inside ▷▷▷

features ▶

treatment information ▷▷▷

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think⊕

opinion & editorial . . .

Get out and vote!

by Glyn Townson

Less than 65 percent of eligible Canadian voters cast a ballot in our federal election last October. Apathy, a lacklustre selection of candidates, and an inadequate amount of lead time or fair warning are the alleged factors in this dismal turnout. Whether we accept these reasons as valid and let ourselves off the hook, or we regret them as lame excuses and hang our heads in shame, the result of our actions as voters is still disheartening: we're stuck with a government that falls far short in its responsibility to the HIV community—again.

Keep that in mind as we approach the provincial election on May 12. In many respects, our provincial government has the strongest impact on issues that affect our membership the most. The party we choose this spring will be directly accountable for developments in social housing throughout BC, the policies and budgets of our regional health authorities, and policing the injection drug user and sex trade communities. They'll also be directly accountable for defining privacy laws as they relate to our medical records in the pending eHealth system, and for increasing HIV awareness and prevention through education in schools and correctional facilities.

For this issue of *living*⊕, we contacted the party leaders to get feedback, in their own words, on a few specific questions related to our community. Their responses—or lack thereof—were disappointing, to say the least. You can read more about that on page 5, but don't let the issues die there. Be sure to canvas your local MLAs with these very questions closer to election time, when they can have no excuse to avoid giving the HIV community the answers we deserve.

Also, be sure to bring two valid pieces of identification to the voting booth on May 12. Valid ID includes a BC driver's licence or ID card. The full list of acceptable ID is available at www.elections.bc.ca. If you don't present adequate ID, you won't be allowed to vote. And if you don't vote, you effectively empower political forces that work against you and your HIV-positive peers.

Despite our dire situation at the federal level, we can absolutely make a difference provincially. We have a variety of parties to choose from in this election, and we've been given fair and adequate time to learn about their platforms on HIV-related issues. Remember, your local representatives are just a phone call or email away. Be prepared to vote on May 12, and make your vote count! ⊕

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

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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REALITYBITES

News from home & around the world

Downtown Eastside crackdown will increase HIV risk, groups warn

A new police crackdown in Vancouver's Downtown Eastside will increase the risk of transmission of HIV and hepatitis.

The B.C. Civil Liberties Association (BCCLA) and six AIDS service organizations made that warning in a letter to Mayor Gregor Robertson, chair of the Vancouver police board, and Chief Constable Jim Chu of the Vancouver Police Department. The groups expressed concern over the VPD's draft 2009 business plan, which calls for an increased police presence in the Downtown Eastside.

The plan would also see intensified street checks and ticketing of residents in the neighbourhood.

In the letter, representatives from the BCCLA, BCPWA, Positive Women's Network, Canadian HIV/AIDS Legal Network, AIDS Vancouver, YouthCo Aids Society, and Asian Society for the Intervention of AIDS stated that the VPD's plan will limit access of the people in the area to critical health services.

They also recalled lessons learned from another crackdown launched a few years ago by the Vancouver police, which targeted drug traders. That crackdown managed only to temporarily displace the drug activity in the neighbourhood.

Source: www.straight.com

New Norvir formulation

Abbott Laboratories has submitted applications with Canadian, US, and EU regulatory authorities to register its new tablet formulation of its protease inhibitor Norvir (ritonavir). The Canadian application was submitted to Health Canada on January 30, 2009. This new, heat-stable formulation won't require refrigeration, which will make it more convenient to use, particularly in developing countries.

Abbott first presented data from a study of bioavailability of the tablet, which compared the heat-stable formulation to the current soft gel capsule, at the XVII International AIDS conference in Mexico City in August 2008.

HIV infection and use of ARV both can have negative effects on arteries: study

Dutch researchers have found associations between HIV infection and unfavourable changes in the arteries, contributing to the ongoing effort to understand why some people with HIV appear to be at elevated risk for cardiovascular problems.

Their cross-sectional study, reported in *The Journal of Acquired Immune Deficiency Syndromes*, measured artery wall thickness and artery stiffness in HIV-positive individuals and in a control group of HIV-negative people. HIV infection was independently associated with both of these indicators of cardiovascular risk, and there was also an association between antiretroviral therapy (ARV) use and artery stiffness.

Since the late 1990s, when treatment advances greatly reduced AIDS-related mortality in wealthy countries, there has been widespread concern about whether using anti-HIV drugs, particularly protease inhibitors, puts people at higher risk for heart attack, stroke and related health problems.

Meanwhile, there is growing evidence that HIV itself harms the cardiovascular system. Because numerous factors may contribute to cardiovascular risk in HIV-positive people, it is difficult to isolate specific causal pathways.

Source: www.aidsmap.com

Judge admits inappropriate treatment of HIV-positive witness

The complaint against the discriminatory conduct of an Ontario judge, launched a year ago by the Canadian HIV/AIDS Legal Network and the HIV & AIDS Legal Clinic Ontario has been vindicated and the committee responsible for judges' training in Ontario will be asked to include HIV in future educational sessions for judges.

During a December 2007 trial, when it was revealed that a witness had HIV and hepatitis C, Justice Jon-Jo Douglas ordered that the witness wear a mask or give his testimony remotely from another courtroom. Media also reported that court staff donned rubber gloves and enclosed exhibits touched by the witness in sealed plastic bags.

In its final decision, the Judicial Council found that Justice Douglas has "taken steps to address those concerns, and that he has learned from the experience," including seeking education about HIV from a local AIDS organization. He has "acknowledged that his behaviour was inappropriate" and expressed regret for any harm resulting from his behaviour.

HIV treatment boosts lung cancer survival in PWAs

HIV-positive people with lung cancer have increased survival if they are receiving antiretroviral (ARV) treatment along with cancer treatment, according to a study published online in the journal *Lung Cancer*. This is one of the first studies to find a direct impact of ARV treatment on surviving a non-AIDS-related cancer.

continued on next page

REALITYBITES

News from home & around the world

Researchers from the Université Paris studied the medical records of 49 people with HIV who were diagnosed with non-small cell lung cancer. They analyzed patients' ARV therapy use, smoking history, age, and other factors associated with lung cancer survival.

They found that ARV therapy increased an individual's survival time by 60 percent: nine months for ARV-takers compared with a little more than four months for the others. They concluded that the increased survival rate resulted from some effect of ARV treatment on the cancer, rather than simply from ARV's ability to reduce AIDS-related complications.

Source: www.aidsmeds.com

Glaxo to cut prices for poor countries

The new chief executive of GlaxoSmithKline (GSK) had said the company will cut prices for its drugs in the developing world. Andrew Witty said GSK would cut the cost of drugs in the 50 poorest nations to 25 percent of the price in the UK and US. He also said the firm would share knowledge of patents and reinvest profits in local clinics. Charities have long campaigned for such a policy as patents prevent cheaper generic versions of drugs.

Formulas and processes owned by GSK under patent will be shared with researchers and 20 percent of the firm's profits in the developing world will be reinvested in hospitals and clinics there. Health campaigners have said more needed to be done but they welcomed the initiative.

Source: BBC News

New HIV social marketing campaign

Montreal organization Séro Zéro, in partnership with organizations from seven other Canadian cities, has launched a new community-based social marketing campaign. "Do you have what it takes?" is the question gay and bisexual men will be asked across Canada.

The campaign was launched because men who have sex with men (MSM) remain the group most affected by HIV in Canada. In 2006, the most recent year for which national statistics are available, 53 percent of new HIV infections occurred in MSM.

The innovative campaign has been designed to foster self-reflection among gay and bisexual men regarding certain aspects of their sex lives. Going beyond traditional HIV prevention messages that focus on condom promotion, the campaign, and related community outreach activities that will be undertaken over the next several months, aims to encourage gay and bisexual men to identify some of the factors that can make them vulnerable to high-risk sexual behaviours.

HIV incidence high and unchanged in rural South African community over five-year period

An investigation of a poor rural community in KwaZulu-Natal, South Africa, indicates that HIV incidence remained high from 2003 through 2007, despite prevention activities in the region, with almost half of all new infections occurring in people who had already received one negative test result through local voluntary testing and counselling services.

When the researchers looked at changes over time in HIV incidence they were unable to find any significant changes in HIV incidence between 2003 and 2007. The rate of new infections essentially remained stable, despite HIV prevention activities taking place in the locality.

Fifty percent of seroconverters reported having attended a voluntary counselling and testing service at least once before subsequently serocoverting, suggesting that post-test counselling may not be having the expected impact on sexual behaviour in those who test negative.

Twenty-four percent of seroconverters reported living in households which had included at least two other HIV-positive members at some time point, indicating the very high impact of HIV in the locality.

Source: www.aidsmap.com ⊕

CORRECTIONS

Positive Contributions

Due to technical problems, the list of Positive Contributions donors in the back of the January/February issue of *living*⊕ was incorrect.
We apologize for the error.

Polli & Esther's Closet appointments

An incorrect telephone number for Polli & Esther's appointments appeared in the January/February issue of *living*⊕. If you wish to book an appointment to shop at Polli & Esther's, please call 604.646.5324.

Grill 'em!

During the upcoming provincial election campaign, ask the political parties where they stand on key issues facing PWAs

by R. Paul Kerston

BC's provincial election is on May 12. BCPWA's Community Representation and Engagement Standing Committee (CRE) wrote to the leaders of the major political parties to get their position on some issues of concern to HIV-positive British Columbians.

Unfortunately, our magazine's production schedule is such that we probably approached the leaders too far in advance of the election. Thus, we didn't get satisfactory responses from any of them. BC NDP caucus staff responded saying their party didn't feel ready to give detailed answers ahead of their election platform's release. Two attempts to reach the BC Green Party leader, Jane Sterk, were unanswered.

> **"Unfortunately, as the Premier it would not be appropriate for me to respond to specific questions on behalf of any political party." – Premier Gordon Campbell**

Premier Gordon Campbell, leader of the BC Liberal Party, responded in writing. Curiously, part of his letter said, "Unfortunately, as the Premier it would not be appropriate for me to respond to specific questions on behalf of any political party—as you have requested."

While we didn't receive answers, the election campaign brings an important opportunity for you to voice your concerns. Find out where the political parties stand on key issues facing PWAs. Approach the candidates in your constituency, either directly at their campaign headquarters or at all-candidate forums.

The questions BCPWA posed to the party leaders were:

1.) eHealth - Given the stigma still associated with HIV-positive status, will your party commit to not proceed with this province-wide electronic health records initiative until such time as procedures are in place which enable HIV-positive people to mask their records, should they choose to do so?

2.) Facial lipoatrophy - Will your party commit to listing, on the Medical Services Plan list of insured services, reconstructive surgery materials and procedures for correction of facial lipoatrophy to alleviate its immediate and long-lasting effects, which include a lack of full employability and social discrimination, among other life-limiting and discriminatory factors?

3.) Psychiatric and psychological services - *Trap Doors: Revolving Doors, Mental Health and HIV/AIDS Needs Assessment*, a Provincial Health Services Authority report in 2008, concluded that one in five Canadians suffer from a mental health disorder, compared to four in five British Columbians living with HIV/AIDS/HCV who disproportionately suffer similarly. Will your party commit to funding that is specifically allocated for regional health authority expenditure on psychiatric services for HIV-positive persons, particularly at St. Paul's Hospital in Vancouver, where the greatest concentration of individuals in BC are treated for HIV?

4.) Reducing HIV transmission - What plans does your party have to substantially reduce the incidence of new HIV infections? ⊕

__R. Paul Kerston__ is BCPWA's treatment outreach coordinator and community representation and engagement (CRE) coordinator.

Up, up, and away

Escalating rents coupled with low vacancy rates are squeezing out even middle-income earners

by Glyn Townson

British Columbia's housing crisis is no surprise to *living*⊕ readers. Even if you're unfamiliar with our past articles on housing threats specific to the HIV community, you've likely learned about the general issue through other news coverage. The average house price in the Lower Mainland exceeds the means of the average local family. The struggle of Vancouver's Downtown Eastside residents to find adequate accommodation in single-room-occupancy hotel slums also attracts frequent media attention. And our province's shamefully growing homeless population has been featured on front pages far and wide for decades.

The housing crisis now reaches beyond those who can afford to buy and those who can barely afford to rent. Mid-income earners who rent in urban centres know first-hand that stability, affordability, and accessibility no longer apply to their housing market and—like all communities affected by the crisis—laws protecting their livelihood are weak, at best.

In Kelowna, the vacancy rate for residential rental properties grew to only 0.3 percent in 2008, from zero percent in 2007. Though strong population growth in combination with declining supply of purpose-built rental units is officially recognized as the cause for this dismal figure, the area's vacancy rate is still expected to increase to only one percent in 2009, and it's predicted that rents will continue to rise.

Likewise, Victoria had one of the lowest vacancy rates in Canada in 2008, while average apartment rents increased by seven percent. This dilemma is mirrored in communities throughout BC, yet no level of government has presented a formal plan to deal with it.

In Vancouver, the vacancy rate is expected to be less than one percent in 2009. But here, mid-income renters face additional challenges. In the downtown West End—a culturally and economically diverse neighbourhood that houses a large portion of BCPWA's membership—evictions are fast becoming de rigeur for longtime residents. There's a predictable pattern: landlords raise rents beyond the capacity of current tenants; those tenants who can't pay are evicted; the vacated suite undergoes minimal upgrades and is put back on the rental market at an incomparably higher rate.

The practice may seem unconstitutional, but our present tenancy laws favour the interests of landlords and, alarmingly, give room for the situation to snowball. The Residential Tenancy Act allows for annual rent increases of up to 3.7 percent, but exceptions can be made if a landlord can prove their rents are significantly lower than other units in the same area. Therefore, if a few buildings on a West End street have already upgraded and upped rents, any other building on that street—upgraded or not—might be eligible for a lawful rent increase above 3.7 percent. Undoubtedly, as we approach the 2010 Winter Olympics, landlords throughout Greater Vancouver will stretch this law to maximize the rental capacity of their properties.

Not all is lost, however. In January 2009, residents of the Seafield Apartments in Vancouver's West End received notice that their landlord had applied for a rent increase, which would nearly double the rents for most suites. By banding together and making their story public, the tenants received coverage by several news sources and drew wide interest in their cause. The application for increase has not yet been approved. Their story also brought about more awareness of the West End Residents Association and Renters at Risk, two local grassroots organizations dedicated to protecting the right to equitable rental housing in Vancouver. As these organizations grow, so too does the likelihood of positive change in the rental housing market.

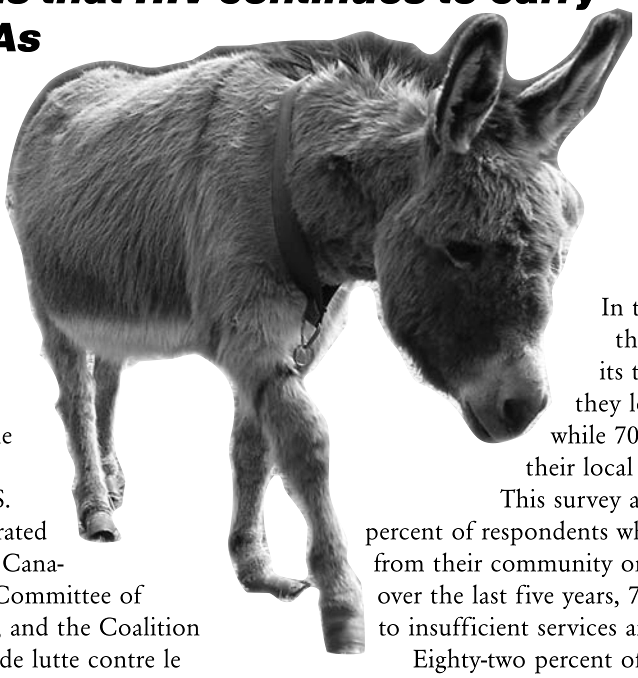
If you find yourself the victim of an unfair eviction, contact BCPWA's Advocacy Department at info@bcpwa.org. ⊕

__Glyn Townson__ is the chair of BCPWA.

Beast of burden

National survey reveals that HIV continues to carry a huge stigma for PWAs

by Zoran Stjepanovic



Where are we 25 years after the discovery of the HIV virus? Last year, P\S\L Research conducted the “HIV+25” survey, sponsored by Merck Frosst Canada, to explore that question. The survey revealed that HIV still carries a huge stigma for Canadians living with HIV/AIDS.

Five AIDS service organizations collaborated on the survey: the Canadian AIDS Society, Canadian Aboriginal AIDS Network, the AIDS Committee of Toronto, AIDS Community Care Montreal, and the Coalition des organismes communautaires québécois de lutte contre le sida. BCPWA didn’t partner in this initiative, however the Society did post flyers about the survey encouraging its members to participate.

The survey explored the impact of HIV on PWAs’ lives, and looked at their knowledge and satisfaction with healthcare and treatments. More specifically, the survey investigated four broad areas: living with HIV; knowledge of HIV and its treatments; sources of information; and treatment and management.

The data was collected between May 28, 2008 and August 19, 2008 through an online survey. A total of 381 HIV-positive individuals from across Canada responded to the survey. Of those who participated, 79 percent were male, 19 percent female, and two percent transgendered. Thirty-four percent identified as heterosexual.

According to the survey, stigmatization is still a big issue after 25 years of HIV. Eighty-two percent of respondents surveyed reported that there’s still stigma attached to being HIV-positive, and 45 percent felt isolated as a result of living with this disease. Fifty-two percent indicated that HIV/AIDS has affected their employability and 44 percent said their co-workers are unaware that they’re HIV-positive.

This survey also demonstrates that there’s still a need for treatment education. Fifty-five percent of respondents indicated they were either somewhat, not very, or not knowledgeable about available HIV treatments, and 17 percent of all respondents didn’t know what an undetectable viral load means. Half of the people wanted to be more involved in their treatment decisions, and 12 percent were dissatisfied with the service they receive from healthcare providers.

In terms of where they get their HIV information and its treatments, 87 percent said they look to their physicians, while 70 percent reported going to their local AIDS service organization.

This survey also showed that among 26 percent of respondents who claimed that support from their community organization has worsened over the last five years, 76 percent attributed this to insufficient services and lack of funding.

Eighty-two percent of respondents were on antiretrovirals. Of those who weren’t on antiretrovirals, close to one third stated too many side effects as the reason for not being on treatment; the most common side effects reported were fatigue, sleep disturbance, and diarrhea.

Forty-five percent felt isolated as a result of living with HIV/AIDS, 52 percent indicated that it has affected their employability, and 44 percent said their co-workers are unaware that they’re HIV-positive.

Overall, this survey demonstrates a need for more education as a high number of participants have some lack of knowledge of treatments available. It’s also clear that a high number of participants turn to their local AIDS service organization for information, as well as turning to healthcare providers. ⊕

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

2009 CAHR conference

The 18th annual Canadian Conference on HIV/AIDS Research will take place in Vancouver from April 23 – 26

Researchers, healthcare providers, public health specialists, community-based workers, people living with HIV/AIDS, and others engaged in the field of HIV research will be gathering for the 18th Annual Canadian Conference on HIV/AIDS Research (CAHR 2009). The conference, organized by the Canadian Association on HIV Research, takes place from Thursday, April 23 to Sunday, April 26 at the Westin Bayshore hotel in Vancouver, BC.

The theme of this year's conference is "Facing the evolving epidemic" and aims to capture the advances in HIV prevention, care, and treatment as we move into the next phase of the epidemic. The program will focus on evolving issues in our understanding of the HIV epidemic including HIV pathogenesis, impacts of the newer antiretroviral drugs, HIV and aging, new methods for estimating HIV rates, mental health and HIV, and the impacts of government policy on prevention.

CAHR 2009 provides a unique and intimate opportunity for those working in the field of HIV/AIDS to make important inroads both in Canada and internationally. The conference also features a number of important ancillary events hosted by related organizations, a workshop dedicated to new researchers, and a dinner reception.

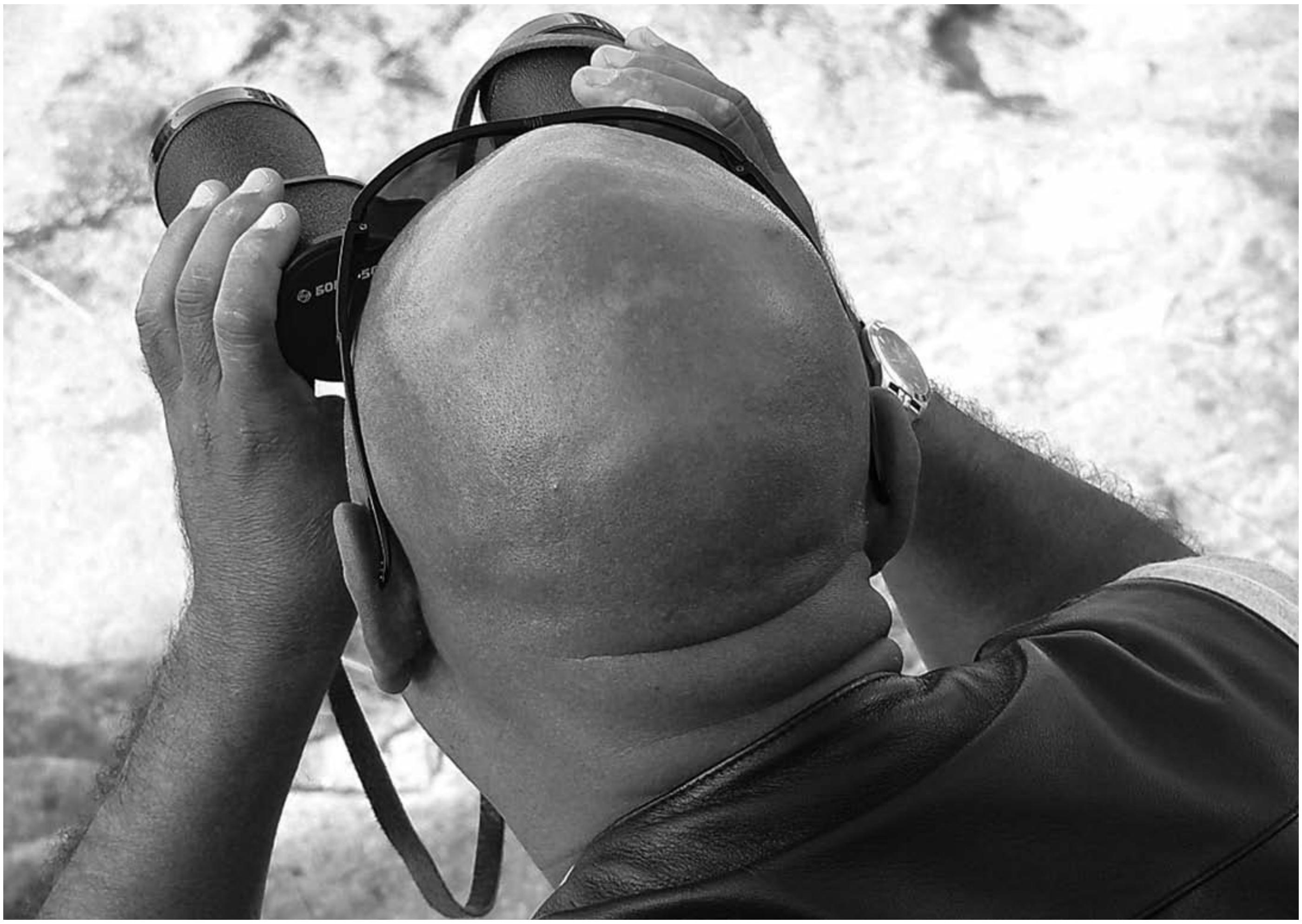
Registration fees for the conference are as follows:

- Early bird rate:
  $350 until March 16 ($400 after March 16)
- Student, fellow, and trainee early bird rate:
  $150 until March 16 ($175 after March 16)
- PWA rate: $50

For more information on the program, community scholarships, registration, or accommodation, visit the conference website at www.seatoskymeetings.com/cahr2009, or contact the conference secretariat by email at cahr@seatoskymeetings.com or by phone at 778.338.4142. ⊕

Looking ahead

Perspectives on the future of the HIV movement in BC



by Francisco Ibanez-Carrasco

What will the HIV epidemic and activism look like in the next 10 years? I learned from Louis-Marie Gagnon, a brother in the HIV movement and executive director of Maison Plein Coeur in Montreal, that we must "be prophetic." Are we doing this in British Columbia?

On October 23, 2008, the Pacific AIDS Network (PAN) and the BCPWA Community Based Research Program hosted a Breakfast Interactive Café for nearly 70 PWAs, AIDS service organization (ASO) staff, volunteers, and public health representatives. Cheryl Dowden from ANKORS in the Kootenays, Rick Kennedy from the Ontario AIDS Network, and Moffatt Clarke from the Public Health Agency of Canada jumpstarted a town hall meeting. There was some resistance to imagining ourselves 10 years from now. Does this mean it'll be business as usual, denial, or that we don't see ASOs or an HIV movement in the future? The event left us with more questions than answers.

continued on next page

Looking ahead

The HIV field is now fully professionalized, which has pros and cons. Often, new ASO staff isn't mentored by activists or staff with institutional memory. Long-time activists burn out because we don't always know how to offer retraining, viable paid work, or volunteering opportunities. New PWAs don't necessarily have a political bone in them.

> **We might have irreversibly moved from social justice to social service models due to funding strings and a current preference for technological fixes.**

One consequence of this professionalization is the loss of activism. We might have irreversibly moved from social justice to social service models due to funding strings and a current preference for technological fixes—such as case management and highly active antiretroviral therapy (HAART) as prevention—both dictated by our faith in epidemiology and clinical work, with no open spaces for idealism and pragmatism to coexist. If we look at what's available in other provinces, the Ontario AIDS Network, for example, offers a leadership program for PWAs across Ontario.

In addition, the HIV field tends to have a higher proportion of female workers, especially with its social workers. However, women continue to be underpaid and social work continues to be devalued as a profession. Now, new ASO staff and volunteers pick up skills and go to higher paying jobs. As a result, we are suffering brain drain. How do we create resiliency and succession?

Research suggests that the excessive proliferation of non-profit services and agencies creates confusion rather than opportunity for consumers. Is Vancouver's Downtown Eastside an example of this for PWAs? What's going on in all of BC?

We need a provincial needs assessment of what PWAs need from ASOs—in conjunction with a new provincial HIV strategy. Do all PWAs need similar services such as employment skills, housing, and nutrition from ASOs all the time along the HIV continuum from diagnosis to treatment, aging, and death?

Opinions expressed at the Café also suggest that in the future, HIV/hepatitis C co-infection might converge into the HIV movement, ASOs will have to diversify fund development instead of relying on the various levels of government, and that ASOs will have to provide all funders with stricter requests for measurement, evaluation, and reporting. One thing was clear: we need to strengthen the coordination and friendship among all ASOs, for which PAN is one tool.

A seven-minute video podcast of the Café is available at www.bcpwa.org. ⊕

***Francisco Ibanez-Carrasco** is BCPWA's Community-Based Research Program facilitator.*

The future of AIDS service organizations in BC

by Lorne Berkovitz

Henry David Thoreau said, "Things do not change, we change." That could not be any truer than in our own local HIV/AIDS community. The HIV virus is unchanged, but whom it affects and our responses to it will alter dramatically in the next five to 10 years.

Some might argue about the relevance of AIDS service organizations (ASOs) in the years to come, but they will undoubtedly remain necessary; only the people affected and the issues ASOs deal with will change.

The population of people affected by HIV is no longer a nicely homogeneous group of gay men. People who acquire HIV now include rural families, injection drug users, sex workers, and Aboriginal people.

In all areas, from prevention and treatment to support, we must work hard to be inclusive and at the same time be aware that the needs of each group are quite different. For example, access and adherence to highly active antiretroviral therapy (HAART) is enormously difficult for people with no permanent address. Therefore advocating for more affordable housing is one of BCPWA's most important mandates.

Access to mental health care is increasingly affecting the lives of PWAs and, subsequently, ASOs. Four out of five people with HIV will need treatment for mental health issues.

Privacy issues will be at the forefront for people in small communities, and just as the prejudices against men who have sex with men initially thwarted finding solutions to the disease, so does the stigma of being an injection drug user, a sex trade worker, or a person experiencing mental health issues.

Access to mental health care is increasingly affecting the lives of PWAs and, subsequently, ASOs. Four out of five people with HIV will need treatment for mental health issues. Support and activism in this area will be essential.

The criminalization of HIV is also emerging as another key issue. The criminal prosecution of PWAs for having sex, protected or otherwise, is a new trend that will definitely put our civil rights to the test.

Manpower will also be an item on all ASO agendas. For the last 10 years, PWAs on long-term disability have filled the rank and file of volunteers. But because they are starting HAART sooner after acquiring the HIV virus, many PWAs may never have to leave the work force. That could leave the pool of volunteers at ASOs perilously low. A great deal of flexibility and imagination will have to go into recruiting new volunteers.

Finally, there's the great recession of 2008. Thus far, we don't know the outcome. But we do know that ASOs will have to find new ways to wrangle funding from governments in deficit and corporations in the red.

The need for ASOs to advocate and serve on behalf of the HIV community isn't over—they are more relevant than ever. However, the issues are changing and ASOs must change with them. It won't be easy. As Billy Crystal noted, "Change is hard." ⊕

***Lorne Berkovitz** is a BCPWA board member and a Treatment Information Program volunteer.*

HIV's emerging cohorts and blurred identities

by Glen Bradford

The HIV/AIDS community is facing a new stage in our health disease continuum. Where did we start and where we are now? And what will define our future?

In the past, HIV-positive people expressed HIV as an identity, such as sexual orientation, social class, or political alliance. We became AIDS activists and professional volunteers. Our external appearance—lipoatrophy, lipodystrophy, and extended bellies—perpetuated the stigma of HIV/AIDS and negative self-image.

We countered this negativity with dark humour and spirituality: AIDS is a wonderful learning opportunity, a spiritual gift—or a punishment for past behaviours. Activists insisted on being called "people with AIDS" rather than "AIDS victims" to make it clear that they weren't powerless. The job of taking care of ourselves in order to avoid death replaced our paid jobs. This made sense, since being HIV-positive affected every aspect of life and meant eventual certain death from AIDS.

continued on next page

Looking ahead

Then there was a shift and a new cohort, when effective treatment became available in the mid-1990s. Combinations of medications could effectively control HIV infection. As fewer people died from AIDS, we starting saying that people were “living with HIV.” This was an improvement, but the medical profession defined us by the results of a blood test. An all-consuming pill regimen defined our new identity. Most people referred to their status by saying, simply, “I’m HIV”, not “I have HIV.”

By the late 1990s, two cohorts existed: one facing the reality of death, the other facing handfuls of pills, beepers, and middle of the night dosages. Antiretrovirals became the new future.

Creating HIV as an identity functioned as a survival tactic, a way to cope with illness, to reveal failing healthcare systems, to expose questionable practices of pharmaceutical companies, and to inform and mobilize.

Now, HIV-positive people are living longer and aging. Symptoms of aging with HIV are becoming blurred. Living longer while being retired for health reasons means we need to fill our time in ways we didn’t anticipate.

There’s new hope and along with it, a third emerging cohort. For many early detected, newly diagnosed people, their experience starts at one pill, once a day. They’ll have minimal side effects and they’re more likely to stay at work or school. They have an “episodic disability”: longer periods of good health and short, intermittent periods of poor health.

Yet many newly diagnosed people see long-term PWAs and think they face the same future: they believe their lives will be shortened, that their dreams and aspirations are over. They believe they are the new “us.”

The health model of HIV/AIDS has evolved to a disease continuum that defines people as having a full disability, an episodic disability, or no disability. Insurance companies are blurring the line between episodic disability and no disability with doctors pushing to get people back to work. Therefore, long-term survivors need to ensure that public health agencies, doctors, and income security programs see us as three separate cohorts. Some PWAs will never work again. Some may want to work part-time and will need income security and rehabilitation programs to help them with part-time employment. Early detected, newly diagnosed people will be able to stay at work.

Our HIV/AIDS status is a key part of our experience. At times it may feel like it sets us apart. The identity of our community continues to blur, as ongoing cohorts evolve and new ones emerge, we shouldn’t allow outside institutions to define how we identify our own concepts of self. Nor should we do it to each other. ⊕

***Glen Bradford** is a BCPWA member and a volunteer in the Positive Prevention Program.*

Generation next: Newly diagnosed with HIV

The bridge from fear to acceptance

by Anonymous

It was June 2008, I was three months shy of my 59th birthday, and one year away from a planned retirement. For several months, I hadn't been feeling 100 percent. I had a staph infection; my inner voice was telling me something. I had been sexually active for years and had many anonymous encounters, and had never been tested for HIV.

At this point, I decided to face all my fears and demons. I went and had a heart-to-heart talk with my doctor and leveled with him. All these years, I was rarely sick, thereby enabling me to avoid the issue of possible HIV infection. My doctor immediately sent me for a full range of tests, and sure enough, the results came back positive.

Added to this was one more complication: I was also co-infected with hepatitis C.

Although shocked, scared, and freaked out, I wasn't surprised, and realized my life would no longer be the same.

After the initial diagnosis, I had further tests done to determine my CD4 count, viral load, chest x-rays, and liver function. Waiting for several weeks and being new to all of this medical diagnosis was probably one of the more difficult periods I have experienced. I had never broken any bones, never been in the hospital, still had my appendix and tonsils, and was terrified by needles. Fortunately, the results were rather good, with my CD4 count in the normal range, my liver functioning normally, and after 40 years of smoking, my chest perfectly clear. The anomaly was that my viral load was very high, which meant that I had probably sero-converted relatively recently.

Oh, if we could only turn back the clock, but we can't.

Spiritually, I know everything happens in life for a reason. I need to search for and address my spirituality as I begin this new journey of living with this diagnosis. I think I know the reasons why and the answers too, but I'll let time and the Spirit unfold these things to me.

As I sit here four months later, with the results of another set of tests under my belt, I feel somewhat like I'm living in a parallel universe, because my results were better than three months ago. The existence of my parallel universe reminds me that, although my health is good now and I feel great, unlike a cold or flu this isn't going to go away. And at some point, I can only assume that I'll need to begin highly active antiretroviral therapy, which is another reality, if not another journey.

Disclosure for me was probably the most fortunate and easy part of all of this. To those friends, family, and colleagues that I have disclosed to, I give thanks for their empathy, compassion, and support. In today's world, and with all the other rampant diseases out there, HIV doesn't carry the stigma that it once did.

I have also been very fortunate that I was able to access a very generous and supportive benefit package through my employment, and with a letter from my doctor, I was able to go on sick leave for a year, thus enabling me to retire a year earlier than planned. The true benefit was that this also gave me the opportunity to stop some of life's patterns and enabled me to begin to address the physical, emotional, and spiritual aspects of my life that were out of balance. This, if I may define it in these terms, is a silver lining, or reason for what has come my way.

I am neither angry nor resentful of my situation, but hopeful and optimistic about this new epoch of my life.

Because HIV is a reportable disease, a wonderful, young public health nurse from Vancouver General Hospital visited me very soon after my diagnosis, and provided me with valuable support, much good information, and resource material. Several weeks after her visit, I received a pamphlet from her about an upcoming, new six-part workshop series for newly diagnosed gay men at BCPWA run by three staff, who are also gay and HIV-positive.

> **Spiritually, I know everything happens for a reason. I think I know the reasons why and the answers too, but I'll let time and the Spirit unfold these things to me.**

Being somewhat timid, I decided to try the workshop, contacted one of the presenters, went for an initial interview, and soon after joined a group of six other men to begin the series. Each series of the workshop covered important and separate issues of HIV, and was extremely informative, interesting, and professionally presented.

What was most powerful about the workshop series was the group dynamics that were present from the beginning: great respect, sincerity, bonding, empathy, compassion, and understanding. For me, the workshop was perfect timing; it very soon gave me a bridge from overwhelming fear and dread to a peaceful understanding and acceptance.

If there are angels walking amongst us, Neil, Glen, and Elgin personify them, and a special thank you to all three, and to BCPWA for supporting and presenting the workshop. ⊕

Road map for the future

BCPWA is undergoing strategic planning for our organization

by Glyn Townson

Strategic planning, although sometimes arduous, is a necessary process to ensure that BCPWA's funding and resources are used in the best way possible. It takes time and effort to develop a clear vision of where we've come from and how we want our organization to grow. Lessons from recent years have revealed that we need flexibility to deal with an ever-changing landscape of funding and adequately address the issues facing the varied populations affected by HIV in our province. It boils down to visioning, creativity, and focusing on priorities—and drafting a plan to guide our agency forward.

In 2003, BCPWA embarked on the development of our current strategic plan for 2005 to 2010 (www.bcpwa.org/about_us/strategicplan). We continue to focus on our strategic plan's relevancy to our membership, and as we approach the last year of our current plan, we identified more flexible planning tools as the keys to future success. The fixed model we've been using has inherent problems. As a non-profit, our funding streams are never guaranteed. In the first year of our current plan, some of our core funding went sideways and we had to abandon many projects we had hoped to accomplish. On the upside, opportunities appeared that we hadn't anticipated. Thus, we're adopting a "rolling" five-year plan. This will provide the agency with a more accommodating planning tool that can adapt to a constantly changing climate.

Meeting the needs of increasing complex populations

As the nature of HIV/AIDS has changed dramatically over the past three decades, so have the needs of PWAs and, consequently, the composition of our membership. As a member-driven organization with a provincial mandate, we have an enormous amount of territory to cover with limited resources. It's important that we use our available resources in effective and efficient ways. Engaging the many populations affected by HIV has become much more complex over the past three decades. Today we face more language, cultural, and gender barriers. There's a greater chasm between those who have access to care and those who don't.

One of the important unfinished goals identified in our current plan is the necessity to find a mechanism to enable a broad survey of PWAs around the province to find out what services are out there, what services PWAs use, and what they feel they need that aren't currently available. BCPWA is in the process of partnering with other AIDS service organizations throughout BC to apply to the Canadian Institutes of Health Research for a grant to take on this task. Our first application a couple of years ago was unsuccessful, but the reviewers did see the merit in our ideas and made recommendations for us to adjust our application and resubmit.

Some exciting projects will be moving forward in the coming months, which start to complete some of the long-term goals of the current plan for satellite operations. After several years of negotiations, BCPWA will have a presence in the Downtown Eastside (DTES) in the Washington Hotel, partnering with the DTES HIV/IDU Consumers' Board, and the Portland Hotel Society, to offer part-time advocacy and treatment information services on site. With the opening of the community courts a block away from the new satellite office, our goal is to provide support where it's needed most.

Another recent development is our partnering with the Fraser Valley Lighthouse Society, Fraser Health Authority, the Provincial Health Services Authority, and the federal government's AIDS Community Action Program to provide a new space for drop-in services and supports to PWAs in the eastern region of the Fraser Valley, an area presently underserved. This project came about because a BCPWA member living in the Fraser Valley wrote to our board of directors explaining the lack of services available to PWAs in that area. Statistics drawn from our membership as well as from the BC Centre for Excellence in HIV/AIDS confirmed the number of individuals in the region and the current level of local services were inadequate. Thus, a plan of action was undertaken with partner organizations.

Adapting programs and services for newly diagnosed people

There's still a lot of work ahead to ensure that PWAs throughout BC have access to services and adequate healthcare, particularly as HIV/AIDS continues to be normalized and made more mainstream. In that vein, we'll need to address privacy issues. PWAs must remain active in the movement.

These issues will continue to grow as most newly diagnosed individuals receiving appropriate treatment and care will lead much more normal lives by continuing their education and jobs. That means BCPWA will need to provide services that fit within a mainstream schedule. BCPWA's Support Services department recently launched a "Suits" monthly networking dinner in Vancouver for PWAs who work or are returning to work. Over the next couple of years, our healing retreats will take place during weekends to allow members who work to attend and thus build community.

Over the next couple of years, BCPWA may also be looking for a new location for our administration and physical operations. The lease on our current building expires in 2012. Depending on how the economy fares between now and then, we may move within the same area if we can find an affordable and practical location, or we may have to move somewhere else if necessary.

Another strategic issue that we've identified is our name. Often, we hear that individuals don't identify with BCPWA because they are living with HIV and don't have AIDS. We're assessing this problem, and we're exploring the possibility of rebranding.

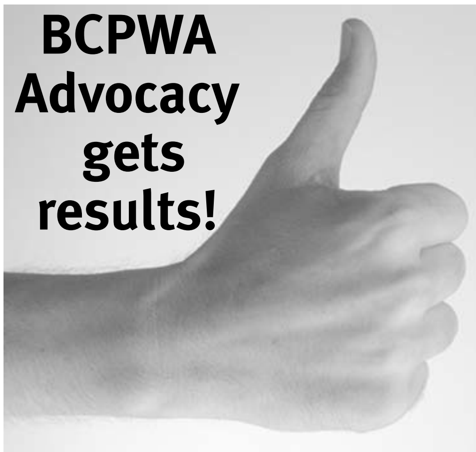
Engaging our members in the direction of the Society

The governance of our organization may also require revisions, now and in the future, to ensure the spirit and voice of HIV-positive individuals in BC remain in control of their destiny. At this year's Annual General Meeting, motions will once again be put forward to move to a mail-in balloting system to elect the board of directors and pass special resolutions. The new system, if adopted, will allow members from throughout the province to be engaged in the direction of our Society.

Our Society was formed to create a platform to enable PWAs to have a meaningful voice at the table on issues concerning their lives and to exercise their fundamental right to participate in those decisions. We can only be successful if our membership remains engaged in these processes. That can a be a difficult challenge with many of us staying at work, engaging in educational pursuits, raising families, and all the things a full life has to offer.

If you're interested in participating and providing feedback in the direction and future planning of BCPWA, please contact the department you're interested in, or forward your comments to any of our members on the society's board of directors. As the new rolling strategic plan evolves, there will be a number of mechanisms for our membership to get involved, including an update at our Annual General Meeting at the end of August. ⊕

__Glyn Townson__ is the chair of BCPWA.



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 December 2008 and January 2009 is:

- **$30,035 in housing, health benefits, dental and long-term disability benefits.**
- **$3,150 in ongoing monthly nutritional supplement benefit for children**

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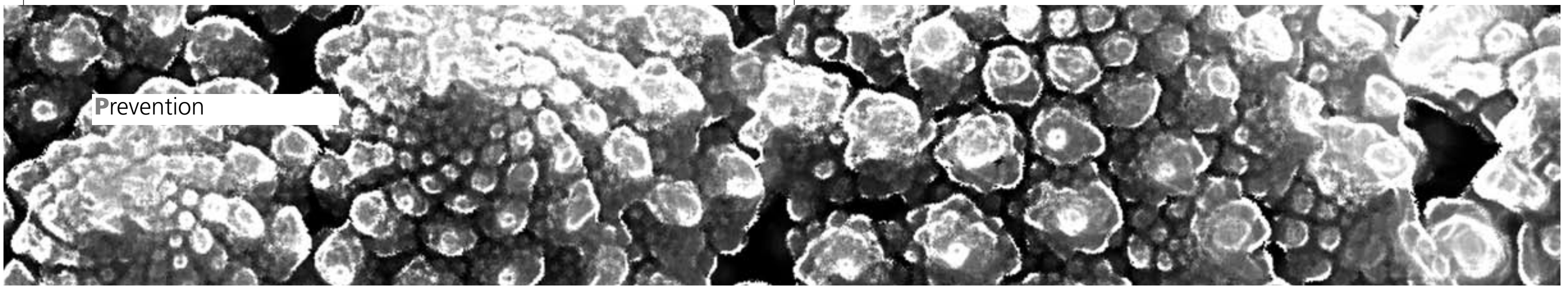

A troublesome trend

Syphilis still rising in gay and bisexual men

by Glenn Doupe and Dr. Mark Gilbert

Fifteen years ago, cases of syphilis decreased in Canada and it looked as though syphilis was on the verge of being eradicated. Then 10 years ago, cases began to increase in BC and have increased steadily ever since. In 2003, the epidemic shifted and the majority of new cases were found among gay, bisexual, and other men who have sex with men. In contrast to other residents of the province, syphilis cases in gay and bisexual men are continuing to increase sharply, from less than 25 cases per year prior to 2003 to 228 cases per year in 2008—about 10 times higher. In 2008, 70 percent of all new syphilis cases in BC were in gay and bisexual men, continuing an upward trend from 60 percent in 2007.

HIV-positive gay and bisexual men are more likely to be infected with syphilis. In 2008, six out of every 10 gay and bisexual men infected with syphilis were also HIV-positive. One explanation for this trend is serosorting—HIV-positive men seeking out other HIV-positive men for sex without condoms. While this is a good strategy for preventing HIV transmission, it isn't effective protection from syphilis. In addition, syphilis is probably diagnosed more often in HIV-positive men who are on HIV treatment, through syphilis testing that is added to routine blood work related to anti-retroviral therapy.

Syphilis can be spread through vaginal, anal, and oral sex (as the giver or receiver), and condoms can reduce the risk of becoming infected. Symptoms aren't a reliable way to alert you to an infection; symptoms can vary from person to person, they can look like other diseases, and they may be minor or not noticeable.

Antibiotics are used to cure the infection. Once you're cured, you're no longer infectious. That doesn't mean you're cured for life! You can get infected again if you have sex with someone with syphilis.

If you're sexually active, it's important to get tested for syphilis every three to six months. Generally, a syphilis test will be positive between nine days and three months after being exposed to syphilis. You can get tested at your family or HIV physician's office, community health centre, or sexually transmitted infection clinic.

Getting tested and encouraging your friends to get tested can help to stop the spread of syphilis. If the test result is positive, it's important to inform your sex partners because they may not be aware they have an infection; you can tell them yourself or public health nurses can help inform your sex partners. People who you've had sex with in the previous three months need to get treated for syphilis; earlier partners need to be tested.

In 2008, six out of every 10 gay and bisexual men infected with syphilis were also HIV-positive. One explanation for this trend is serosorting.

As syphilis infection increases HIV viral load, getting regular testing and prompt diagnosis and treatment will also reduce the likelihood of transmission of HIV to sex partners.

Having a lesion due to primary syphilis can increase your risk of acquiring HIV. Every year, a small number of gay and bisexual men are diagnosed with acute HIV infection and syphilis at the same time, which highlights how interrelated these two infections are.

These trends aren't unique to BC. Outbreaks of syphilis in HIV-positive gay and bisexual men have been identified in cities and countries around the world, on all continents. The search continues for new prevention, testing, and treatment strategies in BC and globally. In the meantime, get tested. That action can have a real, local impact. ⊕

***Glenn Doupe** (l) is clinical team leader for the BC Centre for Disease Control's HIV/STI Outreach Nursing Program, which operates the Bute Street Clinic. **Dr. Mark Gilbert** (r) is a physician epidemiologist with the Division of STI/HIV Prevention and Control at the BC Centre for Disease Control.*

TREATMENT INFORMATION PROGRAM MANDATE & DISCLAIMER

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

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

When you're better, yet worse

An update on immune reconstitution inflammatory syndrome

by Dr. Peter Phillips

During the first few months of highly active antiretroviral therapy (HAART), some people experience new or worsening symptoms. Those symptoms are often attributed to adverse drug reactions and various opportunistic diseases. Increasingly, though, investigators are recognizing immune reconstitution inflammatory syndrome (IRIS) as a possible cause. IRIS occurs when you start HAART and you have a significant reduction in your HIV viral load—with or without an increase in CD4 count—however your condition worsens.

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IRIS is uncommon, but it's also been reported in chronic infections such as leprosy, tuberculosis, and hepatitis B. Among HIV-positive individuals, it was only after the introduction of zidovudine (AZT, Retrovir) that a few reports emerged about episodes of IRIS. However, since the advent of HAART, many more reports have appeared describing PWAs with paradoxical reactions to a variety of opportunistic infections, including *Mycobacterium avium* complex (MAC), tuberculosis, Cytomegalovirus (CMV), *Cryptococcus neoformans*, *Pneumocystis* pneumonia (PCP), and herpes zoster.

As many as 25 percent of HIV-positive individuals who begin HAART with CD4 counts below 200 may experience IRIS. The episode of IRIS often consists of skin lesions due to organisms such as herpes viruses—for example, varicella zoster virus, herpes simplex—as well as molluscum contagiosum, and human papilloma virus. The IRIS complications that pose the greatest risk and occasionally result in death are those related to cryptococcosis, tuberculosis, MAC, PCP, CMV, and a viral infection of the brain called progressive multifocal leucoencephalopathy (PML).

Worsening symptoms and relapses

IRIS may occur as an unmasking of a previously undiagnosed opportunistic infection, which becomes evident with new or worsening symptoms usually during the first few weeks or months after a person with a low CD4 count initiates antiretroviral therapy.

The other form of IRIS is a "paradoxical worsening" or relapse of a pre-existing and often recently diagnosed opportunistic infection. For example, among PWAs who are recently diagnosed with tuberculosis, MAC or cryptococcosis (such as cryptococcal meningitis), there's a roughly 30 percent chance that starting HAART will cause an IRIS-associated flare up of the infection, usually during the first few weeks or months of initiating HAART. In terms of other recently diagnosed opportunistic infections, there is a 12 – 63 percent risk of IRIS with cytomegalovirus virus eye disease, a five to 18 percent risk with PCP, a seven to eight percent risk with shingles, and a seven percent risk with Kaposi's sarcoma.

> **If you start antiretroviral therapy when you have a CD4 count below 200, be aware of the possibility that immune reconstitution inflammatory syndrome can develop.**

The symptoms that may occur with IRIS may involve any organ and depend on the particular opportunistic infection involved. The symptoms are often similar to what you'd expect with the respective opportunistic infections in the absence of IRIS. However, researchers have identified a number of distinctive features that may provide important clues to an IRIS diagnosis, and relate to the fact that the person has a much more functional immune system, which translates into a more vigorous immune response and greater inflammation.

Mild cases go away without special treatment

If you start antiretroviral therapy when you have a CD4 count below 200, be aware of the possibility that IRIS can develop. If you start HAART when your CD4 count is below 200, you should discuss IRIS and potential adverse drug reactions with your doctor.

In terms of managing IRIS, many of the problems are mild to moderate and may go away without any specific treatment other than treating the opportunistic infection. For selected opportunistic infections where the IRIS episode is moderate to severe, anti-inflammatory medications may be beneficial, such as a prednisone or a non-steroidal anti-inflammatory drug (NSAID) such as ibuprofen. It's seldom necessary to interrupt your antiretroviral therapy, but that option should be considered if a life-threatening IRIS complication doesn't respond to prednisone.

The long-term prognosis for most cases of IRIS is good, however occasional fatal cases have been reported, mainly with IRIS related to PML, pulmonary Kaposi's sarcoma, and cryptococcal meningitis. Starting HAART when your CD4 count is 300 may reduce your risk of developing IRIS. ⊕

***Dr. Peter Phillips** is a member of the Division of Infectious Diseases in the Department of Medicine and medical director of the HIV/AIDS ward at St. Paul's Hospital in Vancouver.*

DO YOU NEED BETTER **ACCESS** TO INFORMATION ON **HIV/AIDS TREATMENT?**

THEN PARTICIPATE IN A SURVEY!

British Columbia
Persons With AIDS Society

You can help BCPWA by participating in a research project to assess the changing treatment information needs of HIV-positive people in BC.
The research examines the experiences that HIV-positive people have with access to HIV/AIDS treatment information and the quality of these experiences.
The results of this research will help BCPWA's Treatment Information Program to develop better information alternatives as it plans its future programming.

Why participate?

Ultimately, the research will help you become better informed about the HIV treatment topics that are important to you.

Who should participate?

Complete the survey if:

- You're HIV-positive
- You live in BC
- You have access to a computer
- You're willing to complete an online survey about your experiences with access to HIV/AIDS treatment information

What about privacy?

Your privacy will be protected. You won't have to provide any personal information, and your responses will be kept completely confidential. All results from the survey will be reported in summary form only.

Questions? If you have any questions about this research, please contact 604.893.2239

TO ACCESS THE QUESTIONNAIRE, GO TO:
HTTP://INFOPOLL.NET/LIVE/SURVEYS/S33258.HTM

Authorized by the Persons With AIDS Society of BC, registered under the Election Act, 604-893-2200

Energy crisis

HIV-related fatigue is surprisingly common, but it is manageable

by Leslie Leung

In 1869, a New York neurologist, George Beard, described fatigue as “the Central Africa of medicine, an unexplored territory where few men enter.” This quotation highlights the historically undertreated, complex, and subjective nature of this general symptom.

Fatigue is debilitating. It has negative impacts on social functioning, work productivity, and quality of life. Fatigue is defined as prolonged tiredness that is unresolved by rest. Medical literature categorizes three types of fatigue: physical, psychological, and emotional. Physical fatigue is tiredness related to intense physical exertion or physiological malfunction. Psychological fatigue refers to difficulty in focusing on tasks that require concentration. Emotional fatigue refers to the lack of will to participate in normal activities.

It’s estimated that 50 to 80 percent of HIV-positive people experience fatigue at some point during the course of the illness. Females are more likely to experience fatigue compared to males. People who have more advanced stages of HIV/AIDS tend to report fatigue more frequently. However, there’s insufficient evidence in the medical literature to show that fatigue is directly correlated to CD4 counts or viral load. The broad term, HIV-related fatigue, encompasses multiple factors that contribute to tiredness that appears at the onset of HIV infection.

There are a number of common medical causes of HIV-related fatigue: opportunistic infections, anemia, hormonal imbalances, medication side effects, and mood disorders.

Opportunistic infections

Active opportunistic infections, or infections that occur only in a patient with a compromised immune system (a drop in CD4 white blood cell counts), are common causes of HIV-related fatigue.

When your body fights against an active infection, there's an increase in energy use through various mechanisms: fever, release of inflammatory chemicals, and increased energy transfer from muscle and fat tissues. Some examples of opportunistic infections include mycobacterium tuberculosis, mycobacterium avium complex, Pneumocystis jirovecii pneumonia, toxoplasma gondii (encephalitis due to toxoplasmosis), cytomegalovirus, cryptococcus neoformans meningitis, and candida fungal infections.

Other symptoms in addition to fatigue might include fever, night sweats, blurred vision, diarrhea, skin lesions, and shortness of breath. However, a definite diagnosis has to be confirmed by a complete blood count, tuberculin skin test, chest X-ray, specific tissue culture, biopsies, and viral serology.

Once the diagnosis is confirmed, fatigue can be treated with antibiotics, antivirals, or antifungal medications. However, the best way to prevent fatigue due to opportunistic infections is to use preventative anti-infective medications when your CD4 counts drop below 200 cells.

Non-medicinal preventitive measures include thorough hand washing after contact with potentially contaminated substances, eating fully cooked foods, drinking only water from treated sources, avoiding handling sick pets, avoiding contact with reptiles, and avoiding animal scratches.

Anemia

Anemia is a blood disorder and it's the most common cause of HIV-related fatigue. Up to 60 to 90 percent of HIV-positive people have anemia. Tiredness resulting from anemia occurs when the oxygen-carrying capacity of your blood is unable to meet the oxygen demands of your body tissues.

Anemia is due to one or more of the following three factors: low hemoglobin, a protein that binds to oxygen in the blood; low red blood cells; or decreased capacity of the blood to carry oxygen. Hemoglobin production can be low due to iron deficiency. Loss of blood, chronic renal failure, and bone marrow depression can lead to a reduction in red blood cell production. Finally, folate or vitamin B12 deficiency as well as some genetic diseases can result in abnormally shaped red blood cells, decreasing their ability to carry oxygen.

Other clinical symptoms might include decreased exercise tolerance, dizziness, irritability, and palpitations. Neurological symptoms such as numbness are often present in vitamin B12 deficiency.

In order to diagnose the specific type of anemia, your doctor needs to order a variety of blood tests, including levels of hemoglobin, iron, transferrin, ferritin, vitamin B12, folic acid, red cell counts, and red cell size.

> **Despite the prevalence of mental health conditions among PWAs co-infected with HCV, only 10.7 percent have been able to access formal mental health supports.**

Iron deficiency anemia is usually associated with a smaller red cell size and is classified as microcytic anemia. By contrast, folate/vitamin B12 deficiency anemia is usually associated with a bigger red cell size and is classified as macrocytic anemia.

Depending on the specific type, anemia can be treated by taking supplements of oral iron salts, folic acid, and vitamin B12. Don't self-medicate without consulting your doctors and pharmacist, because the treatment for specific anemia is different. For example, using folic acid for vitamin B12 deficiency might mask symptoms of fatigue without delaying the progression of neurological lesions. In more severe cases of anemia, blood transfusions and injection of erythropoietin, a hormone that stimulates red blood cell production, might be necessary in situations like rapid blood loss, chronic renal failure, or anemia due to medication side effects.

Hormonal imbalance

Abnormal levels of testosterone, cortisol, and thyroid can cause HIV-related fatigue. Fatigue can result if any of these three hormones is disrupted from normal physiological processes.

Hormones are chemicals in the body that are necessary to maintain a balanced, healthy state. Testosterone is a hormone that normally functions to promote protein synthesis, maintain sexual function, increase energy, and produce red blood cells. Cortisol is important to deal with stress by converting energy for immediate use. Thyroxine is vital for regulating metabolism.

Blood tests of hormonal markers can be used to diagnose hormonal imbalance. Symptoms of hypogonadism or a decreased testosterone level might include loss of appetite, weight loss, difficulty concentrating, or a lack of sex drive. Furthermore, symptoms of adrenal insufficiencies, or a

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decreased cortisol level, might include difficulty concentrating or an inability to cope with stress. Finally, symptoms of hypothyroidism, or a decreased thyroxine level, might include dry skin, cold intolerance, and constipation.

Supplementing with the deficient hormone is the mainstream drug therapy for hormonal imbalance.

Medication side effects

Specific antiretroviral, antiviral, antibiotic, cancer, and hepatitis medications can cause fatigue as a side effect. When the onset of fatigue is related to a recent introduction of a new medication, then medication-induced fatigue should be suspected.

Some medications can cause anemia by depressing the bone marrow, the site of red blood cell production; these include zidovudine (AZT, Retrovir), abacavir (Ziagen), valganciclovir (Valcyte), sulfa antibiotics, alpha interferons for hepatitis, hydroxyurea (Hydrea), pyrimethamine (Daraprim), and pentamidine (Pentacarinat). Drugs such as indinavir (Crixivan) and ritonavir (Norvir) might cause general malaise and lack of energy.

> **It's estimated that 50 to 80 percent of HIV-positive people experience fatigue at some point during the course of the illness.**

Many drugs used in highly active antiretroviral therapy (HAART) can cause diarrhea as a side effect, which might interfere with nutrient absorption, leading to fatigue. Finally, drugs that affect the central nervous system such as antidepressants or beta-blockers might also cause tiredness as an adverse effect.

Medication tolerance is highly individual. In general, medication side effects should subside within a few days as your body adjusts to the new medication. However, in more severe cases of intolerance, you might need to substitute a different medication. Side effects will often disappear quickly once you stop taking the offending medication. In some cases, injection of erythropoietin might be effective in countering the side effect of bone marrow depression caused by some medications.

Mood disorders

Depression and anxiety are mood disorders that are commonly associated with fatigue in people living with HIV. Up to 47 percent of HIV-positive peoples have depression; of these, up to 90 percent have generalized anxiety disorder.

Both depression and anxiety are characterized by chemical imbalance in the brain. A type of brain chemical known as serotonin is often abnormally low in people suffering from depression. This chemical imbalance in the brain leads to a spectrum of debilitating symptoms, one of which includes fatigue.

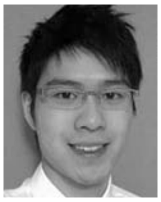
There are no laboratory or blood tests available for diagnosing mood disorders; usually your doctor makes a diagnosis based on a clinical assessment of symptoms. To be diagnosed with depression, you must have five or more of the following on most days for at least two weeks: depressed mood, diminished interest or pleasure, significant weight loss or weight gain, insomnia or sleeping too much, agitation, fatigue, feelings of worthlessness or excessive guilt, difficulty concentrating, and recurrent thoughts of suicide.

Antidepressants are as effective in treating HIV-positive people as they are in treating HIV-negative people. Most of these medications work by increasing serotonin levels in the brain. In general, they take a few weeks to work and have to be taken regularly; stopping abruptly can lead to withdrawal symptoms. Other non-drug measures for depression include cognitive-behavioural and interpersonal psychotherapy.

Even though they aren't indicated for treating depression, psychostimulants such as methylphenidate (Ritalin, Methylin, etc.) and dextroamphetamine (Dexedrine) have been shown to be effective in treating fatigue in HIV-positive people; however, they should be closely supervised by your doctor due to potential addictive properties.

Overall, while fatigue can be a symptom of a more severe problem, once identified, it can be manageable. Here are some general tips on how to manage fatigue:

- Take control and seek professional help to rule out medical causes
- Obtain proper nutrition from a well-balanced diet; take supplements if necessary
- Avoid factors contributing to insomnia, like alcohol, caffeine, recreational drugs, and smoking
- Exercise regularly
- Alternate relaxing activities with more physically demanding ones
- Plan for important activities during the time of the day when your energy levels are highest
- Be patient and set realistic goals. ⊕



__Leslie Leung__ is a community pharmacist who is actively involved in breast cancer research, youth leadership, and first aid training with St. John Ambulance. He also volunteers with BCPWA's Treatment Information Program.

Sticking to it

A recent study looks at how antiretroviral therapy adherence affects viral load

by David Yemchuk

For HIV-positive individuals, the effectiveness of an antiretroviral regimen depends on two key factors: the selection of a combination of antiretroviral medications that will produce a sustainable suppression in viral load, and an ability to adhere to the regimen. Adhering to the drug regimen entails a lifelong commitment and is affected by many variables such as the complexity of the regimen and the side effects of each medication.

Just how adherent must you be in order to maintain suppression of your viral load? This question has been the source of ongoing debate for a number of years. Investigators recently addressed the relationship between viral load and adherence in a study published in the *Journal of AIDS Research and Human Retroviruses.*

Investigators from a hospital clinic in Barcelona, Spain looked at 1,142 patients in a one-year follow-up study. The study recruited patients over a six-month period between 2004 and 2005. Participants met the following criteria: had visited the outpatient pharmacy to pick up their medications during the specified timeframe; treatment naïve and treatment experienced with undetectable viral load (less than 50 copies/ml) at the time of enrolment; and treatment experienced with no detectable viral load during the six months before enrolment.

The antiretroviral regimen of all participants consisted of three groups of backbone combinations: 58 percent were taking non-nucleoside reverse transcriptor inhibitors (NNRTIs); 31.4 percent were taking boosted protease inhibitors (PIs), and 10.6 percent were taking unboosted PIs. People were ineligible for enrolment if they were taking an antiretroviral regimen consisting exclusively of nucleoside reverse transcriptase inhibitors (NRTIs).

Final analysis of the data excluded people who had treatment interruptions or whose regimens had changed before the six months of follow-up. Of the 1,142 patients meeting the study criteria, 899 were HAART experienced, and 243 were receiving first-line therapy (that is, the regimen used when starting treatment for the first time).

Adherence to antiretroviral therapy was assessed at each pharmacy visit throughout the one-year follow-up through pill counts or reviewing prescription-dispensing records. Adherence levels were categorized as: less than 70 percent; 70 – 79.9 percent adherence; 80 – 89.9 percent adherence; and 90 percent or over.

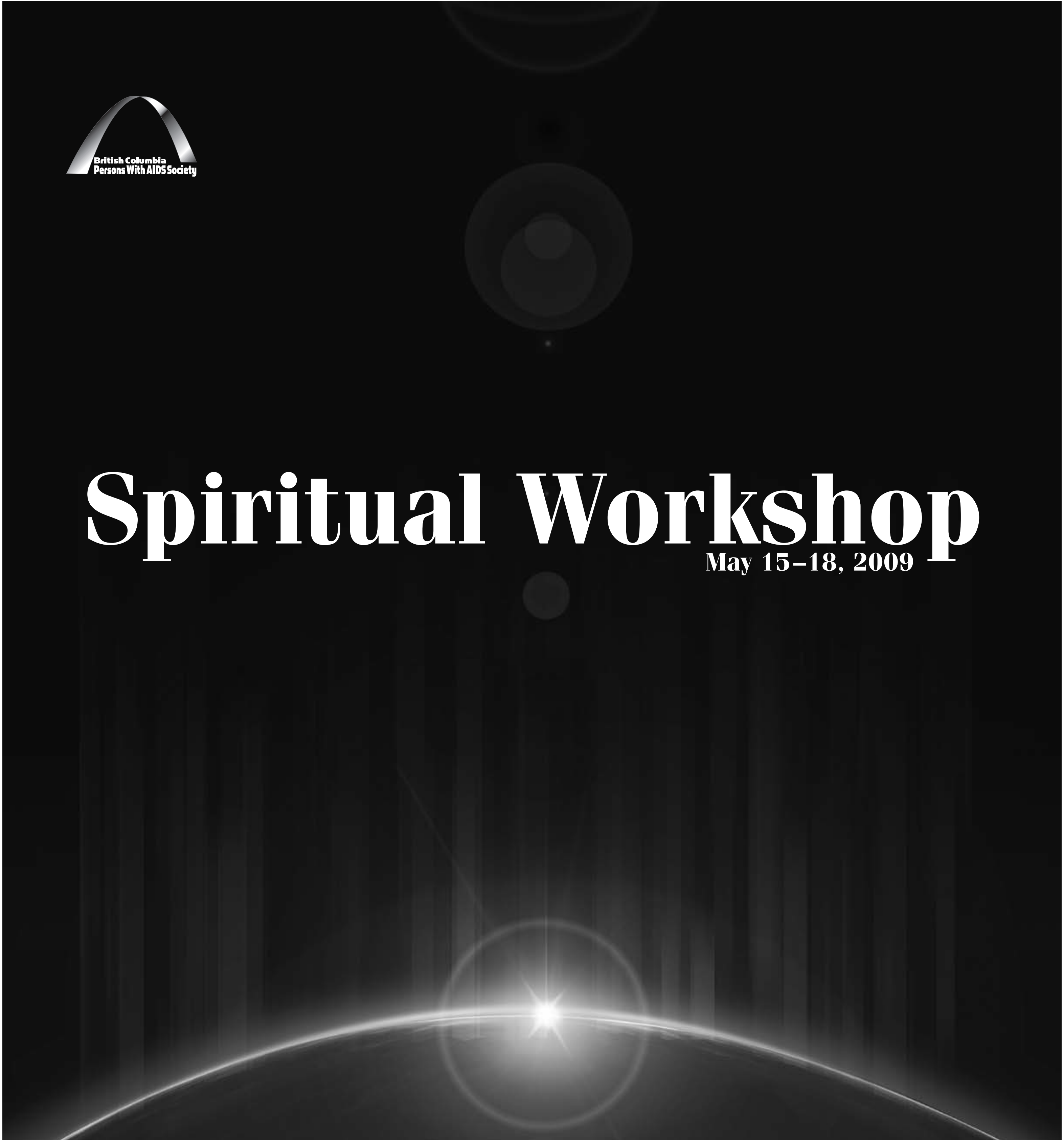
The level of adherence and the antiretroviral regimen were determined to be the only two statistically significant variables in this study. The rate of failure to maintain undetectable viral loads was analyzed across the four adherence levels, and between the three antiretroviral regimens (NNRTI based, boosted PI, and unboosted PI).

Relative to the 90 percent or over adherence group, those who had less than 70 percent adherence had a 77 times increased risk of developing virologic failure (that is, the treatment doesn't reduce or maintain suppression of the viral load), the 70 – 79.9 percent group had a 46 times increased risk, and 80 – 89.9 percent group had a nine times increased risk. The risk of failure was lowest in the NNRTI group, and highest in the unboosted PI group—for all adherence levels. Variables that had a negative impact on adherence were high pill burden, dosing frequency of three or more times per day, and PI-based regimens.

Although this study showed that it's possible under certain circumstances to maintain an undetectable viral load with adherence of less than 90 percent, it must be emphasized that the goal of antiretroviral therapy is to achieve as high a level of adherence as possible. Doing so will help to ensure the regimen works, and it will minimize the risk of developing resistance to the drugs. ⊕

__David Yemchuk__ is a third-year pharmacy student at the University of British Columbia and a BCPWA Treatment Information Program volunteer.

British Columbia
Persons With AIDS Society



Spiritual Workshop

May 15–18, 2009

Non-denominational, unique, supportive and fun.
Join other HIV+ men and women, lakeside at the Bethlehem Retreat Centre on Vancouver Island for a 3 night, 4 day progressive workshop devoted to spirituality.

Organized by the BCPWA Retreat Team.
Designed & facilitated by Rev. Gary Paterson, Minister, St. Andrew's Wesley United Church with his spouse Rev. Tim Stevenson.
Generously supported by the Benedictine Sisters.

Interviews March 2 – April 10, 2009 at BCPWA

Register for an interview 604.893.2200 or 1.800.994.2437

Living well

The Living Well Lab
customizing
wellness

Study shows that complementary therapies improve quality of life

by Dave Boyack

If you've ever had a massage, you may recall having a blissful, relaxed, peaceful feeling. Have you visited a chiropractor? If so, you probably left feeling less pain or gained greater mobility. If you've seen a naturopath, you may have received help in selecting better food choices; perhaps you received an acupuncture treatment or learned about new ways to detoxify your body.

While the benefits of complementary therapies are often anecdotal, few studies have documented the health outcomes of people who receive such therapies. Rarer still are studies that document the health outcomes that complementary therapies give to PWAs.

In 2006, Friends For Life launched the Living Well Lab. It's a community-based study to document if complementary therapies have any impact on PWAs' wellbeing and quality of life. A core group of Friends For Life members were involved with the study from its inception and were trained as peer researchers to conduct and analyze the research. One hundred and ninety-four HIV-positive Friends For Life members responded to a series of five questionnaires over an 18-month period.

The study uncovered significant findings in participants' overall health and wellbeing. Sixty-five percent of respondents rated their general health as "excellent" or "very good" at the end of the study compared to only 37 percent at the beginning. They reported less pain, less stress, and a greater sense of wellbeing. In their view, their quality of life had improved as a result of receiving complementary therapies at Friends For Life.

Other findings showed that Friends For Life's services had a significant impact on members' physical, mental, emotional, social, and spiritual wellbeing. Data shows that members reported feeling less isolated, having more friends, eating better, having less pain, and having increased mobility.

Participants were asked if they noticed any changes in their lives since becoming Friends For Life members and receiving the services there. A dramatic number of people noticed major changes in themselves; 89 percent of them attributed these changes to Friends For Life and 92 percent felt these changes resulted in an improved quality of life.

The study also examined the reasons why members go to Friends For Life and their satisfaction with the services. Three-quarters of participants said they attend Friends For Life for relaxation, 50 percent said for nutrition support, and 48 percent said for daily social support. Study participants also expressed a very high degree of satisfaction with the services, rating their satisfaction levels at eight or nine out of 10. People were particularly pleased with the comfort of the physical surroundings, practitioners listening to them, and that their main health concerns were addressed.

> **Sixty-five percent of respondents rated their general health as "excellent" or "very good" at the end of the study compared to only 37 percent at the beginning. They reported less pain, less stress, and a greater sense of wellbeing.**

Focus groups and personal interviews with Living Well Lab participants revealed a significant communication gap with practitioners, since many indicated they generally don't tell their doctors about their complementary therapy use. People expressed a greater understanding of complementary therapies and a high degree of satisfaction with the Living Well Lab. They also offered some suggestions for improving programming, which Friends For Life staff is currently reviewing.

The Living Well Lab was a joint project with BCPWA and was funded through a grant from the Canadian Institutes of Health Research. It provided Friends For Life and BCPWA with important information for future planning in the delivery of complementary therapies for both organizations' members. ⊕

For further information

For further information about the Living Well Lab, contact project coordinator Andrea Mulkins at amulkins@telus.net.

***Dave Boyack** is a peer researcher on the project.*

BCPWA 2009 Volunteer Recognition Event Dinner

SOUTH PACIFIC
A NIGHT IN THE TROPICS

Thursday April 30
6:00-9:30PM

At the
Holiday Inn & Suites
Vancouver Downtown
1110 Howe St. @ Helmcken

Bring your sarongs and grass skirts!

Prizes for best costume in keeping with theme

Volunteer Tickets $10.00 deposit
($10.00 back at door)
Friends of Volunteers $25.00

For tickets see Marc S, Coordinator of Volunteer Services
t 604.893.2298 **e** marcs@bcpwa.org
or BCPWA, 1107 Seymour St., 2nd floor

Letting go

Find your path to healing by creating space in your life

by Alix Mathias

There's no way around it, life is a constant flow of beginnings and endings. We welcome and celebrate beginnings: births, a new job, finding love, buying a home. Graduations aside, we have a much lower opinion of endings: death, divorce, getting fired. We find something and we feel blessed; we lose something and we feel cursed. We try to clear the clutter and instead discover our new mantra is, "I might need that some day."

But being able to let go of the past and live fully in the present is a necessary step in all healing. Nature hates a vacuum; every time you let something go, you create space for something new to come into your life. Even breathing requires letting go. Any yoga teacher will tell you that the key to a healthy inhale is a complete exhale. Similarly, we need to empty our minds and lives of the old so we can receive that figurative breath of fresh air.

Without consciously letting go, it's easy to get stuck in a rut. Even our thoughts can get old. The way we think about others or ourselves determines our actions, and our actions determine the quality and richness of our experiences: "I'm shy." "Most people can't be trusted." "HIV is incurable."

Our thoughts literally become hardwired in our brain through repeated use. The complex system of neurons known as the neural network increases with use and decreases with disuse. Those obsessive thoughts about your ex-boyfriend or girlfriend result in a larger and larger portion of your brain's real estate being dedicated to him or her. Stop thinking about that person and eventually those neurons will disconnect, making your breakup complete.

Letting go isn't always easy. If you've had painful change thrust into your life, the thought of inviting more change might be highly unappealing. You may have cried out "Enough!" to the Universe after losing a lover, a job, and hope for the future. People in a state of grief understandably cling to things that hold meaning from the past.

Yet healing never lies in the past. Rather, you need to bring all your awareness to the present so you can see what needs to be given the heave-ho. The good news is that you can literally give yourself a good brainwashing by choosing to think affirming thoughts.

Your body knows a thing or two about letting go of the old to make room for the new. You make a new stomach lining every five days, new skin once a month, and a brand new liver every six weeks. One year from today, 98 percent of all the cells in your body will be born again. Your body is dynamic miracle of regeneration.

You can start creating little miracles of change in your own life with big and small gestures. Here are a few ways you can consciously release yourself from the past and make room for a brand new you:

- Write down 10 beliefs or habits you want to drop, then burn them one by one. Do it with flourish, or with friends for more dramatic effect.
- Clean out closets of old clothes. Send the old you to a thrift store.
- Throw away old letters and pictures, especially from relationships that no longer serve you.
- Say "yes" to something you'd normally never do.
- If you keep a journal, either start writing your memoir today or toss your old journals.
- Move your furniture around. You'll be amazed at how different you feel.
- Stop telling "your story"—the one about all the bad stuff that's happened to you. Find new ways to talk about the old you.
- Write a letter of forgiveness to someone who hurt you in the past. Then burn it—or send it if you dare.

Let yourself have a good cry or a hysterical laugh as you let go of people and things that have defined you. You're becoming fearless and showing the Universe that you trust. At first you may find yourself diving headfirst into the Smithrite after that photo of you and Joel (or was it Noel) at the Blondie concert, but it'll get easier. Really. ⊕

***Alix Mathias** is a writer, yogi, and health nut. She operates Catalyst Wellness Services with her husband in the Okanagan.*

Close to the bone

Make some nutrition and lifestyle changes to protect your bones

by Cheryl Collier

Your bones need your help. We hear more about the importance of keeping bones strong when we're young and growing but it's easy to forget to take care of your bones throughout your whole life. Aging is a risk factor for weakening of bones. And research suggests that people with HIV have a higher risk of developing weak bones than their HIV-negative counterparts. Whether this is because of the virus or highly active antiretroviral therapy isn't well understood.

PWAs have a higher risk of getting osteoporosis, a disease characterized by weak bones. People with this disease have an increased risk of broken bones, especially their hips, wrists, and spine. A related condition, osteopenia, is an earlier stage of osteoporosis where bones are beginning to weaken.

Both osteoporosis and osteopenia are diagnosed with a scan called bone densitometry, which measures bone density. This will tell your doctor if you have weak bones in key areas of your body. Keep in mind that bone diseases don't develop quickly—it takes time for bones to weaken. Some risk factors for developing these bone diseases—like aging and family history—can't be changed. However, lifestyle changes can help improve bone health. Whether or not you've been diagnosed with osteoporosis or osteopenia, it's not too late to protect your bones.

Get nutrition working for your bones

Nutrition works in many ways to help keep your bones healthy. To start, calcium and vitamin D are important nutrients for preventing bone loss and treating osteoporosis. The amount of calcium and vitamin D that your body needs depends on your age and increases if you have osteopenia or osteoporosis:

- Men and women aged 19 – 50 need 1,000 mg of calcium per day and 200 IU of vitamin D
- Men and women aged 51 – 70 need 1,200 mg of calcium per day and 400 IU of vitamin D
- If you have osteopenia or osteoporosis, aim for 1,500 mg of calcium per day and 1,000 IU of vitamin D

There are good sources of calcium and vitamin D in food. Along with calcium and vitamin D, sources of calcium from your diet often have other important nutrients needed for strong bones. For example, milk also contains protein, phosphorus, magnesium, vitamin A, and zinc. Dairy products score further points for providing calcium that the body seems to absorb well. If you have dairy allergies or you're lactose intolerant, you may want to replace milk with supplemented soy or rice milk. Give the container a good shake to make sure you're not leaving the calcium behind.

Don't forget supplements

For those who can't meet their nutrient requirements by food alone, supplements of calcium and vitamin D can also be helpful. Remember that here in Canada we can't rely on the sun as a reliable source for vitamin D for a good portion of the year—even if it's sunny out. Let your doctor and pharmacist know if you're taking or planning to take supplements.

When taking a tally of your daily calcium and vitamin D, don't forget to count your supplements. Most multivitamins pack between 175 – 200 mg of calcium and 400 IU of vitamin D. If you take calcium supplements, check if it also contains vitamin D. Most calcium supplements are better absorbed if taken with food and spread out through out the day.

There can be too much of a good thing, however. Keep your daily calcium and vitamin—from your diet and supplements—to less than 2,500 mg of calcium and less than 2,000 IU of vitamin D.

There are parts of your diet that can prevent calcium absorption, such as caffeine. Limit your consumption of coffee, tea, and colas. Too much caffeine—greater than four cups of coffee a day—is associated with increased risk of bone fractures. Here's more food for thought: sipping on too many caffeinated drinks may be replacing a good cup of milk!

Too much salt doesn't do your bones any favours, either. Try to keep your added salt and salty foods to a minimum to help prevent the sodium in salt from robbing your bones of their precious minerals.

Healthy bones need a healthy weight

A low body weight appears to be a key osteopenia and osteoporosis risk factor, in particular for people with HIV. We also

Table 1: **Sources of calcium in your diet**

	Serving size	Calcium (mg)
Dairy products		
Milk: whole, 2%, 1%, skim, buttermilk	1 cup	300 mg
Yogurt, plain	3/4 cup	300 mg
Cheese: brick, cheddar, gouda	1.5 oz	353 mg
Milk: dry powdered	3 tbsp	159 mg
Ice cream	1/2 cup	93 mg
Calcium fortified foods		
Calcium fortified soy milk or rice milk	1 cup	Approx. 300 mg
Meat, fish, poultry, alternates		
Salmon with bones, canned	1/2 of 213 g can	242 mg
Almonds	1/2 cup	200 mg
Beans, cooked (kidney, navy, garbanzo)	1 cup	90 mg
Tofu, set with calcium sulfate	1/2 cup	130 mg
Fruit and vegetables		
Figs, dried	10	270 mg
Orange	1 medium	52 mg

Source: Dietitians of Canada, Practice Based Evidence in Nutrition: Food Sources of Calcium

Table 2. **Sources of vitamin D in your diet**

	Serving size	Vitamin D (IU)
Fortified milk	1 cup	100 IU
Fortified soy beverage	1 cup	100 IU
Fortified margarine	2 tsp	53 IU
Salmon, canned, pink	3 oz	530 IU
Dry cereal, fortified with 10% of recommended daily value	3/4 cup	40-50 IU
Eggs	1 whole	25 IU

Source: Health Canada, Canadian Nutrient File

know that malnutrition is a risk factor for weakening of bones. Eating regular meals and a variety of different types of food is one way to help maintain a healthy weight.

Part of maintaining a healthy weight and keeping strong bones means getting the right amount of protein. People with HIV have higher protein requirements. Poultry, fish, beef, pork, egg, legumes, soy, and dairy products are all possible sources of protein to include with each meal.

That being said, it could be hard to eat a healthy balanced diet if you have a poor appetite or you're feeling unwell. If you're having trouble eating right or you're losing weight, speak with a dietitian.

Other lifestyle tips to consider

Along with keeping up with your bone health nutrition, consider other lifestyle changes that support bone health. Keeping active—in particular with strength exercises— helps to keep bones stimulated and promotes bone formation. Too much alcohol is hard on your bones, so drink it in moderation. More than two alcoholic drinks per day is associated with increased risk of osteoporosis. Quitting smoking is another important way to keep your bones strong.

It's never too late or too early to start thinking about your bones. That's the first step. From there, you can work on making healthy choices. Aim to get the calcium and vitamin D you need through diet, supplements, or both. Work on maintaining a healthy body weight. Enjoy activity, and limit other choices such as alcohol, smoking, caffeine, and salt. Your bones will thank you! ⊕

__Cheryl Collier__ is a registered dietitian with the HIV program at St. Paul's Hospital in Vancouver.

Organ grinder

HIV and meds can wreak havoc on your liver and kidney, so monitor them

by Ashley Smith

HIV and its treatment can compromise the function of your liver and kidney. That's why it's so important to monitor these organs, which are vital to excreting waste and detoxifying your body.

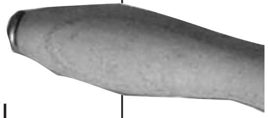
The liver maintains the detoxification of your body, as well as storing nutrients and releasing energy. Liver function tests monitor the state of your liver tissue as well as its ability to release bile—which is necessary for fat digestion—through the bile duct. You'll need a liver function test annually or more frequently depending on your highly active antiretroviral therapy (HAART) and your liver's health.

Like your liver, your kidneys can be harmed by antiretroviral therapy drugs, that's why you need to monitor your kidney function once you start a drug regime. Your kidneys are crucial because they establish the amount of water in your blood as well as the amount of electrolytes. Your kidneys also allow the excretion of soluble toxins from your liver. ⊕

Ashley Smith *is a volunteer with BCPWA's Treatment Information Program.*

Table 1: **Measuring kidney function**

Kidney function tests	Why and when	Normal values
Creatinine	≥ Normal byproduct of muscle breakdown ≥ High creatinine shows that kidney can't cope with normal function ≥ May be high if you're dehydrated, as blood will be concentrated ≥ Might be checked prior to CT scan as special dye given may harm kidneys	Men = 60 – 90 umol/L Women = 50 – 90 umol/L
Blood Urea Nitrogen (BUN)	≥ Measures the amount of urea in blood ≥ If kidneys aren't functioning properly, this may increase ≥ Dehydration will also cause increase BUN	2.5 – 8.0 mmol/L
Glomerular Filtration Rate (GFR)	≥ Looks at quantity of blood filtered by kidney in a given amount of time ≥ Assess kidney function	Men = 70 ± 14 mL/min/m2 Women = 60 ± 10 mL/min/m2



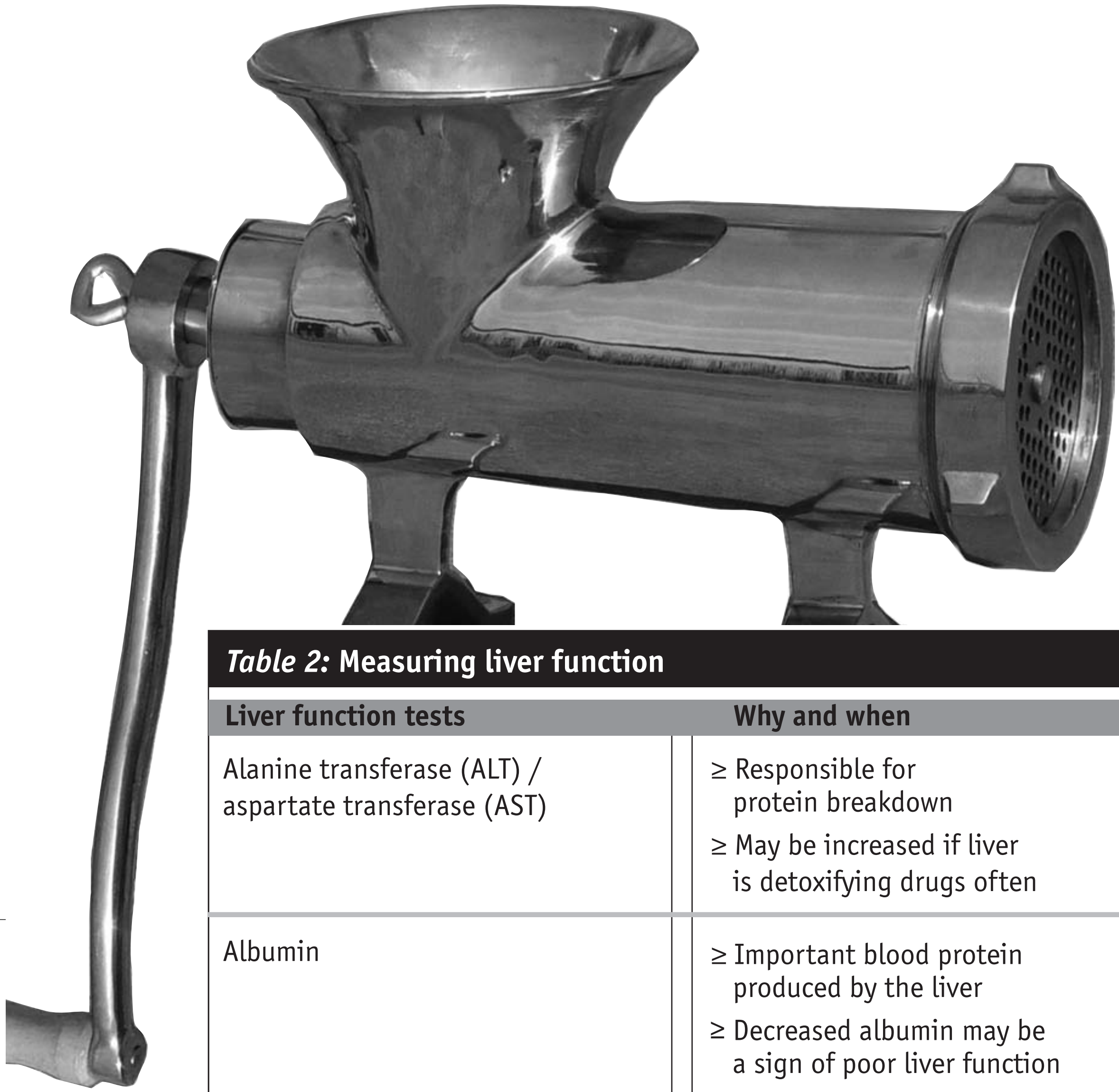


***Table 2:* Measuring liver function**

Liver function tests	Why and when	Normal values
Alanine transferase (ALT) / aspartate transferase (AST)	≥ Responsible for protein breakdown ≥ May be increased if liver is detoxifying drugs often	ALT = 5 – 60 u/L AST = 5 – 43 u/L
Albumin	≥ Important blood protein produced by the liver ≥ Decreased albumin may be a sign of poor liver function	39 – 50 g/L
Alkaline phosphate (ALP)	≥ Liver enzyme that is found in the liver as well as bones, intestine and kidneys ≥ May be indicative of blockage of bile duct if GGT is also high	ALP = 30 – 115 u/L
Bilirubin	≥ Produced by red blood cells as they break down ≥ May leak out to the bloodstream if liver damage is present	Total bilirubin < 20 umol/L
Gamma-glutamyl transpeptidase (GGT)	≥ Liver enzyme that is consistent with blockage of the bile duct ≥ Obesity, excessive alcohol intake and certain medications can raise GGP levels which is indicative of liver disease	GGT = 5 – 80 u/L

The Canadian Observational Cohort Collaboration

by Alexis Palmer

The Canadian Observational Cohort Collaboration (CANOC) was developed to evaluate the impact of antiretroviral care on the health and wellbeing of Canadians living with HIV/AIDS. CANOC provides opportunities for cohorts from across the country to work together on HIV/AIDS issues of national significance and examine research problems that the cohorts couldn't otherwise answer on their own.

This is Canada's first nationwide cohort to examine the effectiveness of antiretroviral therapy on a population's health. CANOC will help provincial and territorial governments and their respective health agencies to better understand current gaps in knowledge, treatment outcomes, and regional trends. It will also help inform best practice guidelines for treating HIV/AIDS.

Currently in the first stages of pooling data and resources, CANOC is comprised of 31 investigators with diverse skill sets from a number of leading Canadian research institutions across the country. It includes cohorts from the BC Centre for Excellence in HIV/AIDS, the Ontario HIV Treatment Network, Clinique Medicale l'Actuel, Montreal Chest Institute Immunodeficiency Service Cohort, the Electronic Antiretroviral Therapy, Maple Leaf Medical Clinic, and the Canadian HIV-HCV Coinfection Cohort Study. It is funded by the Canadian Institutes of Health Research and supported by the Canadian HIV Trials Network.

As of December 2008, over 3,000 participants met the inclusion criteria for the project: Currently, BC has 1,912 participants, Ontario has 585 participants, and Quebec has 604 participants. Over 76 percent are male, 8.4 percent identify as Aboriginal, and the median age is 41 years.

Of the data collected to date, there appears to be a number of differences between regions in Canada. One-quarter of participants in BC reported using injection drugs, compared to eight percent of participants in Ontario, and nine percent in Quebec. The baseline CD4 counts varies by province: 170 cells/mm^3 in BC, 194 cells/mm^3 in Ontario, and 212 cells/mm^3 in Quebec. Preliminary analyses have also shown differences in viral load testing and viral load suppression between regions.

CANOC has also established an award for qualified applicants at the Masters, PhD, post-doctoral, or clinician levels enrolled in an academic program at any Canadian university or research centre. In this first year, three students were selected for CANOC studentships. Aranka Anema, a PhD candidate from the University of British Columbia will work with the CANOC data to assess the impact of food insecurity and malnutrition on HIV treatment outcomes. Luke Swenson, a Masters student at the University of British Columbia, will work with the CANOC group to investigate HIV immune escape and drug resistance with regard to the emergence of antiretroviral drug resistance. The third student, Tony Antoniou from the University of Toronto, will conduct pharmaco-epidemiologic research using the CANOC database. All three awardees have previous experience in the field of HIV/AIDS research and have demonstrated academic and community leadership.

The students' findings, along with other findings, have the potential to significantly improve clinical outcomes of vulnerable groups and to inform clinicians and policy makers about how to best mitigate compounding health and social concerns. Canada is unique in that it has diverse regional differences in populations affected by HIV. Through CANOC, we can examine the variations in clinical management and treatment outcomes within a universal healthcare system. ⊕

__Alexis Palmer__ is a project coordinator with the Drug Treatment Program at the BC Centre for Excellence in HIV/AIDS in Vancouver.

Updates from the Canadian HIV Trials Network

First study to test HPV vaccine in HIV

by Suzanne MacCarthy

CIHR Canadian HIV Trials Network investigator Dr. Deborah Money, executive director of the Women's Health Research Institute in Vancouver, is leading the world's first clinical trial to evaluate the human papillomavirus (HPV) vaccine (Gardasil) in HIV-positive women and girls (CTN 236).

Enrolling in BC at the Oak Tree Clinic, CTN 236 is vital to understanding how safe and effective the nationally administered vaccine is in HIV-positive females.

"HIV-positive women are the most vulnerable to HPV infection, says Dr. Money. "Not only are they twice as likely to be infected with HPV than their HIV-negative counterparts, they generally have more severe genital warts and are more likely to progress to cervical cancer."

The interactions between HPV and HIV are not fully understood. CTN 236 researchers believe that HIV infection, along with co-factors such as age and injection drug use, will substantially affect how a female's immune system responds to the HPV vaccine. Vaccine studies for influenza and hepatitis B have demonstrated a weaker immune response in HIV-positive people.

The HPV vaccine can prevent four of the 30 types of HPV that infect the genital region through skin-to-skin and sexual contact. Types six and 11 cause 90 percent of genital warts; and types 16 and 18 are responsible for an estimated 70 percent of cervical cancer, claiming 400 deaths a year in Canada.

National project manager Lisa Venables notes, "determining the effectiveness of the HPV vaccine in HIV-positive females is crucial before implementation in countries where there's a high prevalence of HIV."

CTN 236 will use the same standard dosing schedule and vaccine amount currently being used in HIV-negative women and girls. Researchers are optimistic that study results will help identify HIV-infected individuals who will most benefit from this vaccine and suggest whether alterations in vaccine dosing, such as boosters, may be recommended.

This is a five-year study recruiting 500 HIV-positive female participants at 16 sites across Canada over a two- to three-year period. Females who have had HPV are still eligible, as most females will not have been exposed to all four types of the virus. The Oak Tree Clinic will be the only BC study site and is expecting to recruit one-fifth of the total enrolment.

The Oak Tree Clinic is located at B4 West, 4500 Oak Street in Vancouver. ⊕

__Suzanne MacCarthy__ is the information and communications coordinator at the CIHR Canadian HIV Trials Network in Vancouver.

Trials enrolling in BC

CTN 239—	Phase II study of AGS-004 an immunotherapeutic agent in combination with ART followed by ART interruption *BC sites*: St. Paul's Hospital, Vancouver
CTN 238—	The MAINTAIN study *BC sites*: Downtown Infectious Diseases Clinic (CIDC), Vancouver; St. Paul's Hospital, Vancouver
CTN 237—	Influenza vaccination strategies using Fluviral in HIV-positive adults *BC sites:* Downtown Infectious Diseases Clinic (DIDC), Vancouver
CTN 236—	HPV vaccine in HIV-positive girls and women *BC sites:* Oak Tree Clinic, Vancouver
CTN 233—	Pharmacokinetics of antiretroviral therapy (ARV) in HIV-positive women *BC sites:* Children's and Women's Hospital, Vancouver; St. Paul's Hospital, Vancouver; DIDC, Vancouver
CTN 222—	Canadian Co-infection Cohort *BC sites:* DIDC, Vancouver; St. Paul's Hospital, Vancouver
CTN 218—	Effect of rosuvastatin (Crestor) on blood vessels *BC sites:* St. Paul's Hospital, Vancouver
CTN 214—	Effect of a One-Year Course of HAART in Acute/Early HIV *BC sites:* DIDC, Vancouver; Cool Aid Community Health Clinic, Victoria
CTN 194—	Peg-Interferon and Citalopram in Co-infection (PICCO) *BC sites:* St. Paul's Hospital, Vancouver; DIDC, Vancouver

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

British Columbia
Persons With AIDS Society

Look for your AGM package in the mail beginning mid-July 2009.

Notice of Annual General Meeting

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

Please note that SIX two-year term positions on the Board of Directors of the Society are to be elected for the period 2009-2011.

WHEN:	Saturday, August 22, 2009 at 11:00AM
WHERE:	TBD
REGISTRATION:	10:00 – 11:00AM
MEETING BEGINS AT:	11:00 AM (sharp)

IMPORTANT DATES TO REMEMBER

By June 19, 2009	Resolutions from the Members to be submitted to the Secretary of BCPWA
Not later than July 14, 2009	Mail out of AGM packages
On August 4, 2009	For individuals who do not receive mail, AGM packages will be ready for pick up from Member Services (reception) desk
August 7, 2009	Last day proxies are mailed
August 14, 2009	Last day proxies may be requested for pick up

Members wishing to have business placed on the agenda for the Annual General Meeting should submit it prior to June 19, 2009. A letter to the Secretary of the Society containing:

(1) a brief paragraph describing the specific intent of the business, and

(2) a properly worded motion pertaining to the business should be sent to the Society's registered office at: 1107 Seymour Street, Vancouver, BC, V6B 5S8

If you have any questions or would like to receive a copy of the Society's Annual Report, please call Keith Morris, Secretary, at 604.893.2214 and leave a confidential message. To ensure accuracy, please spell your last name slowly and leave a contact phone number. All documents (except proxy forms) relating to the AGM are also available on the Society's website at: **www.bcpwa.org.**

A lunch will be served.

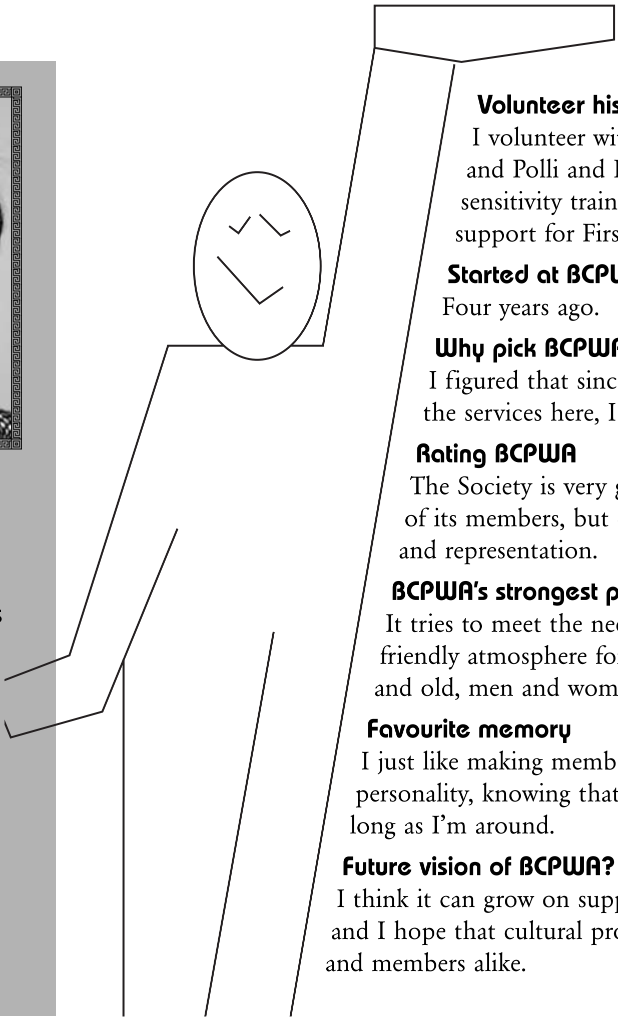
If you require ASL interpretation, please contact the Secretary of the Society.

Volunteering at BCPWA

Profile of a volunteer: Tia Eagle-Claw I

"Tia is a valued volunteer, always a cheerful face in the Internet Café. She can be relied on to hold the fort when other volunteers can't make it in."

Ruth Marzetti,
Director of
information technology



Volunteer history

I volunteer with Member Services, the Internet Café, and Polli and Esther's. I have done First Nations cultural sensitivity training, computer training for members, and support for First Nations members.

Started at BCPWA

Four years ago.

Why pick BCPWA?

I figured that since I became HIV-positive and would use the services here, I would like to contribute what I possess.

Rating BCPWA

The Society is very good in dealing with the needs of its members, but does lack in cultural sensitivity and representation.

BCPWA's strongest point

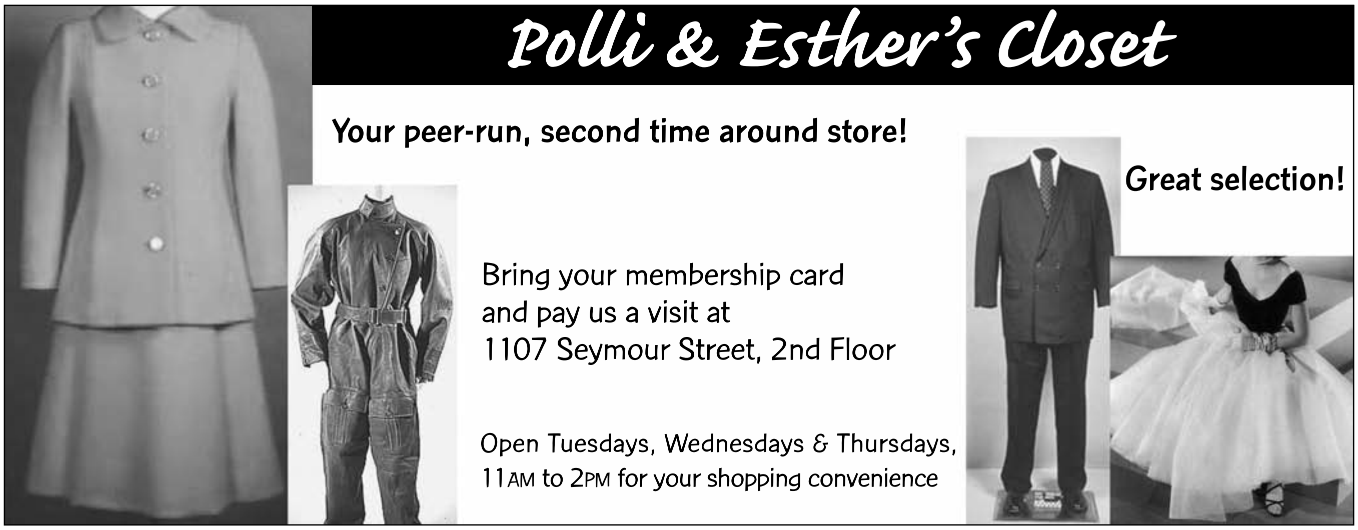
It tries to meet the needs of its members and tries to be a very friendly atmosphere for all involved, from straight to gay, young and old, men and women, HIV-positive and negative.

Favourite memory

I just like making members smile and giddy with my high theatrical personality, knowing that I'll have these newly found friends for as long as I'm around.

Future vision of BCPWA?

I think it can grow on supplying pertinent services for all members and I hope that cultural programs are initiated for all staff, volunteers, and members alike.



PRISON OUTREACH PROGRAM

(POP)

We assist prisoners living with HIV/AIDS through advocating for better healthcare, the early release of terminally ill prisoners and improved harm reduction services. We also provide information on treatment and free services (such as the Complementary Health Fund). We regularly visit provincial and federal correctional centers across the lower mainland to provide support and counseling.

British Columbia
Persons With AIDS Society

The rate of HIV inside Canadian prisons is 10 times higher than it is on the outside. If you are infected with HIV, you might not have any symptoms. In fact, you may not feel sick for 2 to 10 years after being infected!

In prison, HIV is spread through sharing needles, tattooing or piercing equipment and unprotected anal, oral or vaginal sex.

HIV is found in blood, semen (pre-cum), vaginal fluid and breast milk.

Even if a person is a skilled tattoo artist, it doesn't mean that their equipment is clean.

- Clean your tattoo works (needles and shaft) with bleach
- Don't reuse ink. You can't see the HIV or HEP C virus.
- Don't reuse rags, bandages or gloves.

If you share rigs or spoons/cookers, clean them with bleach whenever you can.

Filters should never be shared because they can't be cleaned.

Kill the HIV virus:

Clean your rigs, tattooing and piercing equipment with bleach.

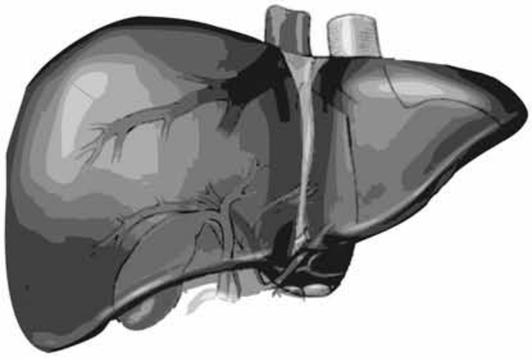
1. Draw fresh, cold water into syringe, and squirt down the drain. Repeat twice.
2. Then do the same with full strength bleach, shake for 30 seconds, squirt down the drain. Repeat twice.
3. Repeat Step 1. Make sure you get all the bleach out before you use the needle again!

Cleaning equipment with bleach is not 100% effective.
Bleach does not kill the HEP C virus.
Cleaning a rig immediately after use works the best.

You WILL NOT get HIV by…

- sharing food or eating food that is handled by someone with HIV
- sharing drinks
- sharing a house
- sharing cigarettes
- sharing a shower
- sharing a toilet or sink

It is a lot easier to be infected with HEP C than it is to be infected wit HIV!



Even if you are HIV-positive, you can still be re-infected with a different strain of HIV! There are many strains of HIV and some are resistant to some medications.

The ONLY way to find out if you have HIV or HEP C is with a blood test. It can take up to 6 months for someone to test positive for HIV after they have been infected! To be sure, get tested now and get tested in 6 months. You can be tested by healthcare.

Protect yourself!

1. Assume that everyone is infected. Some people are positive and they don't know it!
2. Clean your rigs.
3. Use a condom and lots of lube

If you are HIV-positive, newly diagnosed or just have questions, call the Prison Outreach Program at 604.525.8646. This hotline is confidential and it is available to prisoner's everyday from 10:00AM to 10:00PM. Collect calls are accepted.

www.bcpwa.org

where to find help

If you're looking for help or information on HIV/AIDS, the following list is a starting point.

A Loving Spoonful
Suite 100 – 1300 Richards St,
Vancouver, BC V6B 3G6
604.682.6325
e clients@alovingspoonful.org
www.alovingspoonful.org

AIDS Memorial Vancouver
205 – 636 West Broadway,
Vancouver BC V5Z 1G2
604.216.7031 or 1.866.626.3700
e info@aidsmemorial.ca *www*.aidsmemorial.ca

AIDS Society of Kamloops
P.O. Box 1064, 437 Lansdowne St,
Kamloops, BC V2C 6H2
t 250.372.7585 or 1.800.661.7541
e ask@telus.net

AIDS Vancouver
1107 Seymour St, Vancouver BC V6B 5S8
t 604.893.2201 *e* av@aidsvancouver.org
www.aidsvancouver.bc.ca

AIDS Vancouver Island (Victoria)
1601 Blanshard St, Victoria, BC V8W 2J5
t 250.384.2366 or 1.800.665.2437
e info@avi.org *www*.avi.org
AIDS Vancouver Island (Campbell River)
t 250.830.0787 or 1.877.650.8787
AIDS Vancouver Island (Port Hardy)
t 250.949.0432
AIDS Vancouver Island (Nanaimo)
t 250.753.2437
AIDS Vancouver Island (Courtenay)
t 250.338.7400 or 1.877.311.7400

ANKORS (Nelson)
101 Baker St, Nelson, BC V1L 4H1
t 250.505.5506 or 1.800.421.AIDS
f 250.505.5507 *e* info@ankors.bc.ca
http://kics.bc.ca/~ankors/

ANKORS (Cranbrook)
205 – 14th Ave N Cranbrook,
BC V1C 3W3
250.426.3383 or 1.800.421.AIDS
f 250.426.3221 *e* gary@ankors.bc.ca
http://kics.bc.ca/~ankors/

Asian Society for the Intervention of AIDS (ASIA)
210 – 119 West Pender St,
Vancouver, BC V6B 1S5
t 604.669.5567 *f* 604.669.7756
e asia@asia.bc.ca www.asia.bc.ca

BC Persons With AIDS Society
1107 Seymour St, Vancouver BC V6B 5S8
604.893.2200 or 1.800.994.2437
e info@bcpwa.org *www*.bcpwa.org

Dr Peter Centre
1100 Comox St,
Vancouver, BC V6E 1K5
t 604.608.1874 *f* 604.608.4259
e info@drpetercentre.ca
www.drpetercentre.ca

Friends for Life Society
1459 Barclay St, Vancouver, BC V6G 1J6
t 604.682.5992 *f* 604.682.3592
e info@friendsforlife.ca
www.friendsforlife.ca

Healing Our Spirit
3144 Dollarton Highway,
North Vancouver, BC V7H 1B3
t 604.879.8884 or 1 866.745.8884
e info@healingourspirit.org
www.healingourspirit.org

Living Positive Resource Centre Okanagan
101–266 Lawrence Ave.,
Kelowna, BC V1Y 6L3
t 250.862.2437 or 1.800.616.2437
e info@lprc.ca
www.livingpositive.ca

McLaren Housing Society
200 – 649 Helmcken St,
Vancouver, BC V6B 5R1
t 604.669.4090 *f* 604.669.4092
e mclarenhousing@telus.net
www.mclarenhousing.com

Okanagan Aboriginal AIDS Society
101 – 266 Lawrence Ave.,
Kelowna, BC V1Y 6L3
t 250.862.2481 or 1.800.616.2437
e info@oaas.ca *www*.oaas.ca

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

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

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

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

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

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

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

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

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

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

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

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

For more comprehensive listings of HIV/AIDS organizations and services please visit 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 11, 2009	1:00	Board Room	Financial Statements—December / Executive Committee
March 25, 2009	1:00	Board Room	Written Executive Director Report / Director of Support
April 8, 2009	1:00	Board Room	Standing Committees / Financial Statements—January Quarterly Department Reports—3rd Quarter
April 22, 2009	1:00	Board Room	Written Executive Director Report / Executive Committee Director of Development
May 6, 2009	1:00	Board Room	Director of APT

BCPWA Society is located at 1107 Seymour St., 2nd Floor, Vancouver.
For more information, contact: Alexandra Regier, director of operations Direct: 604.893.2292 Email: alexr@bcpwa.org

BCPWA Standing Committees and Subcommittees

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

Board & Volunteer Development
Contact: Marc Seguin
t 604.893.2298 *e* marcs@bcpwa.org

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

Education & Communications
Contact: Adam Reibin
t 604.893.2209 *e* adamr@bcpwa.org

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

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

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

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

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

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

Yes! I want to receive living⊕ magazine

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○ $25 within Canada ○ $50 (Canadian $) International
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○ BC ASOs & Healthcare providers by donation: Minimum $6 per annual subscription
please send ______ subscription(s)

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

○ Enclosed is my donation of $______ for ***living*⊕**

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

www.bcpwa.org

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

Are you HIV-positive?

www.bcpwa.org

living⊕ Magazine

Fundraising Events

Treatment Information

Support Services

Volunteer Opportunities

Advocacy Services

Positive Prevention

Prison Outreach

British Columbia

Persons With AIDS Society

604.893.2200