field. Depending on your discipline or area of study, a practicum, field placement, mentorship, or apprenticeship will provide networking opportunities and will add to your work experience. These opportunities can be very beneficial, especially if you are entering into an employment area where you have no previous work experience.

Many PWAs who have lived on disability benefits for extended periods of time will have significant gaps in their résumés and need to re-establish their work experience and reputation with prospective employers. Some employers may initially offer contract

work (i.e., time limited project work), part-time employment, or casual positions. These options may be appropriate, depending on your employment goals and financial situation, since many PWAs prefer to ease themselves back into the routine of working.

PWAs living on PWD assistance are allowed to earn a maximum of \$500 per month while still maintaining their full disability benefits; any earnings over \$500 are deducted, dollar for dollar, from their monthly benefit cheque. PWAs on PWD will also maintain many of their MEIA medical benefits coverage if they resume full-time work, provided they are working and living in BC.

In an ideal world, education would lead to employment in our chosen fields and we would all be able to manage our student loans without any difficulty. However, if you are having difficulty finding work or have become too ill to work, there are a few options to help with your student loan. There is a grace period of six months following the completion of studies before loan repayment requirements begin. Also, if you are classified as low income or are experiencing financial hardships, you can apply for interest relief; if you qualify, the government will pay the interest on your loans and temporarily relieve you from student loan payments for up to 30 months.

Other programs and services to help manage student loans include: loan reduction, loan remission, principal deferment, and loan forgiveness in certain circumstances. For information, visit the StudentAID BC website at www.aved.gov.bc.ca/studentaidbc/. For assistance with student loan repayment options, see an advocate at BCPWA. ☎

Neil Self completed his BSW in 2005 and is now a MSW student at UBC. He is currently an advocate in the Treatment Information and Advocacy Department at the BCPWA Society and a regular contributor to living ☎





Getting the message

The pros and cons of partner notification in HIV prevention

by **Elgin Lim**

Partner notification is the voluntary and anonymous public health procedure of advising the partners of someone newly diagnosed as HIV-positive that they have been exposed to the virus. When referring to partner notification, the term “partner” includes not only sex partners of the person infected, but also people who have shared equipment for injection drug use or who have engaged in other high-risk activities for HIV exposure.

Notifying partners about possible HIV infection is an effective way to reduce the spread of HIV. The partner notification process provides the opportunity to communicate risk-reduction information to prevent further transmission of HIV by those who may be already infected, as well as HIV prevention information to those who may not be infected. Informing partners of potential exposure allows them the option to confirm their serostatus through HIV testing and, if infected, allows them to make important decisions with respect to accessing appropriate health care and treatment.

Options for partner notification

There are several ways in which HIV-related partner notification can be carried out. First, the newly diagnosed individual may

notify his or her partner(s) directly. If this method is selected, public health professionals can provide helpful information on how to approach partners, what to tell them, and where to refer them for appropriate follow-up services such as testing, counselling, and treatment if needed.

Second, the newly diagnosed individual may opt for their physician or an HIV public health nurse to contact and inform their partners. Individuals who prefer to keep their own identities and serostatus anonymous often select this method of notification. Notification carried out in this manner is undertaken by a physician or HIV public health nurse, and all possible efforts must be made to protect the confidentiality of the client and his or her partner(s).

Finally, newly diagnosed individuals may choose to notify their partners with the assistance of their physician or an HIV public health nurse. For example, an individual may choose to notify a specific partner at his or her doctor’s office with the doctor present. Alternatively, an individual may also decide to notify his or her primary partner with the assistance of a physician or HIV public health nurse, but may leave the task of notifying other partners to an HIV public health nurse in order to maintain anonymity.

Whatever method is used, partner notification is a strictly voluntary process, done with the full consent of the HIV-positive individual. An HIV-positive person's refusal to participate in partner notification should in no way restrict their ability to access any health services they require.

Benefits and limitations

There are a number of compelling reasons to support partner notification. For instance, partner notification can identify partners who have been infected with HIV, but who are unaware of their exposure to the virus. In fact, some studies reveal that as many as 30 percent of an HIV-positive individual's past partners are unaware of their HIV status. In this case particularly, partner notification can promote early diagnosis of someone recently exposed, and can prevent the newly infected person from unknowingly transmitting the virus to others.

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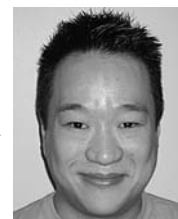
Another benefit to partner notification is its potential to help modify the high-risk behaviours of individuals before engaging in future risk activities. Research findings presented at

the Fourth Conference on Retrovirus and Opportunistic Infections in 1997 showed that rates of condom use were significantly higher, and the number of new sexual partners was lower, amongst the group of study participants who received HIV counselling resulting from partner notifications, compared to those who received no counselling.

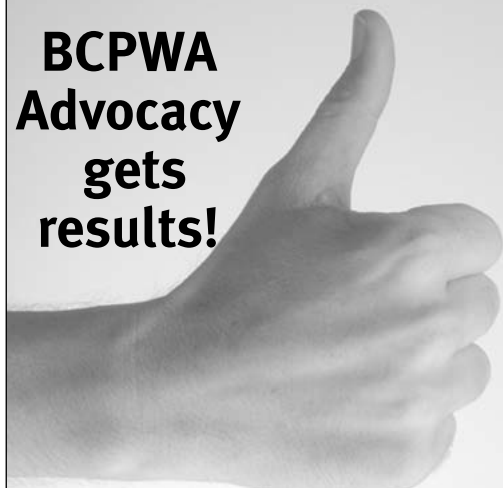
In addition to the benefits, however, it is also important to recognize the limitations associated with partner notification. Obviously, the ability to notify partners of a newly diagnosed individual is only as effective as the contact information provided by the individual. As well, the HIV-positive individual may not be able to identify a particular partner or partners in situations involving high-risk anonymous encounters. And, in some circumstances, it is possible that the HIV-positive individual simply does not want to disclose identifying information at all. Since partner notification requires the voluntary participation of the HIV-positive individual, some partners may not be notified.

Finally, partner notification should be conducted with great sensitivity and care, taking into account social and cultural factors, such as the possibility of violent reactions from past partners. In some cases, the only possible exposure to HIV may be from one individual; being able to identify who put them at risk of infection may be obvious. Domestic violence screening must be part of all post-test counselling before any form of partner notification is initiated. ⊕

*Elgin Lim is the director of
prevention programs with the
BCPWA Society.*



**BCPWA
Advocacy
gets
results!**



The BCPWA Society's Advocacy Program continues to work hard to secure funds and benefits for our members.

The income secured for October 2007 and November 2007 is:

- **\$27,000** in debt forgiveness.
- **\$20,130** in housing, health benefits, dental and long-term disability benefits.
- **\$2,250** in ongoing monthly nutritional supplement benefit for children



treatment. information

TREATMENT INFORMATION PROGRAM MANDATE & DISCLAIMER

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

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

Current standards of care and treatment

News from the BCCfE antiretroviral update – November 2007

by **R. Paul Kerston**

Roughly every six months, researchers and clinicians from the BC Centre for Excellence in HIV/AIDS (BCCfE) present updates in HIV standards of care and medication use to area healthcare practitioners as well as BCPWA Society members and treatment program staff. The most recent update presentation, which took place in late November, offered the latest information concerning HIV specialist care, laboratory tests, treatment programs, HIV/hepatitis C co-infection, as well as new antiretroviral (ARV) therapies, including documented side effects.

Some highlights from the Centre's most recent ARV update meeting are summarized below.

Standards of care

Dr. Rolando Barrios and Dr. Silvia Guillemi, both of the Centre's Immunodeficiency Clinic (IDC), explained the proper standards of care following diagnosis, including medical history, laboratory tests, and immunizations. They advise the following:

Medical history and examinations:

- ▶ Complete medical history, including a list of all currently prescribed medications and allergies.
- ▶ Psycho-social history to determine mental health issues, if any, and to ensure that appropriate medications are prescribed or avoided; for example, efavirenz (Sustiva) is not recommended in certain cases.
- ▶ Complete physical examination, accompanied by a review of respiratory, digestive, cardio-vascular, nervous, skin, and other body systems.

Blood laboratory tests:

- ▶ CD4 cell count and fraction/percentage
- ▶ HIV plasma viral load
- ▶ Complete blood count and lymphocyte differential (counts five specific types of white blood cells and diagnoses active infections)
- ▶ Liver function tests
- ▶ Kidney function tests
- ▶ Cholesterol measurements (to assess heart health)

Genotyping and virtual phenotype testing including:

- ▶ HLA-B*5701 genetic testing (abacavir (Ziagen) hypersensitivity screen)
- ▶ Viral hepatitis screening for types A, B, and C (to check for current or prior infection)

Disease screening and early disease detection:

- ▶ Toxoplasmosis (may indicate need for prophylaxis and/or treatment)
- ▶ Syphilis (requires urgent medical treatment)
- ▶ Tuberculosis (if CD4s are >200; test results are inconclusive with CD4 levels <200)
- ▶ Sexually Transmitted Infections (particularly gonorrhea and chlamydia)
- ▶ Vaginal, cervical, and rectal cancers (PAP smears for men and women)

Vaccinations:

- ▶ Pneumococcal disease
- ▶ Annual flu shots
- ▶ Hepatitis A and B (if not already immune)

Confirm prior immunizations (and provide any needed boosters) for:

- ▶ Polio
- ▶ Tetanus
- ▶ Haemophilus influenza type B
- ▶ Meningitis
- ▶ Measles, mumps, and rubella (no boosters unless CD4 counts are relatively strong; otherwise, live virus in the vaccine is potentially dangerous)

Genotyping and virtual phenotyping

Dr. Richard Harrigan, research laboratory director at the BCCfE, presented on the topic of genotyping and the associated virtual phenotyping procedure. HIV genotyping refers to the actual DNA sequence of the virus; the phenotype reflects the physical traits or behavior expressed by the genotype. HIV genotyping has historically been the more commonly used technology for drug resistance testing while phenotype testing measures the amount of medication necessary to suppress viral replication. According to Dr. Harrigan, genotyping is an extremely advantageous practice that should be a standard of care prior to initiation of treatment. This test is a significant shift in medical opinion since, only a few years ago, genotyping was carried out only following drug failure.

Dr. Harrigan also stressed the usefulness and accuracy of the HLA-B*5701 genetic test which screens for abacavir (Ziagen) hypersensitivity. This test is important for the roughly five to eight percent of HIV-positive people who experience a serious adverse reaction to this medication; it is critical for people with abacavir (Ziagen) sensitivity to

discontinue use of this medication, and especially not to resume this drug or combination therapies containing abacavir (Ziagen), as this could be fatal.

HIV/hepatitis C co-infection

Dr. Mark Hull presented on the topic of HIV/hepatitis C (HCV) co-infection. According to his report, detection of HCV may be possible as early as seven or eight weeks following exposure, even though there is unlikely to be any sign of illness at that time. Hull stressed that “HIV has been demonstrated to have a significant impact on HCV infection” with decreased rates of spontaneous clearance of hepatitis C and higher HCV viral loads. Also, with HIV/HCV co-infection, there is an increased risk of damage to the liver with the HIV drug nevirapine (Viramune) as well as with full dose ritonavir (Norvir), although this last drug is rarely used now.

Proposed treatment protocol for HIV/HCV co-infection involves treatment of hepatitis C initially, if a person’s CD4 counts are >350. Where CD4 counts are <200, HIV treatment should be prioritized. To maximize a successful treatment response, an 80 percent adherence to the HCV medications is required. New guidelines on treatment with pegylated interferon and ribavirin (Pegasys RBV or Pegatron) indicate medication for 24–48 weeks, depending upon virus type. Results at four weeks of HCV treatment are predictive of overall success.

New antiretroviral treatments

Dr. Julio Montaner, director of the BCCfE, focused on several items related to new antiretroviral (ARV) therapies. First, Dr. Montaner stated that the new medication darunavir is at least equal in effectiveness to the lopinavir/ritonavir combination (Kaletra), and is designed for and works well with both treatment-naïve and more drug-experienced patients. The most common side effect documented with darunavir (Prezista) has been an associated rash in some patients. Dr. Montaner also mentioned that raltegravir (Isentress) is the next drug in the integrase inhibitor class, and results appear promising.

Finally, Dr. Marianne Harris reviewed toxicity profiles of the new ARVs presented by Dr. Montaner. She also noted side effects from the new medication, Atripla (a combination of three generics: efavirenz, emtricitabine, tenofovir), which include possible kidney problems, rash, headaches, and dizziness. ☹

A list of 2008 current antiretroviral drugs in BC can be found on page 4 in the Reality Bites section.

R. Paul Kerston is the program coordinator for BCPWA Society’s treatment outreach program and community representation and engagement initiatives.

Conference report

CATIE learning institute and OHTN research conference

by **Zoran Stjepanovic** and **R.Paul Kerston**

In late November, BCPWA treatment information staff attended the Canadian AIDS Treatment Information Exchange (CATIE) learning institute followed by the Ontario HIV Treatment Network (OHTN) research conference. Although based in Ontario, both events offered valuable information for people working in the AIDS movement and living with HIV in BC.

CATIE conducted a learning institute on the day prior to the OHTN conference, bringing together frontline HIV treatment information educators from across the country. One workshop provided training and skills development on presenting HIV research findings, and several other presentations were aimed at preparing attendees for the research conference.

The OHTN conference, entitled *Addressing HIV Vulnerability: From Biology to Policy*, adopted and reflected this theme throughout many presentations, sessions, and oral abstracts.

In one session focusing on the increasing number of HIV-positive immigrants and refugees in Canada, a group of researchers in Ontario looked at strategies to improve access to mental health services for this population by addressing social vulnerabilities. The research team identified some key barriers faced by immigrants and refugees, and proposed responses including addressing service inequities, bridging gaps in health-care coverage, promoting service providers' cultural competency, and enhancing service delivery and coordination.

Another presentation focused on providing services to Aboriginal people living with HIV/AIDS. The researchers found that traditional Aboriginal wellness practices have improved health outcomes and treatment adherence within the Aboriginal HIV-positive population.

Oral abstracts included a session entitled *Beyond HAART*. One abstract noted that, as with the general population, HIV-positive men and women frequently have low fibre intake. Adequate daily intake for adults varies from 21 to 38 grams daily, depending on sex and age. And, according to a research study involving male participants, dietary fibre maintains healthy bowel function, lowers blood cholesterol levels, and controls blood sugar levels; it may also help in maintaining a healthy body weight and in preventing colon cancer. Given

HAART tendencies toward cholesterol imbalance and higher blood glucose levels, a high fibre diet may help.

Another noteworthy but small-scale study showed that where HIV-positive individuals vaccinated against hepatitis B produced insufficient (<100 IU/ml) hepatitis B surface antibodies (HBsAb), there was roughly a 20 - 40 percent annual loss of HBsAb, and an almost entire loss of acquired immunity after four years. Proposed solutions include a booster inoculation after three years. Also, if CD4 counts are relatively high at the time of HIV diagnosis, a vaccination against hepatitis B is recommended in the absence of previous exposure or inoculations.

A session entitled *Clinical Complexities of Co-infection* showed that while gonorrhea stimulates HIV production by infected CD4 cells, the body's interferon-alpha is involved in an anti-HIV response, suggesting that gonorrhea's effect on HIV-1 may partly depend on how the balance between CD4 cell counts and interferon-alpha is maintained during co-infection.

Finally, the *TRACE* study showed that 94 percent of gay men engaging in anal sex have anal dysplasias, with roughly 80 percent of this number exhibiting pre-cancerous lesions. Further, there is at least a 50 times higher risk among gay men to develop anal cancer than among the general population. Treatment includes either single or multiple laser treatments, or several applications of TCA, a reportedly painless acid (See "Worry warts," pp 20 - 22, issue #53 as well as "What is anal dysplasia," pg 30, issue #48, *living* ☺).

Zoran Stjepanovic (l) is the BCPWA Society treatment information coordinator and **R.Paul Kerston** (r) is BCPWA Society's treatment outreach coordinator and community representation and engagement (CRE) coordinator.



Worry warts

Human papillomavirus (HPV)

by Rob Gair

HPV and cervical cancer

About 20 years ago I recall a female friend grumbling about having to get a Pap test. At the time, I knew that Pap tests were used to screen for cervical cancer but my notions about the procedure and its purpose remained vague until well after my pharmacy training when I was involved in the care of a woman who was dying from this type of cancer. I still recall my disbelief when the patient's nurse told me that cervical cancer is caused by human papillomavirus (HPV).

I was surprised to learn that the disease was transmitted sexually and wondered just how widely known this information might be. It turns out that the medical community suspected a sexual link to cervical cancer as early as the 1920s but it wasn't confirmed until the 1970s when HPV was finally identified as the causative organism. Yet the public remained generally

unaware of the connection between cervical cancer and sex until a new vaccine for HPV brought the virus “out of the closet.” The role of HPV in the development of anal and possibly throat cancer has also since been revealed. Despite our improved knowledge, however, HPV and its pathology remain controversial and misunderstood, especially in HIV-positive men and women.

What is HPV?

Human papillomaviruses are a group of viruses that may cause warts or pre-cancerous lesions on skin and the mucous membranes that line body cavities. They are highly contagious and strains that are sexually transmitted affect up to 75 percent of sexually active adults. Condoms reduce infection rates but they are not 100 percent preventative.

There are over 100 types of HPV, which are classified numerically. Most types cause benign or invisible skin infections that resolve on their own. In particular, four types are recognized to cause harm: types 6 and 11 cause visible warts in the genital or anal areas but do not cause cancer; and types 16 and 18 do not cause visible lesions but may lead to pre-cancerous growths on the cervix or anus, sometimes called dysplasias. The pre-cancerous cells usually clear on their own; in rare cases, they can lead to cancer. Recently, a vaccine (Gardasil) has been developed to protect against these four strains of HPV.

What is a Pap test?

The term Pap is a short form for Papanicolaou’s stain, named for the Greek-American physician who developed the procedure in the 1940s. The Pap test was originally designed to detect pre-cancerous cells in the cervix. The screen is only intended to identify individuals who have a higher likelihood of developing cervical cancer. It is not used to diagnose illness, but rather to initiate investigation and treatment to reduce the chance of cancer in later years. More recently, the Pap test has been applied as a screening method for anal cancer.

HPV is highly contagious and strains that are sexually transmitted affect up to 75 percent of sexually active adults.

In the case of a cervical Pap test, a spatula is inserted into the vagina and it is moved around the mucosa (skin) at the point where the vagina meets the cervix. The spatula lifts cells off the mucosa and, once removed from the body, the cells are smeared against a glass plate for staining and microscopic analysis. Abnormal cells can be detected visually by their shape and colour under the stain.

In the case of anal Pap tests, a similar procedure is performed by inserting a Q-tip-like swab approximately two inches into the anal canal. A similar smear is carried out so that the cells can be viewed under the microscope.

Pap tests are a sensitive screening procedure for cervical cancer, decreasing the rate of cervical cancer deaths in women by about 80 percent. However, the anal Pap test has not proven to be as effective for anal cancer screening. One study suggests that the sensitivity of the anal Pap screen might be improved if, in addition to the normal visual analysis, the smear was also tested for HPV DNA.

HPV in gay men

HPV is common in gay men. Most infections are invisible, but still contagious. Visible infections present as warts on the genitals or around the anus. These are treated like common warts with burning or freezing and they are generally benign. The same strains of HPV that are associated with anal cancer in men cause cervical cancer in women, and the disease exhibits a similar progression in both cases: no visible warts initially, but after cells in the anus are infected with HPV, abnormalities in their growth patterns may develop (anal dysplasia). If the infection is not detected or treated, cancer may result.

The anal cancer rate in gay men is high compared to current statistics for cervical cancer in women. In addition, men with HIV are even more likely to develop anal cancer. Still, the actual number of cases in BC is small (only about six cases per year). Studies indicate that the majority of HIV-positive gay men who are given Pap tests will show some degree of dysplasia. But there is no link between an abnormal Pap test and anal cancer in this group, and current treatment is largely ineffective.

There are several factors to consider with respect to anal dysplasia in HIV-positive gay men. First, HIV-positive men with abnormal Pap tests usually don’t develop anal cancer for a number of years, if at all. As well, while lower CD4 counts are associated with increased risk of anal dysplasia, the introduction of HIV medications does not appear to improve the dysplasia. Finally, treatment of anal dysplasia in HIV-positive men is not very effective. To date, laser therapy shows the best results for reducing recurrence of dysplasia in the short term (six months), but the long-term effect remains unknown.

Currently, the Anal Dysplasia Clinic at St. Paul’s hospital will examine patients who are referred by their doctors. Men at highest risk for anal cancer include those who are HIV-positive, who have had previous HPV infection (warts or dysplasia), and previous CD4 counts below 200 (also linked to an increased risk for serious dysplasia).

Vaccine controversies

Recently, the pharmaceutical company Merck introduced Gardasil, a new vaccine against HPV types 6, 11, 16, and 18.

12 tips about human papillomavirus (HPV)

1. HPV is a virus that infects skin and the mucous membranes that line body cavities.
2. There are over 100 types of HPV and all are highly contagious
3. Sexually transmitted types of HPV are common in all sexually active people. Many people who are infected show no visible signs.
4. Some types of HPV cause visible warts on the genitals and around the anus. These do not cause cancer.
5. Others types of HPV cause invisible pre-cancerous growths (dysplasia) on the woman's cervix or inside the anus (men and women).
6. Most of these dysplasias clear on their own, but sometimes can lead to cervical or anal cancer.
7. HPV is common in gay men. Rates of anal cancer are high compared to rates of cervical cancer. This is especially true for HIV-positive gay men. However, the numbers of actual cases are small.
8. Pap tests have successfully reduced the number of deaths from cervical cancer in women.
9. Anal Pap tests are not as effective at predicting cases of anal cancer as cervical Pap tests are for predicting cervical cancer.
10. A new vaccine against four common types of HPV is available. Currently it is recommended for pre-sexual females aged nine to 13. Its use in males is still being studied.
11. If you are concerned about HPV or anal cancer, see your doctor.
12. To reduce your chances of HPV infection, use condoms and limit your number of sex partners.

The vaccine is most effective if administered before people become sexually active.

Currently the vaccine is recommended for pre-sexual females between the ages of nine and 13. This group has been targeted because, in later years, they are the most vulnerable to serious disease from HPV, specifically cervical cancer. However, widespread vaccination of young girls is not without controversy, mostly because the majority of women with high-risk HPV infection do not develop cancer and the vaccine is expensive.

Recent estimates suggest that 324 girls need to be treated at a cost of \$500 per person to prevent one case of cervical

cancer. This estimate assumes that the vaccine provides lifelong protection; however, the vaccine is not currently known to be effective beyond five years. Assuming the vaccine wanes by 3 percent each year, the number of vaccinations needed to prevent a single case of cervical cancer climbs dramatically to 9,080. As well, vaccine protection does not preclude the need for regular Pap tests because there are other cancer causing strains of HPV that may become more prevalent when types 16 and 18 are suppressed. The debate continues within the medical community about the value of widespread HPV vaccination of girls, but the initiative is largely popular and most governments are announcing budgets for such programs.

The same strains of HPV that are associated with anal cancer in men cause cervical cancer in women, and the disease exhibits a similar progression.

The value of vaccinating boys has also been debated, although less vigorously. On the surface it makes sense to vaccinate boys because men will likely acquire and transmit HPV to their partners early in their sexual lives. However, most heterosexual men do not suffer serious disease from HPV and studies have not been completed in boys to evaluate the effectiveness and safety of the vaccine. Gay men are known to have much higher rates of anal cancer from HPV infection so pre-adolescent vaccination of all boys may decrease infection rates in this group, although this has not been proven. A Merck-sponsored study is currently investigating 4,000 healthy men between the ages of 16 and 26 who have had no more than five sexual partners. Five hundred of these men are self-identified as gay.

Using the vaccine to stimulate stronger immune control over established anal dysplasia in gay men has been touted as an attractive option, although there is no data to confirm whether or not this would work.

In the meantime, both women and men can reduce their chances of HPV infection by using condoms during sex, staying healthy, and limiting their number of sexual partners. ⊕



Rob Gair is a pharmacist at the BC Drug & Poison Information Centre



On a positive note

The Living Well Lab proves to be a useful tool to track health and wellness

by **Andrea Mulkins and Dave Boyack**

Many of us have heard how complementary medicine has been used for thousands of years in numerous cultures throughout the world. But does it really work? Does it really improve people's health?

What we today refer to as complementary and alternative medicine (CAM) was the foundation for treating a range of ailments, aches, and pains long before Western medicine emerged as our primary form of health care. Centuries ago, Greek, Chinese, and other societies used CAM to improve the health of their citizens. Still, some critics and skeptics dismiss the effectiveness of alternative therapies, claiming a lack of "proof."

An interesting story is emerging about the effectiveness of CAM right here in Vancouver. The Living Well Lab (LWL) is a project funded by the Canadian Institutes of Health Research that operates through the Vancouver Friends For Life Society (FFL). The LWL evolved out of a series of discussions initiated by J. Evin Jones, Co-Executive Director of FFL, with representatives from the BC Persons With AIDS (BCPWA) Society. In 2004, both organizations were offering naturopathic services to their members, and Evin sought a way to collaborate in providing CAM services to people living with life threatening illnesses, including HIV. Representatives from FFL and the BCPWA Society formed a committee to further explore ideas around this project and subsequently launched the Living Well Lab.

Today, the LWL is an online resource for FFL members that helps them track their general sense of well-being and record any changes or improvements to their health. It also functions as an evaluation tool for FFL programs since data indicates that the CAM therapies provided by FFL have made a significant difference in the wellness of their members.

During 2007, over one-quarter of FFL members completed a series of surveys, participated in one-to-one interviews, and attended focus group sessions related to the LWL. Their involvement has provided valuable insight into how CAM has impacted their quality of life. Preliminary data demonstrates how CAM therapies have significantly improved members' overall health and well-being.

Some of the key findings from the LWL research include the following:

- ▶ Participants have complex health issues; the most common concerns are HIV, depression, and pain
- ▶ Nearly half of participants deal with mental health issues
- ▶ Members have experienced significant improvements in energy levels, as well as decreased levels of pain and stress through CAM therapies
- ▶ Members have experienced a range of positive changes since coming to FFL, including: decreased anxiety, and increased confidence related to improved health and an enhanced social network
- ▶ The most popular CAM therapies are: vitamins, traditional Chinese medicine, massage therapy, naturopathy, and healthy lifestyle activities such as exercise and eating organic foods
- ▶ Half of focus group participants do not communicate with their medical doctors about CAM use
- ▶ Focus group participants who do speak with their doctors about CAM use have some reservations about sharing this information
- ▶ Some participants are frustrated with having to educate their doctors about CAM use and some don't discuss CAM with their doctor because their doctor never inquires

FFL staff are examining the preliminary data and discussing ways to integrate the insights of members at the Wellness Centre. We hope these findings will not only demonstrate the effectiveness of CAM, but that FFL and the BCPWA Society can better meet members' needs and plan for expanded services. If you have any questions about the LWL, our preliminary findings, or how you can support or become involved with the project, please contact Andrea Mulkins, LWL Coordinator at andrea@friendsforlife.ca. ☎



Andrea Mulkins is the coordinator of the Living Well Lab and **Dave Boyack** is a peer researcher on the project.



Expose yourself

Illuminating news about sunlight and vitamin D

by *Alix Mathias*

Just when you found the perfect hat and a sunscreen that doesn't make your face break out, news of the health benefits from sunlight exposure are making headlines.

For decades, the significantly higher cancer rates in northern countries compared to southern developing nations have been a mystery to medical researchers. Growing evidence suggests that this discrepancy is not caused by pollution, but, rather, sunlight exposure and the body's production of vitamin D. Evidently, Canada's geographic latitude and limited sunlight exposure (never mind rainy Vancouver) prevent us from producing sufficient vitamin D—especially with our indoor lifestyle and sun avoidance.

Remember rickets? Tiny Tim? At the turn of the century, children living in impoverished conditions, many working in dark factories or mines, developed bone deformities from vitamin D deficiency. This condition was virtually eliminated through supplementation. The medical world was shocked recently to learn that rickets has made a comeback among babies and young children in North America. This reemergence is due in part to the use of sunscreen and extreme sun avoidance measures now practiced by parents.

To put skin cancer rates in perspective, 1,500 people die each year in the US from skin cancer, while 1,500 people die each day from other cancers. An American study released in 2007 compared the health of some 1,200 female patients, some of whom took a vitamin D supplement while others did not. The number of patients who reduced their risk of cancer by taking a vitamin D supplement was an unprecedented 60 percent. Since then, several other studies have supported the finding that vitamin D might be key to cancer prevention.

While most modern medical research and media coverage focuses on the cancer-sunlight-vitamin D connection, it is important to remember that the role of vitamin D in supporting immune function is well established. Exposing the body to sunlight (or even artificial ultra-violet light) increases the number of white cells in the blood. White cells are vital to your

immune system's response to organisms that cause infections and illnesses.

Vitamin D is produced when bare skin is directly exposed to bright sunshine. You can generate all the vitamin D required with about 20 minutes of sun exposure. Remember, however, that due to the angle of the sun, no vitamin D is generated in Canada from November to February.

The Canadian Cancer Society now recommends 1,000 IU per day of vitamin D to avoid deficiency. In food form, one serving of salmon contains about 360 IU, a glass of fortified milk about 100 IU, an egg 25 IU, and a tablespoon of cod liver oil 1300+ IU. The good news is that vitamin D is one of the most affordable supplements on the market.

Sunscreen blocks out 95 percent of the vitamin D producing UVB rays while leaving the skin-damaging UVA light. By blocking UVB, we "tolerate" much more UVA radiation before becoming aware that the skin is burning. Sunbathing without sunscreen until the skin tone changes colour—then covering up—may be the safest way to get your daily vitamins and practice safe sun exposure.

Vitamin D is only one of the many health benefits of natural light. Recent experiments with full-spectrum lighting have shown its multiple benefits in healing jaundiced infants, improving students' academic performance, boosting dairy production in cows, and more. Traditional healers such as Chinese Medicine practitioners have long known that natural light stimulates the pituitary and pineal glands, thus regulating hormones. Exposure to natural light also helps us sleep deeply at night and therefore heal more efficiently.

So remember to expose yourself regularly—it's good for your health. ☺

Alix Mathias is the wellness services manager at the Vancouver Friends For Life Society.



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Constructing meaning

Reflections on life, identity, and spirituality

by Jari Dvorak

Since my HIV diagnosis 20 years ago, my view on life has changed considerably. Long gone is the initial cheerful perception that, with modern medicine, my life will be business as usual. Now it's more like: how do I keep the ups and downs of HIV and aging from undermining my sense of stability? I'm looking around to see if there is a new, more helpful meaning for whatever life I have left. The old philosophy that I grew up with was existentialism, but that nihilistic angst no longer works for me.

Then I discovered Integral Philosophy—a perspective, worldview, and movement, much as its name suggests, that integrates the body, mind, heart, and soul. I find this approach much more positive and growth-oriented.

Integral Philosophy also happens to be the subject of a recently published book by Joe Perez entitled *Soulfully Gay: How Harvard, Sex, Drugs, and Integral Philosophy Drove Me Crazy and Brought Me Back to God* (Boston: Integral Books/Shambhala Publications, 2007). The book is a sensitive and honest exploration of philosophy and spirituality and offers some meaningful insights for people who are looking for a more optimistic sense of direction.

Soulfully Gay is the personal memoir of an intelligent, well educated gay man wrestling with fundamental issues of meaning and self-acceptance. Perez finds himself on a quest to understand what it means to be gay at the intersection of conflicts between his Catholic upbringing versus his openly gay lifestyle; and his authentic mystical experience versus his questionable diagnosis of bi-polar disorder. He seeks to integrate the multiple dimensions of his life experience: progressive HIV infection, hot steamy sex, overcoming addiction, looking for true love, etc. In the process, Perez finds new understanding through the study of Integral Philosophy. He begins a cautious journey of pulling himself together again...this time as a soulfully gay man.

Looking inward: spiritual self-examination

At the beginning of the book, Joe Perez identifies as an educated agnostic. Still, it becomes clear that science and medicine no longer hold the answers to his loneliness and emotional turmoil. Diagnosed with HIV since age 24, and after many years on medications, Perez begins to deal with his inner life. In 2004, he embarks on a process of emotional healing

and chronicles his journey in his daily internet weblog (blog); these entries document how he discovers and comes to embrace Integral Philosophy.

With a background in Philosophy and Theology from Harvard, followed by Harvard's Divinity School, Perez had come to the painful conclusion that the Catholic teachings and gay sex just didn't fit together. The resulting emotional upheaval sets him up one day for an extraordinary event. He describes the experience as a trance-like state, with an almost sexual intensity, yet completely rational and lucid. Because of his theological background, Perez recognized that an experience of this kind is typically described in religious texts as an encounter with God, or the Divine, or the Ultimate Reality. However one might phrase it, it was a mystical experience.

Yet Perez felt conflicted as an out gay man. He had studied religion at great length and had rejected it for its dishonest and judgmental views on homosexuality. Unable to quite dismiss the mystical experience as just an illusion, he struggles to find some reasonable context for what happened to him.

What follows is relentless questioning. First, Perez dives into a study of psychology and anthropology to find a rational answer to the meaning of the mystical experience. Then he begins to consider other religions. Should he convert to a different religion? Is the truth in shamanisms and Wicca? He finds some unexpected new spiritual angles among the proponents of gay spirituality and explores the gay tantric practices of Body Electric. They make him realize that there was no good reason to be ashamed of his gaydar, of his body, or of his attraction to men.

Around the same time, Perez hears about the philosopher Ken Wilber and the emerging Integral Philosophy. Curious but skeptical, Perez reads Wilber's book *The Theory of Everything*, and in its pages he discovers a new, more helpful perspective on life.

Integrating disparate parts: validation and self-acceptance

Integral Philosophy builds on the pioneering work of developmental psychologists in the sense that it explores stages of individual growth. The mystical core of religions similarly deals with stages of evolution, of the human mind. Integral Philosophers such as Wilber point to an unfolding of an individual's spectrum of consciousness: from infantile states, to adolescence, to mature rational states. But the spectrum extends to integral and transrational stages described by saints, sages, and mystics. It invites one to continue in personal development. It offers some tools for a new way of thinking.

This philosophical approach validates Perez's identity as a gay man. It also offers him a useful context for his mystical experience. According to current research studies, mystical experiences can happen to anyone. Each person interprets the event through the lens of his or her background. A New Age spiritual practitioner might think of it as an encounter of the

third kind. For a southern Baptist, it is an encounter with Jesus. A very rational person might attribute it to a burst of serotonin. But seen through the Integral lens, the mystical experience is a promising peek at the next stage of personal growth. This interpretation impresses Perez the most.

Throughout his blog, Perez deals with liver problems, ups and downs of CD4 cell counts, and health related anxiety. He reflects on his recovery from crystal meth addiction as he marks the milestone of five years drug-free. He is eager to learn to think and speak integrally. He finds the new skill of integrating useful. As he continues to test the soundness of the Integral approach, Perez becomes convinced that it is revolutionary. Through it he finds new ways to frame his many disparate experiences into a coherent unity. The answers to his long standing questions float into his mind. "Like duh! How could I have been so f@#%ing blind?"

I'm looking around to see if there is a new, more helpful meaning for whatever life I have left.

For Perez, Integral Philosophy becomes the new standard for considering and integrating a variety of viewpoints. He begins to see events in his life like fragments of a jigsaw puzzle that, up until this point, didn't quite fit. He had been spending his whole life arranging the pieces into pretty patterns, revealing how lovely each little piece was by itself. Then, it seemed like Ken Wilber just looked at Perez's arrangement and said: "That is not pretty. That's a mess. Here's how it's done." Suddenly, Perez views the complete picture on the front of the puzzle box. For once, everything makes sense.

Joe comes to a new level of understanding how to live and grow as a gay man. He begins to discern a gradual continuous unfolding of stages in his life. Earlier stages were much about coming out of the sexual closet and finding an identity as a gay man. Further stages are about a search for an expanded sense of identity and unity: coming out as a soulfully gay man. This second coming out is full of risks. Fewer gay men reach that stage. But it has its rewards. It brings new meaning and increased self-acceptance.

And, as Perez concludes, "If that is the beginning of a new religion, then so be it." ☺



Jari Dvorak is an AIDS activist from Toronto. He would like to hear from others who find Integral Philosophy useful.



Shot in the dark

STEP AIDS vaccine study discontinued

by James Wilton

On January 24th 2005, the HIV Trials Network (HVTN), the National Institutes of Health (NIH), and pharmaceutical corporation Merck & Company formed a unique partnership and announced they were advancing to a phase II proof-of-concept study using one of Merck's new HIV/AIDS vaccine candidates.

Initially, the V520 vaccine was described as one of the most encouraging to date, capable of protecting monkeys from HIV and inducing a strong immune response in early human trials. The study, known as STEP, set out to determine if the vaccine was capable of preventing HIV infection in humans, or decreasing viral loads among volunteers who became HIV infected during the period of the study.

The vaccine candidate chosen for the trial used a weakened adenovirus, known to be one of the viruses that cause the common cold, to which scientists attached HIV-like properties. The weakened adenovirus was unable to cause cold symptoms in vaccine recipients, but was capable of simulating an HIV infection in order to create an anti-HIV immune response. Unlike most vaccines that create antibodies, this vaccine was designed to create killer CD4 cells capable of recognizing and destroying HIV-infected cells.

The STEP study recruited 3,000 HIV-negative volunteers, between the ages of 18-45, who were considered to be high risk for HIV infection based on their sexual behaviour. The majority of study participants were men who have sex with men (MSM) and female sex workers located in North and South America, the Caribbean, and Australia. Half of the volunteers received the vaccine while the other half received a placebo in a randomized double-blind fashion.

Organizers of the study encountered a potential problem during the recruitment of phase of the trial. If, prior to receiving the vaccine, volunteers had been naturally exposed to the same common cold virus used in the study, then antibodies against the adenovirus would already be present in their blood. These antibodies could attach to the vaccine and disable it before the killer CD4 cells had the opportunity to respond. As a result, the trial investigators decided to study the effect of adenovirus antibodies on vaccine efficacy by ensuring that half of the volunteers recruited had low adenovirus antibody levels while the other half had high adenovirus antibody levels.

On September 21st 2007, preliminary data from the STEP study was analyzed and the decision was made to discontinue vaccinations immediately. Although the complex data is still

being analyzed, the results suggested that vaccinated individuals with high adenovirus antibodies were more likely to become infected with HIV than if they were given a placebo. Except for one heterosexual woman, all of the volunteers that became infected during the study were MSM and therefore the trial results can only be applied to this group. Of the 778 males in the high adenovirus immunity group, 22 out of 392 vaccine recipients became infected while only nine out of 386 in the placebo group became infected. Even among the individuals with no adenovirus antibodies, no protective effect was observed between the vaccine and placebo groups. The vaccine was also ineffective at reducing viral load in vaccine recipients that became infected during the course of the study.

At this time, it is unknown whether the increased susceptibility among study participants with high adenovirus antibodies was a direct result of the vaccine, differences in the study population, chance, or an unknown biological phenomenon. Follow-up analysis of the study populations revealed that vaccine recipients were more likely to engage in high risk behaviours, possibly explaining why a higher infection rate was observed in this group. Men with high adenovirus immunity were also more likely to be uncircumcised and therefore without the putative protective benefit of circumcision. Furthermore, the high level of adenovirus antibodies may be indicative of some other biological, social, or behavioural factor that places this group at a higher risk of contracting HIV. Organizers of the STEP trial will continue to monitor infection rates among volunteers in their search for answers to determine whether increased risk persists over time.

Regardless of the reason for increased susceptibility to HIV infection, the preliminary study results were determined to be unacceptable since over 90 percent of individuals in developing countries, where a vaccine is needed most, have high adenovirus immunity.

The future of adenovirus-based vaccines remains uncertain and the increased susceptibility to infection raises ethical issues that must be addressed before attempting another trial. Some scientists argue that the vaccine should never have proceeded to phase II trials because the pre-trial results were unconvincing.

...The increased susceptibility to infection raises ethical issues that must be addressed before attempting another trial.

The pressure to produce an AIDS vaccine may be leading to vaccines entering clinical trials without adequate testing. Nonetheless, the study cannot be called a complete failure: the trial showed unprecedented engagement, commitment, and organization of all involved which allowed the study to quickly answer the questions it set out to answer.

For further information about the STEP study and other AIDS vaccines visit www.stepstudies.com/ and www.hvtv.org. ☺

James Wilton has a BSc in Microbiology and Immunology from UBC and is currently a cancer researcher at Canada's Michael Smith Genome Sciences Center.

We need people like you. BCPWA has volunteer opportunities in the following areas:

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All the sor(e) did details on mouth and stomach ulcers

by Kristin DeGirolamo

Mouth ulcers, or open lesions in the mouth or throat, can be caused by a number of conditions, including canker sores, herpes simplex, oral cancer, oral thrush (candida fungus), or cytomegalovirus (CMV). Although mouth ulcers are frequently mild and not a cause for concern, they can also be a symptom of opportunistic infections. Stomach or peptic ulcers, however, are more serious than mouth ulcers and require treatment with antibiotics and/or acid reducing agents. Some of the treatments for ulcers can cause interactions with HIV medications, so it is important for PWAs to see their doctor if an ulcer is suspected.

Mouth ulcers

A typical minor mouth ulcer is usually painful, generally located on the cheeks, lips, tongue, or gums, and is red or yellow in color with an inflamed (red) border. Mouth ulcers can appear alone or in groups, and are usually about the size of an eraser on the end of a pencil. The painful stage for mouth ulcers lasts three or four days, and the sores usually resolve within seven to ten days.

A major mouth ulcer is usually more severe, has an irregular border, and may last for up to ten weeks. These more severe sores can cause swollen lymph glands, a feeling of sickness, and even a mild fever.

If you are having recurrent mouth ulcers, it may be due to periods of intense stress, hormonal changes (for women), or a deficiency of vitamin B12 and C; these causes can be discussed with a doctor or pharmacist.

If you have a mouth ulcer for the first time that has uneven discoloration, is deep and not painful, remains present for more than three weeks, or is larger than one centimetre in diameter, then you should see a healthcare provider prior to taking any self-care measures.

For simple self-care measures, keep your mouth clean at all times by gargling with warm salt water (approximately half a teaspoon per cup water), and avoid spicy, acidic, or salty foods as well as very hot or cold meals. Also, don't use mouthwashes with a high alcohol content as these can further irritate your ulcer. If you or your healthcare provider suspect a vitamin deficiency is causing the ulcers, try eating more fresh fruits and vegetables, or take supplements if necessary.

Pharmacies sell a variety of sprays and rinses to reduce the pain. In addition, topical steroids are available by prescription for

mouth ulcers, but oral steroids may be needed for ulcers in the throat. Always consult your pharmacist prior to buying anything over the counter to ensure there are no drug interactions with your other medications.

PWAs should pay close attention to mouth ulcers that may be or become more serious. These include sores that resemble oral thrush (caused by *candida*), a fungus that normally lives in the body but can multiply excessively and cause topical or systemic fungal infections. These mouth ulcers tend to start small, and then become a large white/yellow covering on the mouth and cheeks; when scrapped away, red inflamed skin appears underneath. If your mouth ulcers begin to look like this, it can be the sign of an opportunistic infection that requires treatment with an antifungal agent, so go see your doctor.

Although mouth ulcers are frequently mild and not a cause for concern, they can also be a symptom of opportunistic infections.

Stomach or peptic ulcers

A stomach ulcer is caused by a small erosion or hole in the lining of the intestinal tract. These ulcers mostly occur in the stomach or upper small intestine and can range in size from an eighth of an inch to three-quarters of an inch in diameter.

What causes these erosions? A bacteria called *Helicobacter pylori* (*H. pylori*) weakens the protective mucous layer of the stomach lining, which allows the acid normally present in the stomach to destroy the underlying cells, causing a hole to form. Irritation can also be caused by an excess secretion of hydrochloric acid. Stress does not cause stomach ulcers, although high levels of stress can aggravate stomach ulcers that are already present. Stomach irritants such as chronic use of anti-inflammatory medicines (NSAIDs), smoking, or excess alcohol can also cause ulcers due to their irritation of the stomach lining.

Symptoms of stomach ulcers include a burning sensation in the stomach area that can last from 30 minutes to three hours. This pain may feel like heartburn, indigestion, or hunger and can

be felt in the upper abdomen or below the breastbone. The burning sensation can occur before or after eating or may awaken you at night. For some people, eating, resting, drinking milk or using antacids may relieve the pain, but if stomach ulcer symptoms are present, consultation with a doctor is recommended.

Other symptoms include weight changes, appetite changes, bloating, burping, nausea, and vomiting. More serious symptoms that require immediate medical attention are sharp, sudden, and persistent stomach pain, bloody or black stools, bloody vomit or vomit that looks like coffee grounds, as this indicates a bleeding ulcer and you should go directly to your doctor or the nearest emergency room.

Diagnosis and treatment

A doctor can diagnose an ulcer through an x-ray or endoscopic procedure. If you are diagnosed with an ulcer caused by *H. pylori*, treatment is necessary with antibiotics and acid reducing agents such as proton pump inhibitors (PPI). The antibiotics of choice are metronidazole, clarithromycin, and amoxicillin taken twice daily. Tetracycline is sometimes also prescribed, but since the dosage is taken four times a day, it is not as convenient. PPIs include omeprazole, lansoprazole, rabeprazole, esomeprazole or pantoprazole that can be taken once or twice daily.

If the ulcer does not appear to be caused by *H. pylori*, your doctor may prescribe only the acid reducing drugs. These drugs

help heal the ulcer and reduce pain and discomfort caused by excessive acid. A stomach lining protector containing bismuth subsalicylate (Pepto-Bismol) may also be used to further coat and protect the stomach; however, this type of product may prevent absorption of some medications, so consult with a pharmacist before using it.

The chart below summarizes the effects of commonly prescribed ulcer treatments—antibiotics and PPIs—with antiretroviral (ARV) therapies.

Amoxicillin and metronidazole have no documented interactions with any of the ARVs listed and may be a suitable option for PWAs.

For alternative therapies, a combination of the following herbs and plants has been shown to decrease acid in the stomach: licorice, peppermint leaf, German chamomile, caraway, lemon balm, clowns mustard (*Iberis amara*), celandine, angelica, and milk thistle. These herbs do have the potential to interact with ARVs so make sure to consult your healthcare provider prior to starting any herbal therapy. Bananas, boiled cabbage, and goats’ milk were historically thought to help naturally heal ulcers and could also be added into your diet, along with any medicines your doctor prescribes. ☺

Kristin DeGirolamo is a UBC pharmacy student and BCPWA treatment information volunteer.

ARV Drugs	<p>Tipranavir (Aptivus) Saquinavir (Fortovase) Lopinavir-ritonavir (Kaletra) Efavirenz (Sustiva, Stocrin) Darunavir (Prezista)</p>	Saquinavir (Fortovase)	Nelfinavir mesylate (Viracept)	Nelfinavir mesylate (Viracept)	Darunavir (Prezista) Fosamprenavir (Lexiva)	Nevirapine (Viramune)	Lamivudine-zidovudine (Combivir)	Didanosine (Videx)	Atazanavir (Reyataz)	Atazanavir (Reyataz)
Ulcer Drugs	Clarithromycin	PPIs	PPIs	Azithromycin (same family as clarithromycin)	PPIs	Clarithromycin	Clarithromycin	Tetracyclines	PPIs	Clarithromycin
Notes	Increases clarithromycin, but no dose adjustment is needed except for those with kidney problems	Increases saquinavir levels; doctor may monitor side effects of saquinavir	Decreases nelfinavir levels, may increase viral load and resistance; do not combine	Increases azithromycin, but no dose adjustment is needed; doctor may monitor side effects such as liver function	No dosage adjustments needed	Decreases clarithromycin levels; doctor may choose a different antibiotic	Decreases the absorption of zidovudine (AZT); taking the medications at least two hours apart prevents this	The antacid component of didanosine will decrease absorption of tetracyclines; taking the medications at least two hours apart prevents this	Atazanavir needs acid to be absorbed; PPIs decrease acid, decreasing atazanavir levels, possibly leading to resistance and an increased viral load. Use another agent	Increases clarithromycin which can cause heart problems; may need to decrease dose by 50%



HAART to heart

Balancing blood lipid levels

by Cheryl Collier

Highly Active Antiretroviral Therapy (HAART) has been changing the face of HIV since its introduction in the 1990s. However, HAART, particularly protease inhibitors, can cause metabolic changes including insulin resistance, lipodystrophy syndrome (abnormal fat build-up and/or loss in various areas of the body) and dislipidemia (abnormally high or low levels of lipids or fat in the blood).

There are a number of commonly measured blood lipids: LDL cholesterol (low density lipoprotein), HDL cholesterol (high density lipoprotein), total cholesterol, and triglycerides. LDL is commonly known as the “bad” cholesterol, which works to take the cholesterol from the liver to other areas of the body. HDL, on the other hand, is known as the “good” cholesterol, bringing cholesterol from the body back to the liver where it can be processed. Total cholesterol refers to the combination of LDL and HDL. Lastly, triglycerides are a major fat in your blood, which can be used as an important energy source for the body; too much in your blood, however, is a risk factor for heart disease.

Blood lipids are usually checked with routine blood work every two to three months if you are on HAART. If you are not on HAART, the frequency with which you are tested will depend on your risk level for heart disease.

In order to get an accurate reading, you need to fast (no food or drink except water) for ten to twelve hours prior to

this type of blood work. Your doctor can explain your results in comparison to normal ranges, but the numbers can change depending on your risk level for heart disease. Along with increased cholesterol and triglycerides, factors like age, diabetes, smoking, and blood pressure are all well known to bump up the risk of heart disease. In fact, HIV itself is a risk factor, and can cause changes in blood lipid levels.

It is well known that high levels of cholesterol accelerate the development of atherosclerosis. Atherosclerosis occurs when artery walls become hard and narrow. Narrow arteries slow down the amount of blood that flows to areas of the body; this means the tissues receive less oxygen. It also means that your heart has to work harder to pump the blood. As atherosclerosis worsens, the risk of a heart attack or stroke increases.

Nutrition choices are key to maintaining the appropriate balance of blood lipid levels.

Fats: don't judge a book by its cover

While it is common knowledge that fat in a person's diet can affect cholesterol and triglycerides in the blood, keep in mind that it is not a good idea to try to cut out all fats from your diet. Fat is important for absorption of vitamins like A, D, E, and K, which are needed for various activities in the body. Fat is also involved in cushioning your joints and organs and helps

control body temperature. However, the fats in food are not all created equal. There are different types that make up the total amount of fat in food. Aim to replace the bad fats with the good fats:

Saturated fat. Saturated fats increase the LDL cholesterol, acting as a “bad” fat. You can find saturated fats in processed foods, coconut oils, palm oils, butter, cheeses, and fatty cuts of meat.

Trans-fat. Trans-fat is also considered a “bad” fat. These types of fats also increase your LDL cholesterol and decrease your HDL cholesterol. Trans-fats can be found in partially-hydrogenated (hard) margarines, baked goods, and many packaged snack foods.

Polyunsaturated fat. Polyunsaturated fats are healthy fats found in sunflower, soybean, and safflower oils. Omega-3 fatty acids are also polyunsaturated fat and the best source is fish and fish oil supplements. These healthy fats can also be found in plant sources such as flax and flaxseed oil. Omega-3 fats help control triglyceride levels.

Monounsaturated fat. Monounsaturated fats are helpful for improving cholesterol levels. Find monounsaturated fats in olive and canola oils, avocados, almonds, and walnuts.

Nutrition tips to help keep your cholesterol and triglycerides in check:

- ▶ *Watch out for “bad fats.”* Cut down the amount you consume by avoiding greasy meals and processed foods. Stay clear of the fat readily visible on meats. Read the nutrition labels on food items to compare the amounts of saturated and trans-fats in different products. Note that if the label indicates “partially-hydrogenated,” the product contains trans-fats.
- ▶ *Choose healthier fats.* Try cooking with olive or canola oil. Use a non-hydrogenated margarine for a spread, but be careful not to use too much. Restrict added fats to one to two teaspoons per meal.
- ▶ *Limit dietary cholesterol.* We used to believe that cholesterol in the diet had a strong effect on the cholesterol in the blood. We now know that people with increased cholesterol do not need to eliminate foods high in cholesterol, but should limit them to two or three servings per week. One serving is the equivalent of one whole egg, three-quarters of a cup of shrimp/prawns, or two ounces of organ meat.
- ▶ *Cash in your Omega-3s.* Fatty fish like canned tuna, salmon, and herring provide your body with a boost of Omega-3. Aim for a meal with fish twice per week. If you have high triglycerides, you may benefit from taking an Omega-3 fish oil supplement containing between two to three grams (2,000 to 3,000 mg) of fish oil per day. Recent research shows that Omega-3 fish oils can be helpful for lowering triglycerides in people with HIV. You can also get Omega-3s from vegetarian sources like flax seed oil, but some scientific studies suggest that Omega-3s from fish have the best effects for heart health. Ask your doctor or dietitian if you are interested in learning more about Omega-3 supplements.
- ▶ *Maintain a healthy weight.* Keeping your body at a healthy weight helps prevent cholesterol and triglyceride levels from climbing.
- ▶ *Eat regular meals.* Erratic eating habits can bump up triglyceride

levels. Eating regular meals, as well as a nutritious snack between meals, helps your body process food better.

- ▶ *Limit alcohol use.* Alcohol causes the liver to produce more triglycerides. Abstaining from alcohol is the best choice if your triglycerides are very high. If you are going to drink alcohol, remember that moderation means one to two standard drinks daily for men, and one (or none) standard drinks daily for women. As glass sizes vary, note that one standard drink equals five ounces of wine OR one and a half ounces of hard liquor OR 12 ounces of beer. Alcohol is also very high in empty calories, so it tends to contribute to unhealthy weight gain, which also worsens dyslipidemia.
- ▶ *Keep an eye on your sweet tooth.* Sweet, sugary foods work to increase triglycerides and can add empty calories. Limit soft drinks, and try to eat a piece of fruit instead of drinking too much juice. Choose smaller portions of desserts.
- ▶ *Add fibre.* Try oats, barley, and psyllium for soluble fibre which cuts down cholesterol absorption in the gut. When increasing your fibre, look for food labels that read: “an excellent source of fibre” or “good source of fibre.” Products containing more than three grams of fibre per serving are a good choice. Choose whole grain breads and cereals. Be sure to include fruit and vegetables with each meal and try adding legumes (beans, lentils) to your soups, salads, and casseroles.
- ▶ *Get nutty.* In particular, reach for the almonds and walnuts, which are packed with healthier fats. As well, nuts contain plant protein that may decrease cholesterol production in the body. Be careful to not go overboard, however, since nuts are packed with calories. Keep portions to one-quarter of a cup five times a week.
- ▶ *Give soy a shot.* Try experimenting with tofu, edamame, and soy milk. Blend half a cup of frozen berries, three ounces of soft tofu, and a cup of one percent milk for a tasty snack that contains both soy and fibre.

Sometimes people think that because their medications have caused an increase in their cholesterol or triglyceride levels, this means they do not need to make changes to their diet. However, research has shown that making dietary changes can reduce cholesterol and triglyceride levels. If you want to keep your blood fats in check with lifestyle changes, ask your doctor for a referral to a registered dietitian. We recognize that other medical conditions or social situations may play a role in the nutrition choices you are able to make. A dietitian can help you balance the big picture and set nutrition goals that are right for you. ⊕

Cheryl Collier, MSc, RD is a clinical dietitian with the HIV program at St. Paul's Hospital, Vancouver, BC. She also works as a research dietitian with the Portfolio Diet Study, a multi-centre research project based out of St Michael's Hospital in Toronto, ON which investigates the effects of a vegetarian diet on cholesterol.

New study highlights women's issues

by Jennifer Chung

Women make up more than 40 percent of all HIV cases globally and 27 percent of new cases in Canada. While the number of women living with HIV worldwide continues to climb, little research is available on the way the virus and HIV drugs affect women differently than men. To generate more evidence for this field of research, Dr. Mona Loutfy of the Women's College Research Institute in Toronto is spearheading a new study to observe HIV-positive women on combination antiretroviral therapy. Loutfy hopes to gain more data on antiretroviral drug levels in women and its link to adverse events.

"Understanding the reasons for the differences of adverse events between HIV-positive men and women is critical and needs to be evaluated within a large cohort. We don't know whether these differences relate to hormonal influences, drug metabolism, adherence, fat distribution, or other factors," says Loutfy.

This trial (CTN 233) will examine levels of antiretrovirals and how these drugs are processed in HIV-positive women. Historical data from HIV-infected men will enable Loutfy's research team to compare variances in drug levels between men and women. The study will also investigate whether antiretroviral drug levels are associated with body weight in women, as well as higher frequency and severity of adverse events such as nausea, diarrhea, liver toxicity, and lipodystrophy.

"If we find there are increased drug levels in women, then we could propose that it might be beneficial to adjust drug dosages if women are really suffering from side effects. Also, this study will allow us to understand the drug levels, side effects, and their predictors in women so that we can better counsel them on all these issues," says Loutfy.

According to Loutfy, when HIV clinical trials began in the 1990s, women were excluded due to concerns over pregnancy and lactation. However, over the past decade, as more women have become infected with HIV, there has been an increasing need to understand how antiretroviral drugs affect this group.

Enrolment of women in clinical trials continues to be a challenge for a number of reasons. For instance, women tend to be primary caregivers and have childcare responsibilities, making it difficult for them to attend clinic and follow-up visits regularly. This study is unique because it attempts to address these issues through higher reimbursement fees for participants and the inclusion of AIDS service organizations (ASOs) in trial recruitment.

Louise Binder, a member of the CTN's Community Advisory Committee which reviewed and approved the study protocol, feels this study will provide much-needed data on HIV drugs and women.

"This study will help fill some gaps in the information available about how women metabolize HIV drugs in the body," says Binder. "There are few pharmacokinetic studies that involve women only and we are very glad that Dr. Loutfy is investigating this area further."

CTN 233 is seeking to enrol 80 female participants across Canada, including ten volunteers at the Oak Tree Clinic in Vancouver. ☉

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)
Study sites: Downtown Infectious Diseases Clinic (DIDC), Vancouver
- CTN 214** — Effect of a One-Year Course of HAART in Acute/Early HIV
Study sites: DIDC, Vancouver; Cool Aid Community Health Centre, Victoria

- CTN 222** — Canadian Co-infection Cohort
Study sites: DIDC, Vancouver

For more information about these trials and other CTN studies, please visit www.hivnet.ubc.ca or call 1.800.661.4664

SIMPLY POSITIVE

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.



Women & HIV

HIV can be spread by blood, through sex and by sharing drug equipment such as needles, spoons and crack pipes.



If you have shared drug equipment or had sex with someone who has HIV, you may be at risk for HIV.

You might not know if you've been exposed to HIV. Get a blood test to know if you have HIV.



When you get HIV, you may get a flu-like illness and then feel healthy for many years. Not everyone gets the flu-like illness. There may be no way of knowing you have HIV unless you have a blood test.



Women with HIV may have problems with their sex organs that are not easy to see.

Many women with HIV get yeast infections that won't go away or keep coming back after treatment, even though they feel healthy otherwise.



A pelvic exam and PAP smear every six months can find diseases of the cervix, such as cancer, which are more common in women with HIV. Genital warts and genital herpes are also common and can be worse in women with HIV. Find a doctor you're comfortable with, and who knows about HIV.

Even if you have HIV you can still have a healthy baby. Talk to your doctor before you get pregnant to find out about ways to stop your baby from getting HIV.



Some types of birth control such as the IUD may increase the risk of diseases in women with HIV. Talk to a doctor or nurse about choosing the best birth control for you. Only condoms help protect against HIV and other sexually transmitted diseases.

There are many important issues about HIV to deal with. Support is available. Take your time to find out what's best for you.



Good nutrition, low stress and enough sleep may help keep your immune system strong.



Women's groups and community HIV/AIDS groups can help you and your family have a healthy life by providing an open and safe place for you to get support.



TREATMENT INFORMATION PROGRAM

1107 Seymour Street, 2nd Floor
Vancouver, BC V6B 5S8

† 604.893.2243 † 604.893.2239 e treatment@bcpwa.org
1.800.994.2437 † 604.893.2251 www.bcpwa.org

Volunteering at BCPWA

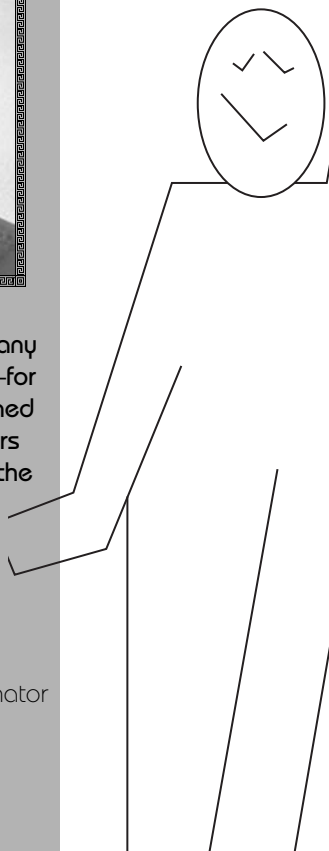
Profile of a volunteer:

Mikey



"Mikey has been actively involved at BCPWA—in many different volunteer roles—for a long time. He even trained me on the phone line years ago. His contributions to the Society are much valued and appreciated by all those he has helped along the way."

Zoran Stjepanovic,
Treatment services coordinator



Volunteer history

I've done quite a few things here. I first started in the Lounge, and helped out in the Advocacy Department. Later, I was a volunteer on the front desk and was also a volunteer co-coordinator with four others. I worked with Ann Carlson teaching computers to members. I also did some volunteer work in the Support Department and IT. Now, I am giving Reiki treatments twice a month with the Treatment Program and also volunteering at the membership services desk.

Started at BCPWA

February, 1996.

Why pick BCPWA?

I decided to volunteer because BCPWA had done so much for me when I moved here back in 1995. I was very ill back then. When I got better, I wanted to be able to give back and help out where I was able.

BCPWA's strongest point

Three points, I think: the willingness of all the volunteers here; being around to see services continue to grow; and working hand in hand with staff towards the same goals.

Favorite memory

Working in the Lounge with Harold and Gordie.

Future vision of BCPWA?

I hope that BCPWA can get more funding so they can add more services where needed.

Polli & Esther's Closet

Your peer-run, second time around store!

Bring your membership card
and pay us a visit at
1107 Seymour Street, 2nd Floor

Open Tuesdays, Wednesdays & Thursdays,
11AM to 2PM for your shopping convenience



Great selection!



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 Serv- ice Society

1284 F Gladstone Ave, Victoria, BC V8T 1G6
t 250.388.6620 f 250.388.7011
e varcs@islandnet.com
www.varcs.org/varcs./varcs.nsf

Victoria Persons With AIDS Society

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

Wings Housing Society

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

YouthCO AIDS Society

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

For more comprehensive listings of
HIV/AIDS organizations and services please
visit BCPWA's website at www.bcpwa.org
and click on "Links and Services" under the
"Empower Yourself" drop-down menu.

Upcoming BCPWA Society Board Meetings:

Date	Time	Location	Reports to be presented
March 12, 2008	1:00	Board Room	Standing Committees / Financial Statements — January Quarterly Department Reports — 3rd Quarter
March 26, 2008	1:00	Board Room	Written Executive Director Report / Director of Support
April 9, 2008	1:00	Board Room	Executive Committee / Director of Development
April 23, 2008	1:00	Board Room	Written Executive Director Report / Standing Committees Financial Statements — February
May 7, 2008	1:00	Board Room	Director of TIAD
May 21, 2008	1:00	Board Room	Written Executive Director Report / Executive Committee Financial Statements — March

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

☎ 604.893.2298 ✉ marcs@bcpwa.org

Community Representation & Engagement

Contact: Paul Kerston

☎ 604.646.5309 ✉ paulk@bcpwa.org

Education & Communications

Contact: Julia Smith

☎ 604.893.2209 ✉ julias@bcpwa.org

IT Committee

Contact: Ruth Marzetti

☎ 604.646.5328 ✉ ruthm@bcpwa.org

living⊕ Magazine

Contact: Jeff Rotin

☎ 604.893.2206 ✉ jeffr@bcpwa.org

Positive Gathering Committee

Contact: Stephen Macdonald

☎ 604.893.2290 ✉ stephenm@bcpwa.org

Prevention

Contact: Elgin Lim

☎ 604.893.2225 ✉ elgin@bcpwa.org

Support Services

Contact: Jackie Haywood

☎ 604.893.2259 ✉ jackieh@bcpwa.org

Treatment Information & Advocacy

Contact: Adriaan de Vries

☎ 604.893.2284 ✉ adriaand@bcpwa.org

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* 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

If at first you don't succeed... trial, trial again

by Michael Connidis

Lipo and virus and pills...oh my! I know, I'm still on this *Wizard of Oz* kick. But lately, I've been feeling a bit like Dorothy Gale must have felt trying to make her way home to Kansas, watching the wizard's hot air balloon float up and away without her. Standing here on the HIV treatment platform, I long for my Auntie Virals back on the other side of the rainbow. I'd try clicking my heels together if I thought I could transform myself out of this situation, but my ruby slippers are a bit worse for wear these days.

At first, the treatment possibilities seemed promising: fewer meds and maybe even once-a-day dosing. What an improvement that would be. But I hadn't expected to revisit medications I had grappled with—and been badly battered by—long before.

Ten years ago one of my HIV meds offered me a quality of life that pretty much consisted of me and my toilet bowl. Enough said. When I was reintroduced to my nemesis, some time later in a *new and improved* formula, I thought to myself: I've been down this yellow brick road before. Sure enough. And while the second time around was marginally less intense and frequent, the gist of it was essentially the same.

Another *experimental* combination that I have tried included one drug that helped to bring me back from the brink many years ago. But at a price: my body fat vanished. The changes in my torso and limbs haven't been all bad. Being ripped definitely highlights the muscles I do have. But it's the facial changes that have been the most noticeable—and most noticed—aspect of my physical transformation.

I first became aware of how others view my "HIV face" while reading a bedtime story to my nephews. I was in uncle heaven, deeply engrossed in story-time with one nephew huddled up on either side of me, when the six-year-old piped up, "Uncle Michael?" He raised his hand to my face and gently placed the tip of his index finger in the hollow below my

Lately, I've been feeling a bit like Dorothy Gale must have felt trying to make her way home to Kansas, watching the wizard's hot air balloon float up and away without her.

cheek bone. "Why do you have holes in your cheeks?" he innocently asked. His four-year-old brother, who had drifted away from the story gazing about the room, suddenly snapped to attention, swivelled his head around, and locked his eyes onto my face. I explained to the boys how the fat under my skin disappears because of the medication I take for HIV.

Several questions were answered to the satisfaction of their inquisitive young minds, and we continued on with the bedtime story. Over the years, the transformation has continued.

These days, the bones in my face are even more defined. When I smile I turn into a Shar-Pei (way cuter than Toto!), the loose skin of my cheeks crumpling into a series of folds. I often think about cosmetic treatments, wondering what my face might look like. Friends and acquaintances who have tried different methods to fill in their hollowed faces have been very encouraging. They have shared their personal experiences and some have even let me feel the results of their treatment.

The improvement in their appearance is dramatic and the impact on their self-image and self-confidence is undeniable. I'd get my face filled tomorrow if I felt more comfortable with a procedure that I could afford.

The regimen of meds I am test driving now will, in all likelihood, change—at least I find comfort in thinking so. I try to remain confident that an effective and well-tolerated regimen has my name on it. After all, I know there are Good Witches and Bad Witches. But as long as I'm stuck in Oz, I'll try to make the best of it. There's a great spa over at the Emerald City where I hear they work magic on the face and body. That will be good preparation for my journey home. ☺

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

