

inside

**05▷ GENERATION NEXT**

Personal accounts from people who are recently diagnosed with HIV.

**07▷ ACCOLAIDS**

BCPWA's 2009 awards gala honours heroes in the BC AIDS movement.

**12▷ ADVOCACY**

A new human rights movement aims to ensure everyone has access to HIV treatment, even in developing countries.

**15▷ PREVENTION**

Serosorting and barebacking is not risk-free.

**40▷ LAST BLAST**

The hard reality of flagging sexual interest.

features

**09 THE CRIMINALIZATION OF HIV**

Since 1989, 75 PWAs have been charged with aggravated sexual assault. Some have been sentenced to jail. How did HIV and sex come to be criminalized?

**20 DOCTORS' PRACTICES**

As HIV treatment evolves, what are the emerging trends in physician practices? Living Positive speaks to three doctors.

**17▷ NUTRITION**

- ▶ The effects of sugar consumption are not so sweet. It can damage your immune system.
- ▶ How to beat heartburn before it develops into something more serious

**23▷ ANTIRETROVIRALS**

Therapeutic drug monitoring can help you determine the best dosage for you

**24▷ CROI 2009**

A report on the 16th Conference on Retroviruses and Opportunistic Infections.

**27▷ WOMEN'S ISSUES**

The latest studies on HPV and HIV-positive women.

**28▷ DRUG COVERAGE**

The catastrophe of unequal drug coverage across Canada and how to fix it.

**30▷ GENERAL HEALTH**

Men tend to get squeamish talking to their doctors about their prostate.

**32▷ SIDE EFFECTS**

If you're HIV-positive, you're more susceptible to skin cancers from the sun.

**33▷ LET'S GET CLINICAL**

The latest news and trials at the CIHR Canadian HIV Trials Network.

**34▷ DIAGNOSTICS**

Part 3 in our series of understanding blood test results.

**36▷ STRAIGHT FROM THE SOURCE**

The Antiretroviral Cohort Collaboration.

treatment  
information

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# think ⊕

opinion & editorial . . .

## The work we do

by Glyn Townson

If you're an avid *Living Positive* reader, you know that this opinion/editorial page is usually reserved for the board chairperson to share his/her thoughts on pressing social, governmental, and BCPWA business, and to give you a call to action on those matters. Over the coming months, there's no shortage of issues and events in our community that need your support—and I urge you to visit [www.bcpwa.org](http://www.bcpwa.org) and subscribe to BCPWA eNews to keep up-to-date. However, in this edition of the magazine, I want to take the opportunity to acknowledge the outstanding work our organization does every day to empower British Columbians living with HIV/AIDS. We've made some great achievements and we deserve to be proud.

Most recently, from March 27 to 29, BCPWA was one of 13 AIDS service organizations from across the province to host the 2009 Positive Gathering. The highly successful annual conference developed for and by HIV-positive British Columbians was coordinated by BCPWA and I'm particularly proud of the result. Our theme this year was "Strength in Diversity" and it was wholly evident in the wide variety of ethnicities, genders, sexualities, and ages represented at the interactive, informative, and relevant workshops.

Positive Gathering is only one example of our strengthening provincial focus. Over the past few months, our Prevention Department team has made a great start in connecting with individuals who are newly diagnosed with HIV in Kelowna

and Victoria through the Newly Diagnosed Workshop series. Presented in conjunction with local AIDS service organizations, this series offers newly diagnosed and HIV-naïve individuals optimism, support, and information on everything from the legal aspects of disclosure to disease progression and complementary therapies. Our next workshop is planned for the Fraser Valley. If you're interested in having our team visit your community, contact Elgin Lim, director of prevention, at [elginl@bcpwa.org](mailto:elginl@bcpwa.org).

Be sure, we haven't forgotten about those newly diagnosed individuals who don't have immediate access to our workshops. BCPWA is working closely with the BC Centre for Disease Control to provide each HIV public health nurse in the province with a supply of information packages tailored specifically for the newly diagnosed population. These will include educational resources and information on how to connect with relevant programs and services, from BCPWA and beyond.

So, when you read this issue of *Living Positive*, I ask you to remember that it's just one part of the puzzle. Our work certainly doesn't end here, and we're proud to offer all our services to the HIV community across BC. ⊕



Glyn Townson is  
BCPWA's chairperson.



# REALITYBITES

News from home & around the world



## Prezista approved by Health Canada

Prezista can now be used by people with HIV regardless of their treatment history. On February 11, 2009, Health Canada approved Prezista for treatment-experienced PWAs. Then on March 13, 2009, Health Canada approved it for treatment naïve PWAs as well. Manufactured by Tibotec Pharmaceuticals, Prezista (generic name darunavir) is a once-daily protease inhibitor taken in combination with ritonavir (Norvir).

## Kaletra might cause heart rhythm disturbances

The US Food and Drug Administration (FDA) has revised the prescribing instructions for the protease inhibitor Kaletra (lopinavir plus ritonavir) to include a new warning about heart rhythm disturbances that might be caused by the drug. While the agency points out that studies haven't definitely linked Kaletra to these problems, it is nonetheless suggesting that healthcare providers be cautious when prescribing the drug to anyone with underlying heart problems or to those using other drugs known to cause heart rhythm disturbances.

According to the FDA, two types of heart rhythm problems might be associated with Kaletra. The first, known as PR interval prolongation, consists of prolonged electrical impulses in the atria and has been noted in some people taking Kaletra. In particular, there have been several case reports of serious conduction problems in the atria, known as atrioventricular block.

The second heart rhythm problem involves slowed conduction of electrical impulses in the larger ventricular chambers. This is called QT interval

prolongation, and there have also been cases noted in people taking Kaletra.

Source: [www.poz.com](http://www.poz.com)

## Phase 1 trial on ABT-450

Abbott and Enanta Pharmaceuticals are initiating a Phase 1 trial of ABT-450, an oral protease inhibitor to treat chronic hepatitis C (HCV). The trial will be a double-blind, placebo-controlled study. The objectives include assessing safety, tolerability, and pharmacokinetics.

ABT-450 has demonstrated favourable potency in-vitro across various HCV genotypes and highly-resistant strains.

## US launches AIDS campaign aimed at most affected

US officials have launched an AIDS awareness campaign that focuses on the groups most likely to be infected, starting with black men and women and later targeting Latinos and others.

Several studies have shown that AIDS prevention messages aren't getting through to the people who need to hear them most.

The campaign focuses on one statistic—that every 9 1/2 minutes on average another American becomes infected with HIV. The five-year, \$45 million USD campaign will use video, audio, print, and online advertising to urge people to abstain from sex or use condoms, and to talk frankly about the risks of HIV with sexual partners. The campaign will also include efforts to get the media and entertainment industries to carry safer-sex and prevention messages.

The AIDS Healthcare Foundation called the advertising plan a disappointment and urged the government to instead spend \$200 million to get more people tested for HIV.

Source: *Thomson Reuters*

## HIV detectable in semen of men with undetectable viral loads

At the 16th Conference on Retroviruses and Opportunistic Infections in Montreal, two back-to-back oral presentations affirmed that HIV is indeed often detectable in semen despite undetectable viral loads in blood plasma. The two studies found measurable HIV RNA in 3 to 14 percent of seminal fluid samples taken from study participants with undetectable plasma viral loads.

Since the "Swiss statement" of January 2008, which described HIV-positive individuals on effective antiretroviral therapy and without sexually transmitted infections as "sexually non-infectious," the issue of how antiretroviral treatment affects sexual infectiousness has been hotly debated. In particular, case reports have indicated that HIV may indeed be present in the semen of men who are on successful antiretroviral therapy, with undetectable blood plasma viral loads.

Source: [aidsmap.com](http://aidsmap.com)

## Process proposed to expedite export of low-cost HIV drugs

Canadian Senator Yoine Goldstein has proposed a bill that would reform Canada's Access to Medicines Regime (CAMR) by expediting the process of exporting generic drugs for diseases such as HIV to developing countries. The bill would address provisions in the Patent Act, which in 2004 was amended to create exemptions to intellectual property rules, thereby allowing generic drug manufacturers to produce low-cost drugs for diseases in developing countries.

Since 2004, only one shipment of drugs has been exported by the generic drug manufacturer Apotex. At the time

*continued on next page*



# REALITYBITES

News from home & around the world



of shipment, Apotex said the process was too cumbersome and costly.

The law currently requires generic pharmaceutical companies to qualify for each individual shipment of drugs exported. Goldstein's proposal would allow generic drug companies to send multiple shipments of a drug to several countries without having to re-qualify for each shipment. Under the bill, nongovernmental organizations would also be able to buy and distribute generic medications through CAMR.

Source: [www.kaisernetwork.org](http://www.kaisernetwork.org)

## HIV treatment alone is often enough if catch KS early

The majority of people who catch AIDS-related cancer Kaposi's sarcoma (KS) in its earliest stage and quickly begin taking antiretroviral therapy may not require treatment with chemotherapy, according to a study presented at the 15th Annual Conference of the British HIV Association in Liverpool.

To determine the success of antiretroviral therapy on KS progression, researchers at Chelsea and Westminster Hospital in London examined the medical records of 254 HIV-positive people who were diagnosed with KS over a 12-year period. Less than one fifth were taking antiretrovirals at the time of their KS diagnosis, and only 7 percent had an undetectable viral load. Most of the people had their KS diagnosed at the earliest stage. In all of these people with very early KS, treatment was initially restricted to antiretroviral therapy alone.

It turned out that antiretroviral therapy alone was sufficient to at least halt KS disease progression in the majority of the

people with early stage KS. Only 22 percent required additional treatment with chemotherapy, and only one person died from KS.

Source: [www.aidsmeds.com](http://www.aidsmeds.com)

## Thousands in Uganda, Kenya misdiagnosed as positive

A new study suggests that thousands of HIV-negative Kenyans and Ugandans were incorrectly diagnosed as positive due to faulty tests at voluntary counselling and testing centres.

The study involved 6,255 people between ages 18 and 60 who sought counselling and testing services at sites in both countries. When two different tests were performed on participants, 131 had

"discrepant" results where one was positive and the other negative. On the third test, 27 were confirmed to be HIV-positive.

Researchers found that rapid tests such as Determine, Uni Gold, and Capillus are normally used in poor societies because they're cheap and that confirmatory tests aren't usually done at testing sites in either country.

The risk of inaccurate diagnoses rises when rapid tests are done once without a confirmation test. Therefore researchers suggest that positive results always be administered with a follow-up test before a diagnosis is made.

Source: [www.poz.com](http://www.poz.com) ⊕



Photo by Leonid Dushyn

CBC's Fred Lee ("Steppin' Out") was hosting the live auction at this year's AccolAIDS gala on April 19<sup>th</sup>.

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## ***Generation next: Newly diagnosed with HIV***

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# AN EMOTIONAL ROLLER COASTER

*by Wes*

I discovered that I was HIV-positive in December 2007. My partner, Patrick, and I had decided we should both get routine testing done. We were coming up to our 10th anniversary together and were leaving soon on a much-anticipated three-week vacation to South America. So it was a busy time for us.

When I got the call that my family doctor wanted to discuss my test results with me, I was surprised. No doctor had ever wanted to discuss any test results with me and I had always gotten the results over the phone. At first I didn't understand and asked his receptionist to just read them to me over the phone. When his receptionist said no, that the doctor wanted me to come in to discuss the results personally, I remember thinking to myself: "This can't be good."

I called one of my best friends, Steve, who is in the medical profession and he tried to reassure me that it could be anything and not necessarily something catastrophic. But I could feel he was just trying to not make me panic.

Since I told the receptionist that I was leaving town in a couple of days, he scheduled me to see the doctor right away as his last appointment of the day. I was worried but kept telling myself it could be anything. Since I thought I had been pretty safe sexually, I wasn't even thinking that it would necessarily be an HIV diagnosis. Or I was pushing it out of my mind. I'm not sure.

When I got to the doctor's office, was it my imagination or was the receptionist avoiding eye contact? Was he feeling sorry for me knowing that my life was about to disintegrate? What did he know that I didn't know? I was feeling a little paranoid.

When Jim, my doctor, called me in, I sat down. He took out my file, looked at it, and said quite simply that my test had come back positive for HIV but that Patrick's had come back negative. It's still kind of a blurry memory—I guess I was in a state of shock.

### **A compassionate doctor**

For once I was happy that Jim was so detail-oriented in his explanations. He took his time with me. He gave me his HIV 101 course. He told me I wasn't "sick" but that the test showed I had been exposed to the virus. He told me I didn't have AIDS. He said that I might not ever develop AIDS-related illnesses, and that I would probably never die of AIDS. He explained the basics of HIV infection, T-cell counts, viral loads, medications, and all the progress made in the field of HIV research in the last years.

Jim said that on average, people didn't need to go on medication until five to seven years after infection. For the time being, he said, I should try to live my life normally. He also told me to get more complete blood work done and the results would be ready by the time I returned from vacation. He was very kind and empathetic. I felt so grateful that I had chosen him, a gay doctor—who I knew had experience in the field if HIV/AIDS—as my family doctor almost 16 years ago. He spent a good hour with me.

When I left his office, I started to feel the panic and fear. I called Steve, who once again was reassuring. I went home. I told my partner, Patrick. I guess I cried a little. He wasn't angry with me. He was supportive, which is what I needed at that

moment. I was mostly worried about him because we had had unprotected sex up until about a week before getting tested, so he wasn't out of the woods yet and would need to be retested in a few months.

I felt really angry with myself. For over 15 years I had been leading a healthy lifestyle: excellent diet, gym every day, biking everywhere, and absolutely no drugs or alcohol. How could I have screwed up my life like this at age 55?

I still don't really know how or when I got infected: I was almost always the top and never let guys cum in me. I now know that *low risk* doesn't mean *no risk*.

### **A range of emotional reactions**

I felt more embarrassment than shame. Embarrassed that I could have been so stupid to get infected when I "knew better." That's why I didn't want to tell my friends.

I felt the fear of condemnation. I started hearing those old biblical tapes in my head from childhood about reaping what you sow and men who lie with men. At the same time, I told myself that this wasn't rational.

I was afraid of getting sick. I hadn't really lived through the AIDS epidemic in Canada. I hadn't seen people getting sick and dying by the droves, but I had seen a few people become ill and die. Most of my friends who were HIV-positive were healthy and built like brick shit houses. They worked and had normal, productive lives. They were so healthy-looking that I usually even forgot that they were HIV-positive and I sometimes joked that they looked better than the rest of us. But I was still afraid. I wanted to take something right away to make it go away.

**I was determined that my HIV status wouldn't become the focus of my life as long as I was healthy. But I did feel the need to somehow deal with it.**

I was terrified that I wouldn't be able to work, that I would be poverty-stricken, and that my whole life would go down the drain.

All of a sudden, I found myself thinking about how to best use the remaining five to seven years of my life. Somehow, my brain had turned my doctor's reference to five to seven-year period before needing to go on medications into a death sentence! I started thinking about insurance, moving, subsidies, and all kinds of crazy ideas.

I was acutely aware that even though I felt fine, there was something deadly coursing through my veins and I didn't like it. I started magnifying every sensation in my body and imagining it was the start of AIDS.

Sometimes I felt dirty and that everything inside my body and coming out of my body was dirty.

### **Getting more advice and information**

Fortunately, we were leaving on vacation right away, the holiday season was upon us, and I just decided to deal with it all later. I actually managed to block almost everything out and enjoy myself until we returned from vacation in mid-January. Then the anxieties came back with a vengeance.

I felt very isolated, even though I have a lot of friends. Steve cautioned me about disclosure, since once something is said, it can't be unsaid. This was good advice. I only told one other very close friend. I went through a few rough weeks of angst and depression. But the spiritual and practical tools for living that I've learned as an active member of a 12-step program really helped me deal with my feelings and get through this period. I remember some days just white-knuckling it and telling myself, "This too shall pass." I did tell a couple more trusted HIV-positive friends about my diagnosis, more for practical advice and support than for anything else. I didn't want pity.

I was determined that my HIV status wouldn't become the focus of my life as long as I was healthy. But I did feel the need to somehow deal with it. So I answered an ad for newly diagnosed people to see a specialist and set up an appointment for Patrick and myself.

The appointment was a big help. Once again, I felt a lot of reassurance and hope. The doctor even said to my partner: "We're not going to let Wes die of AIDS." He explained the ins and outs of the available medications, treatment, and living in a serodiscordant relationship. Patrick got tested again and the results came back negative. I felt a great deal of relief.

Life goes on

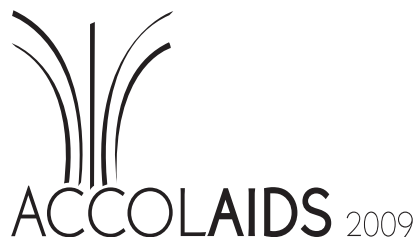
Life is busy. I've continued to get my blood work done on a regular basis and the results just keep getting better: "normal" T-cells and plummeting viral loads. So I've felt better and managed to keep my diagnosis on the back burner. At the same time, I still had a nagging need to somehow deal more fully with the whole issue of being HIV-positive. I joined Friends For Life and BCPWA just because I thought I should, might need it someday, and might be able to do some good as a volunteer at some point.

Then last fall, I saw a poster advertising a six-week BCPWA workshop for newly diagnosed men. The workshop was the best thing I could have done. I learned a lot and through it have become much more comfortable as a healthy guy who is HIV-positive.

Sure, I still have moments when I experience some of those initial negative feelings like fear, anger, and embarrassment. But they're fleeting moments and no longer stretch into hours, days, or weeks. Today, my primary desire is to forget the threat of death, get on with the business of living, and enjoy my overall feelings of hope and optimism. ☺

**Wes** is a member of BCPWA.

# All-stars



## Awards gala honours heroes in the BC AIDS movement

**O**n Sunday, April 19, the 8th annual AccolAIDS awards gala took place in the elegant Pacific Ballroom at the Fairmont Hotel in Vancouver. This recognition and fundraising event honoured outstanding achievements of individuals and organizations working in the BC AIDS movement.

### SOCIAL/POLITICAL/COMMUNITY ACTION

#### Portland Hotel Society (PHS) Community Services Society



Created in 1993, PHS Community Services Society is a non-profit society that provides professional support and permanent accommodation for hard-to-house adults, and individuals afflicted with mental illnesses and addictions. PHS operates on a no-eviction policy.

Currently operating out of four housing facilities in Vancouver's Downtown Eastside (DTES), residents receive

round-the-clock care from a team of mental health workers, with doctors and nurses visiting on a regular schedule. In addition, residents have access to a wealth of services including at-home support, nutritional counselling, general counselling, and art classes from local artists.

Few organizations demonstrate the degree of tenacity and creativity in advocating for those on the margins of society. PHS has been on the frontlines, lending dignity and stability to the lives of people living in the DTES.

### UNSUNG HEROES

#### Andrew Johnson



Andrew was involved in the HIV/AIDS movement from the beginning. He began as a volunteer with the AIDS Committee of Toronto (ACT), where his passion for caregiving led him to become a registered nurse. He wrote the manual "Living with Dying, Dying at Home" for ACT to support friends, families, and loved ones trying to cope with the daily reality of caregiving.

Nationally, Johnson was a founding member of the Canadian Association of Nurses in AIDS Care, a board member of the Interagency Coalition on AIDS and Development and the Canadian AIDS Society, and he served on the federal government's Ministerial Council for HIV/AIDS.

As executive director of AIDS Vancouver, Johnson was able to focus his commitment to community development and was proud to have contributed to strengthening and growing both the case management and gay men's health programs.

Returning to front line nursing and teaching, Johnson worked at the Dr. Peter Centre, Vancouver Community College, and at Vancouver's St Paul's Hospital in the HIV/AIDS unit in IV therapy, and at the John Ruedy Immunodeficiency Clinic.

### PHILANTHROPY

#### Kim Osborne



Kim Osborne is a restaurateur with a vision and a passion for making a difference. As the founder and coordinator of Chefs for Life, a culinary extravaganza for food and wine aficionados from Vancouver to Whistler, she has raised more than \$700,000 for Vancouver Friends for Life Society, a not-for-profit wellness centre that provides complementary and alternative health and support services for individuals living with life-threatening illnesses, primarily HIV/AIDS.

Each year, Osborne begins working months in advance to single-handedly coordinate participating chefs, wineries, corporate sponsors, and media to produce the most spectacular and revered event on the Vancouver dining and social circuit.

With her energy, enthusiasm, community spirit, and tireless dedication to making Chefs for Life bigger and better every year, Osborne is the epitome of someone with heart and soul.

### KEVIN BROWN PWA HERO AWARD

#### Kath Webster



For over a decade, Webster has worked in numerous ways to address the issues facing people living with HIV, particularly women. An inspiring role model and leader, she currently chairs the board of directors for the Positive Women's Network.

As part of BCPWA's Treatment Information Program, Webster has developed HIV treatment education materials and presented countless workshops. She uses her personal experience living with HIV to educate, support, and advocate for others. She has also shown great commitment to

the AIDS Walk for Life by volunteering for the past 10 years as a team leader for the event.

In the words of her nominators, “Kath is a truly remarkable woman, who has worked quietly, but with courage, strength, and perseverance, to help improve the lives of positive people. She has become a treasured volunteer in the women’s HIV community as well as the HIV community as a whole.”

**HEALTH PROMOTION AND HARM REDUCTION**

**MAT Program**



Vancouver’s Maximally Assisted Therapy (MAT) Program opened its doors 10 years ago to improve access and adherence to antiretroviral therapy for HIV-positive participants with complex social and medical challenges.

Located in the Downtown Community Health Centre, the MAT Program consists of a multidisciplinary team that supports adherence to antiretroviral therapies in an encouraging, non-judgmental, drop-in location, as well as provides assistance navigating government bureaucracy, locating affordable housing, and accessing social services.

The patient-centered model and dedicated staff have made it possible to develop bonds with marginalized, mentally ill, and difficult-to-engage clients. The staff delivers all of these services in difficult conditions, continuously working to lower the barriers that clients face every day.

Despite the challenges MAT clients face, as of January 2009, the median six-month adherence rate was 99.5 percent and viral loads were undetectable in 90 percent of patients.

**SCIENCE/RESEARCH/TECHNOLOGY**

**Dr. Mark Tyndall**



Dr. Mark Tyndall’s research into HIV care for injection drug users and marginalized populations has been recognized both nationally and internationally. His research, clinical work, and inspiring leadership have improved our understanding of the challenges faced by people living with AIDS in the DTES. Further, Mark’s presence and commitment to the residents of

the DTES, as well as his advocacy efforts, have led to the implementation of innovative programs and improvements in access and care.

As a researcher, Dr. Tyndall is the foremost expert on HIV. His leadership and involvement on the VIDUS Study, MAKA Project, CHASE Project, Insite, Vancouver Native Health, and the Merck Vaccine Study have been instrumental. A supporter

of VANdoc, Mark has worked in Africa as a clinician, researcher, and epidemiologist.

The grace, humanity, and humility in which Dr. Tyndall carries out his work is an inspiration to others.

**MEDIA AWARD**

**Xtra! West**



Since 1993, *Xtra! West* has been at the forefront of Vancouver’s gay community. With a bi-monthly readership of 54,000 readers, the publication has its finger on the pulse of the community.

*Xtra! West* is a leader in delivering consistent, well-researched coverage of HIV/AIDS-related issues. While the mainstream media chooses to focus on the criminalization of HIV, *Xtra! West* delivers a more balanced approach, publishing articles about transmission and health issues, as well as the global fight against HIV/AIDS. The publication’s work with HIV-positive columnists also provides readers with a unique and personal account of living with HIV.

A true community partner and reliable information source for HIV-positive persons, *Xtra! West* provides support to AIDS service organizations through event sponsorship, discounted advertising rates, and educational support.

**INNOVATIVE PROGRAMS AND SERVICES**

**Boys ‘R’ Us**



Boys‘R’Us began in 1997 through a partnership between the then Vancouver Richmond Health Board and

several community-based AIDS service organizations when it was identified that there was a lack of services for male and transgendered sex workers working in the Yaletown neighbourhood of Vancouver.

The program’s goal is to provide a safe, respectful place for male and transgendered sex workers. The program provides participants with a way to connect with others, and gain valuable harm reduction skills and a feeling of safety for a few hours. It also creates a safe setting for participants to relax, talk about their lives, and discusses the issues they face.

All of this is delivered in a non-judgmental and supportive fashion. Boys ‘R’ Us has become an example of a successful population-specific program developed and delivered collaboratively with community partners. ⊕





# Crime & Punishment?

## **Exploring how HIV came to be criminalized**

*by Glenn Betteridge*

*This article is not legal advice. It contains information about the law. It is not a substitute for getting legal advice. Speak with a lawyer if you want legal advice.*

**In** March 2006, a young gay man from Vancouver was featured in the news. There was a photo of him with a broad smile and raising a martini glass. The headline stated that he had been charged with aggravated sexual assault for

allegedly not telling his sex partners that he has HIV. The Vancouver Police Department was looking for people who had sex with him.

Later in 2006, a photo of a sex worker from Vancouver's Downtown Eastside appeared in morning newspapers. She, too, was charged with aggravated sexual assault, reported to police by her boyfriend for allegedly not disclosing her HIV status to him.

*continued on next page*

## Cover Story

According to the Canadian HIV/AIDS Legal Network, which tracks HIV legal and policy developments, police have charged approximately 75 people with aggravated sexual assault since 1989. The vast majority have been HIV-positive men who have had sex with women. About 10 cases involved men having sex with men. Fewer than 10 women have been charged. Some of the people charged have been sentenced to jail, some for many years. How did HIV and sex come to be criminalized?

### The legal rule from the *Cuerrier* case

The criminalization of HIV and sex took a significant step in 1998. The Supreme Court of Canada, in a case called *R. v. Cuerrier*, decided that a person living with HIV who didn't disclose his HIV status before having sex that carried a "significant" risk of passing on HIV could be found guilty of assault—or sexual assault or aggravated sexual assault—under the Criminal Code.

In the words of Justice Cory of the Supreme Court: "Without disclosure of HIV status, there cannot be a true consent. The consent cannot simply be to have sexual intercourse. Rather it must be consent to have intercourse with a partner who is HIV-positive. True consent cannot be given if there has not been a disclosure by the accused of his HIV-positive status."

The *Cuerrier* case was about unprotected sexual intercourse between a man and a woman. The man didn't disclose his HIV status to, or use a condom with, two female sexual partners. Since the *Cuerrier* case, police, prosecutors, and courts have applied the law to unprotected sex between men.

### The legal grey areas: condoms, oral sex, and sex between HIV-positive people

Under the criminal law, it isn't clear whether a person living with HIV has a duty to disclose his or her status if he or she uses a condom for sexual intercourse. And it isn't clear whether an HIV-positive person has a duty to disclose before protected or unprotected oral sex. Oral sex and sex with condoms carry a lower risk of HIV transmission than unprotected anal or vaginal sex—but we don't know for certain if they reduce the risk of HIV transmission to the point where it's no longer a "significant risk" in the eyes of the law.

Other factors can also affect the risk of passing on HIV: things like HIV viral load, sexually transmitted infections, whether the HIV-positive person is the active or passive partner during sexual intercourse, and the biological differences between men's and women's bodies. The effect of these factors on an HIV-positive person's duty to disclose isn't clear.

These legal grey areas can make it a real challenge for people living with HIV to make decisions about when they have a legal duty to disclose their HIV status before

having sex with someone. There are a number of appeals currently before the courts in Canada. These appeals may help clarify things.

The Supreme Court took a second look at the criminal law and HIV non-disclosure in a case from Newfoundland called *R. v. Williams*. The Court opened the possibility that HIV-positive people have a legal duty to disclose to sex partners who they know to be HIV-positive where the sex will expose the other HIV-positive person to a significant risk of HIV re-infection. If HIV re-infection could seriously harm an HIV-positive person's health, the HIV-positive person who didn't disclose before sex could be in legal hot water. Thus far, there are no known legal cases like this.

### HIV and the criminal law beyond sex

Of course, sex isn't the only way that HIV is passed between people. Sharing needles and other drug-injection paraphernalia also carry a high risk of HIV transmission. So people *might* have a legal duty to disclose their HIV status to their injecting partners before they share needles and other equipment with those partners. However, there are no known criminal cases where an HIV-positive person who uses drugs has been charged for exposing someone to HIV by sharing drug equipment.

A mother can also pass HIV to her fetus during pregnancy, or to her child during birth or through breast-feeding. In 2005, the police charged an HIV-positive woman with a number of criminal offences. She hadn't disclosed her HIV status to her medical team and, as a result, her doctors weren't aware that the newborn needed to be given HIV antiretroviral medications to reduce the risk of HIV transmission. The woman also exposed her newborn to HIV through breast-feeding.

As part of a plea bargain, the woman pled guilty to criminal charges. Because the case didn't go to trial, a court didn't state the legal duties pregnant women have. But it is reasonable to assume that pregnant women have a legal duty to disclose their HIV status to their medical team during pregnancy—and a legal duty not to expose their children to HIV through breast milk.

### Clearing up some "myth-conceptions"

HIV non-disclosure can have harsh consequences. It's also complex and confusing. It's no surprise, therefore, that some people living with HIV may have misconceptions about their legal duties.

In some communities, myths about the criminal law and HIV disclosure may be circulating. Here are a few points that may help clear up some myths and misconceptions:

- If there's a significant risk of passing on HIV, if you lie ("I'm HIV-negative.") or you don't tell your partner about

your HIV infection (“She didn’t ask, I didn’t tell.”), you can be charged and convicted

- ▶ You can be charged and convicted even if you didn’t know or think that you had a legal duty to disclose
- ▶ If there’s a significant risk of passing on HIV, you have a legal duty to disclose your HIV infection; no matter where you meet or have sex with the other person; whether the sex is anonymous, you know the person, or how long you’ve known the person; or whether you have sex for fun, to make money, or in exchange for drugs or other things

You may not want to disclose that you have HIV because the other person might tell others or post your HIV status on the internet. Although this may make it more difficult for you to disclose, it doesn’t change your legal duty under the criminal law.

**A person can be convicted of aggravated sexual assault for not disclosing his or her HIV-positive status before having sex that poses a significant risk of HIV transmission, even if the other person doesn’t actually become infected. In other words, it’s a criminal offence for an HIV positive person to expose someone through sex to a significant risk of getting HIV.**

### **Making disclosure count**

If you’re going to disclose your HIV status to your sex partner, avoid code words or hints. Don’t assume your sex partner knows what words like “poz” and “positive” mean. It’s best to tell him or her that “I am HIV-positive” or “I am infected with HIV.”

Also, make sure your sexual partner understands what “HIV infection” or “HIV positive” means. Some people still don’t know that HIV is the virus that causes AIDS; HIV infection is a serious health condition and there’s no cure; and HIV can be transmitted during some sexual activities.

### **How to protect yourself against people who might lie**

Judges and juries have decided many of the legal cases about sex and HIV disclosure based on credibility—based on who they believed or didn’t believe was telling the truth. Even if you told a person before sex that you’re HIV-positive, after you have sex the person might lie and say you didn’t. So you may want to get evidence that you disclosed your HIV status before sex. Here are some suggestions:

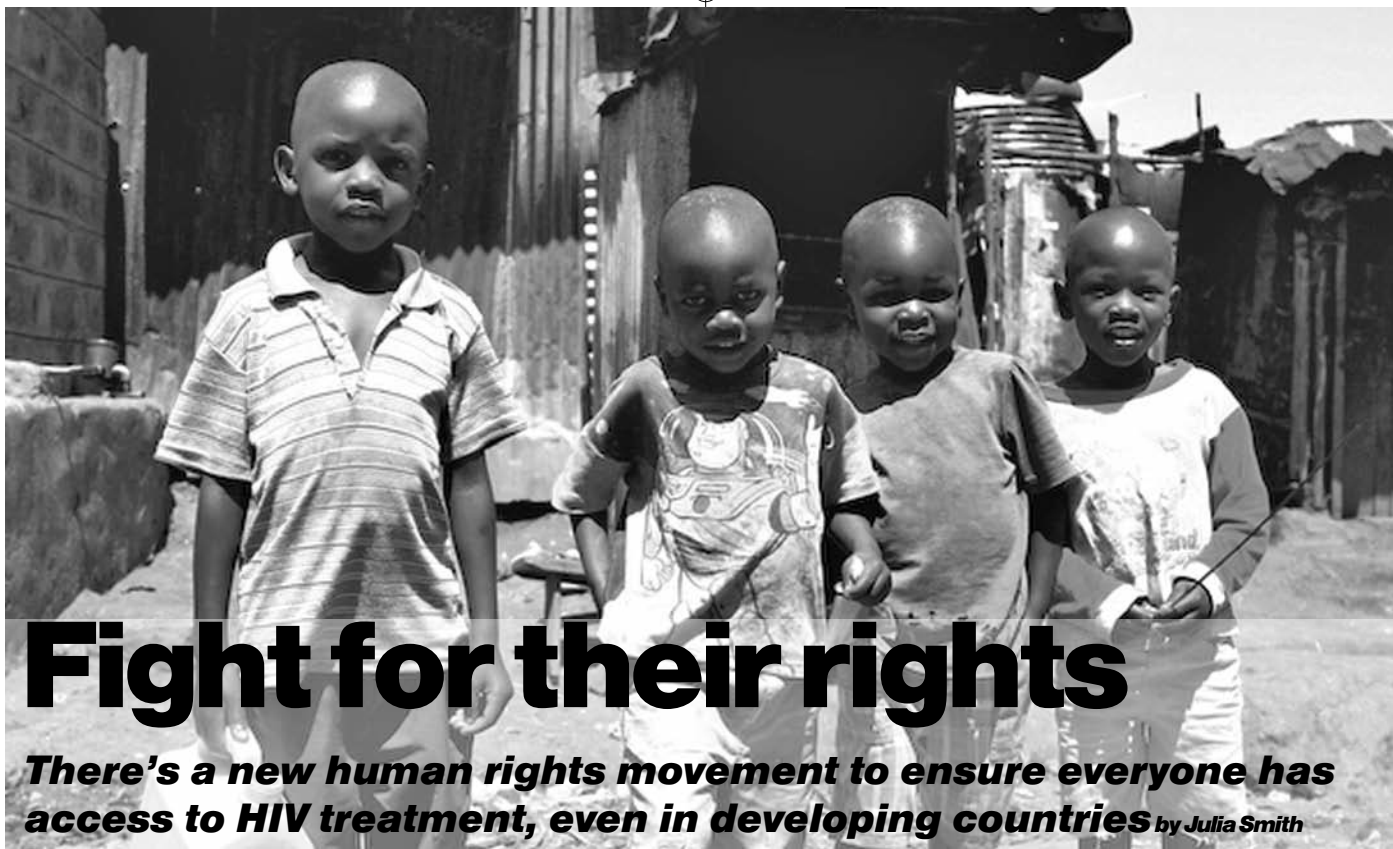
- ▶ Have witnesses. Tell the person you want to have sex with that you’re HIV-positive in front of a friend or someone you trust. Your friend becomes a potential witness who can say that you disclosed your HIV-infection. A group of friends is even better.
- ▶ Double check: Have a friend ask the person if he or she knows that you’re HIV-positive. If the person answers that he or she knows, then your friend can be a witness.
- ▶ Save online conversations and emails. If you disclose in an internet chat or by email, be clear about your HIV status. The person should acknowledge that you’re HIV-positive. Save an electronic copy of what you wrote and the other person’s response. Print it out, too.
- ▶ Create support and counselling records. If you’re thinking about getting into a relationship, you and the person can go to see a counsellor or support worker together. Ask the counsellor to make notes of the session. During the session, disclose that you’re HIV-positive.
- ▶ Sign a document. Before having sex, ask the person to sign and date a paper acknowledging that you’re HIV-positive and that he/she knows what it means. This is also the most unrealistic strategy.

You may not like what the criminal law says. You may not agree with it. It can seem very harsh and unfair. But it’s still the law. When you have information about what the law says, hopefully you’ll be able to make more informed decisions about your life and your sex life. ☺

*This article is based on an article originally published in Positive Side magazine, published the Canadian Treatment Information Exchange. Some of the information in this article was taken from HIV disclosure: a legal guide for gay men, published by the HIV & AIDS Legal Clinic (Ontario) and the Canadian AIDS Treatment Information Exchange.*



**Glenn Betteridge** is a legal and policy researcher and advocate living in Toronto.



# Fight for their rights

***There's a new human rights movement to ensure everyone has access to HIV treatment, even in developing countries*** by Julia Smith

I was working at Emmanuel Center, a home for street children in Nairobi, Kenya when I met Rusila. We just had a staff meeting and decided that we couldn't take in any more children. With 250,000 street children in Nairobi, we had to draw the line somewhere, and we could only accommodate 40.

Then Rusila walked through the door with her eight-year-old son, Dickson. She begged us take him in. Dickson had started living on the streets when she was forced to quit work, because she was dying of AIDS. Her last wish was to find him a home.

Rusila's two younger children were already placed at a special orphanage for HIV-positive children. She said she was grateful that starved-looking Dickson was "healthy." Something in her voice, which was proud but pleading, affected us and—despite our earlier resolution—we created a space for Dickson. Rusila kissed him once and walked out the gate without looking back. She died the following month.

## **A death sentence without access to treatment**

If Rusila had lived in Canada, or even one of Nairobi's wealthy suburbs, she would have access to healthcare and treatment, and would have lived long enough to raise her son herself. Instead, she died in the slums she lived in, and her son is being raised in an institution, which is struggling to meet the needs of just a handful of the millions of AIDS orphans. The fact is, while some people live with HIV/AIDS, others die from it.

Recent advances in antiretroviral treatment mean that, for some, HIV is becoming a manageable chronic condition. However, for the majority of PWAs who live in poverty, it remains a death sentence. This reality is spawning a new human rights movement, led by PWAs around the world—a fight for the right for treatment no matter where people live, what their income is, or who they are. It's a crucial fight, as the current situation is grim.

Of the over 22 million PWAs in Africa, only two percent are on antiretrovirals. According to Donna Barry, a policy analyst with Partners in Health—an international organizations that campaigns for universal access to antiretrovirals among other causes—this is because "AIDS medications are simply not affordable for those who need them most."

For example, in 2005, the World Bank suggested the Kenyan government implement an antiretroviral cost-sharing program, wherein it would subsidize the cost of the medications but still charge PWAs the equivalent of two dollars per day. Since the average income was about the same, this program was doomed to fail. More recently, the development of generic medications has reduced the cost of first-line antiretrovirals, in developing countries, to about \$150 a year per person but, as most PWAs in Africa live on less than a dollar a day, the price remains prohibitive.

## **Price gouging by Roche**

The World Health Organizations estimates that 15 percent of the world's population consumes 90 percent of its pharmaceuticals. The pharmaceutical company Roche was recently named one of the "Top Ten Worst Corporations in 2008" by Alter Net for putting a \$25,000 price tag per year on enfuvirtide (Fuzeon), which can save the lives of people who have exhausted all other treatments. When lobbied to reduce the price, Roche Korea's spokesperson reportedly said, "We are not in business to save lives, but to make money. Saving lives is not our business."

Roche made \$266 million off enfuvirtide last year, but argues it can't afford to reduce the price to make it more affordable to public health services in Asia or Africa. Roche also produces valganciclovir (Valcyte), which treats a common AIDS-related infection called cytomegalovirus that causes blindness or death. Médecines Sans Frontières, an international

health organization, successfully lobbied Roche to reduce the price from \$10,000 for a four-month course, to \$1,899. However, the price is still restrictive, plus Roche will only sell at the reduced price to non-profit organizations in developing countries, not to governments that are trying to equip public health services.

But the cost of medications only makes up a third of the total cost of HIV/AIDS treatment. Simple necessities like nutritious food, clean water, and access to doctors are expensive in developing countries.

“We are hitting walls with the number of people we are getting on treatment because of lack of healthcare workers and other inputs,” says Barry. “We have to be strengthening overall healthcare systems.”

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### **Systemic barriers to accessing services**

Structural adjustment policies, widespread poverty, and other factors have led to declining healthcare infrastructure in Africa. For example, in Malawi, which has one of the highest HIV infection rates in the world, the doctor-patient ratio is two doctors per 100,000 people. In comparison, in Canada the ratio is two doctors per 1,000 people. Furthermore, systemic human rights violations also prevent PWAs from accessing essential services, according to Susan Gruskin from the Harvard Program on International Health and Human Rights. She writes: “Homophobia, gender inequalities, stigma, and discrimination against individuals in vulnerable groups have all been identified as major barriers to accessing services.”

The UN Charter on Social and Economic rights includes “the right to the highest attainable standard of health,” which ought to include the right to life-prolonging treatment. Yet Gruskin notes that governments need to be reminded that HIV treatment is a human right: “In the past few years ... political and technical guidance in the HIV field has been moving away from engagement with human rights, particularly, but not exclusively, in the area of antiretroviral treatment scale-up.”

Barry agrees that governments need to be pressured to address rights violations and implement universal treatment programs. “Despite progress over the last few years, there is still

a lack of political will,” she says. “If you have the political will, then the finances, etcetera, will fall into place.”

A recent study from Harvard University found that the South African government could have prevented 365,000 AIDS-related deaths if the government had provided antiretroviral treatment. The country, which is home to the highest number of PWAs in the world, was plagued for years by a denialist government under former president Thabo Mbeki, who refused to believe that HIV causes AIDS.

### **The fight continues in South Africa**

South African activists participated in strikes—where PWAs refused to take antiretrovirals until the medications were made universally available—and protests, in a long fight for universal access to antiretrovirals.

Finally, in 2003, the South African government announced its national treatment program, but to date only 28 percent of PWAs in need are on antiretrovirals, due to slow implementation and lack of healthcare resources. The South African Treatment Action Campaign, run by PWAs, is continuing to fight for the right to treatment in South Africa.

“It is the PWA activists who have been active domestically that are speaking up for other groups and that are making a big difference,” says Barry. “They have channeled their activism to a bigger worldwide stage. It’s been incredibly helpful.”

Barry stresses that support for good domestic policies, such as harm reduction programs, can influence aid delivery overseas. “People forget our domestic policies have huge influence internationally.” Barry also says PWAs are making a difference on a personal level by connecting internationally. “Sharing self-care stories can help others cope. Pairing up treatment support groups internationally is also great.”

As the fight for the right to treatment rages on, I take Dickson to visit his younger brother at the children’s HIV home. Dickson’s little brother, now six but the size of a four-year-old, wheezes with each breath and has difficulty hearing. As Dickson tells him stories about their mother, who the little one can barely remember, I wander through the nursery.

A toddler appears from behind a crib, laughs at me, and hides her face. As we play peek-a-boo, I think how in Canada there are very few HIV-positive children. Successful application of antiretrovirals has all but stopped mother-child transmission. But in Africa, there are over two million HIV-positive children—a completely preventable child epidemic. The global inequality is daunting, but not impossible to rectify if PWAs and their allies join forces on this new human rights campaign. ☉



**Julia Smith** is completing her MA in Peace Studies at the University of Bradford in the UK.

# PWAs subject to public health orders

by Ross Harvey

**HIV**-positive British Columbians have been subject to public health orders seven times since the late 1980s. The identities and circumstances of the individuals subjected to the orders have not been divulged—such information is, thankfully, strictly confidential.

However, a letter from Provincial Health Officer Perry Kendall in response to inquiries made by BCPWA chairperson Glyn Townson confirms that the orders were issued: once in the 1980s, three times in the 1990s, and three times in this decade to date. The letter also confirms that they were issued because of HIV.

In his letter to Townson, Kendall said, “In most cases the orders were issued to persons known or suspected to be infected with HIV, who public health officials had sound reason to believe were putting others at risk of infection in a non-consensual manner, and/or who had refused counselling and who were not making voluntary changes to their behaviour.”

Such orders are issued by the medical health officers in each of BC’s five regional health authorities. However, as Kendall notes in his letter, “Medical Health Officers who are considering making such orders almost invariably consult with my office.”

Under BC’s *Health Act*, sec 11(1), “If a medical health officer has reasonable grounds to believe that a person has a reportable

communicable disease or is infected with an agent that is capable of causing a reportable communicable disease, and the person is likely to willfully, carelessly or because of mental incompetence expose others to the disease or the agent, the medical health officer may order the person to ... comply with reasonable conditions the medical health officer considers desirable ... take or continue medical tests or treatment for the purpose of identifying or controlling the disease or agent, (and/or) place himself or herself in isolation, modified isolation or quarantine as set out in the order.”

HIV was designated a “reportable communicable disease” in 2003.

It isn’t clear under what authority such orders were made prior to that time, and Townson has written back to Kendall seeking clarification on this and a couple of other minor points. We’ll convey the results of that correspondence when it becomes available. ☺



Ross Harvey is BCPWA’s executive director.

**BCPWA  
Advocacy  
gets  
results!**



**The BCPWA Society’s Advocacy Program continues to work hard to secure funds and benefits for our members. The income secured for February 2009 and March 2009 is:**

- ◀ **\$37,848 in housing, health benefits, dental and long-term disability benefits.**
- ◀ **\$500 in ongoing monthly nutritional supplement benefit for children**



# When positives attract

**What are the risks when HIV-positive men ditch the rubbers with each other?**  
by Derek Thaczuk

For many HIV-positive gay men, serosorting—choosing sexual partners of the same HIV status—means having the pleasure of condomless sex, without causing new HIV infections. Websites like poz4play.com and poz4poz.com describe the ideal: “by choosing only HIV-positive partners, we could actually reduce new infections to zero.”—all while having hot, “raw,” condom-free sex.

Naturally, though, nothing is 100 percent risk-free. Serosafe sex comes with three concerns: sexually transmitted infections (STIs), HIV reinfection, and—ironically—the lurking threat of new HIV infections.

## Are you both really “poz”?

The goal of serosorting is avoiding new infections by picking partners who already have HIV. But studies show that men misread each other’s statuses more often than you might think. The thinking

goes like this: he’s poz too because I’ve seen him at the AIDS committee / he wouldn’t bareback if he wasn’t / it’s obvious that I am / etcetera. Meanwhile, HIV-negative guy thinks, “he must be neg too,” for whatever reasons of his own. Hot, unprotected sex—and possible new infection—ensues.

Outcomes like this can be avoided: just make sure you’ve talked openly and clearly about each other’s HIV status, and are clear on just what you’re agreeing to.

## STIs

STIs are an obvious risk, especially from unprotected sex. In fact, HIV-positive guys may be more vulnerable to catching them. Sometimes this means no more than a trip to the clinic and a course of antibiotics. But some STIs, like herpes, are lifelong, so think about the risks you’re willing to take.

STIs can also go undetected if they don’t cause obvious symptoms. This can easily happen with, let’s say, a syphilis sore in, well, let’s call it a hard-to-see spot. You may want to get screened for STIs regularly if you’re having unprotected sex.

## Getting HIV... again

Reinfection, or superinfection, means getting or passing on a strain of HIV different from the one you already have. In the worst scenarios, this new strain could lead to serious disease more quickly, or be resistant to the antiretroviral drugs you’re taking.

Reinfection isn’t just a theory: it’s been proven to happen. The million-dollar questions are how often, and how often does it actually lead to the problems just described?

We don’t have all the answers, partly because the highly detailed genetic analyses

*continued on next page*

## Studies show that men misread each other's statuses more often than you might think.

required makes reinfection hard to study. Here are the key findings we do have.

- ▶ A study group of 78 recently-infected gay men in California, who were not on highly active antiretroviral therapy (HAART), became reinfected at a rate of 5 percent per year
- ▶ Rates of between 4 and 9 percent per year have been seen in heterosexuals in Africa
- ▶ A study of 49 long-term partners who are both HIV-positive, all on treatment with undetectable viral loads, found no evidence of reinfection. The investigators

- speculate that long-term partners might develop immunity to each other's viral strains
- ▶ Dutch study of people with sudden, dramatic increases in detectable viral load (while off treatment) found that reinfection was the probable cause in two out of 14 cases
  - ▶ Dutch researchers also found that reinfection was not the reason for treatment failure in a group of 101 men and women, even in those who had unprotected sex during treatment
  - ▶ Nearly all known cases of reinfection have happened within the first few years after initial HIV infection. Reinfection has also been seen, although much more rarely, in people who have been infected longer
  - ▶ Many researchers also speculate that reinfection may be less likely in people who are on HAART—evidence tends to support this, although large numbers have not been studied
- For some HIV-positive guys, this evidence may reinforce a personal decision

that reinfection isn't a big enough risk to concern them. Others, who've kept up their condom use with all their partners, may want more reassurance before changing their minds. Ongoing studies will add to our knowledge of this controversial subject. ☉

### Further online reading

Further information about reinfection and other risks is available at:

- ▶ [www.thebody.com/index/treat/superinfection.html](http://www.thebody.com/index/treat/superinfection.html)
- ▶ [www.barebackhealth.net](http://www.barebackhealth.net)

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



## SPECIAL RESOLUTIONS FOR THE 2009 BCPWA AGM

Many national HIV/AIDS service organizations have adopted mail-in balloting systems to elect their board of directors. With our growing, diverse membership of over 4,600 people, BCPWA is considering adopting a similar procedure to elect its directors.

Our current system of nominating and voting for our board of directors from the floor at our yearly annual general meeting (AGM) made sense when our membership was primarily in the Vancouver area.

However, in 1993, our Society evolved from a regional agency serving the Vancouver area, to one

serving the entire province of British Columbia. Thus, the current system no longer reflects the best interest of our at-large membership, who may live outside the Metro Vancouver area. The proposed changes, if passed, would include a mail-in nomination and mail-in ballot system allowing for greater participation by our full-voting members throughout the province.

At our AGM in 2008, a special resolution was proposed to adopt a mail-in ballot system and was narrowly defeated. The Membership Engagement Standing Committee reviewed the feedback from our last AGM and has recommended that the special resolution be brought forward again to the 2009 AGM with some minor changes. Look for your AGM package in the mail and ensure your voice is heard. Should the special resolution pass at this year's AGM, our membership could move to the new mail-in ballot system for the 2010 election.



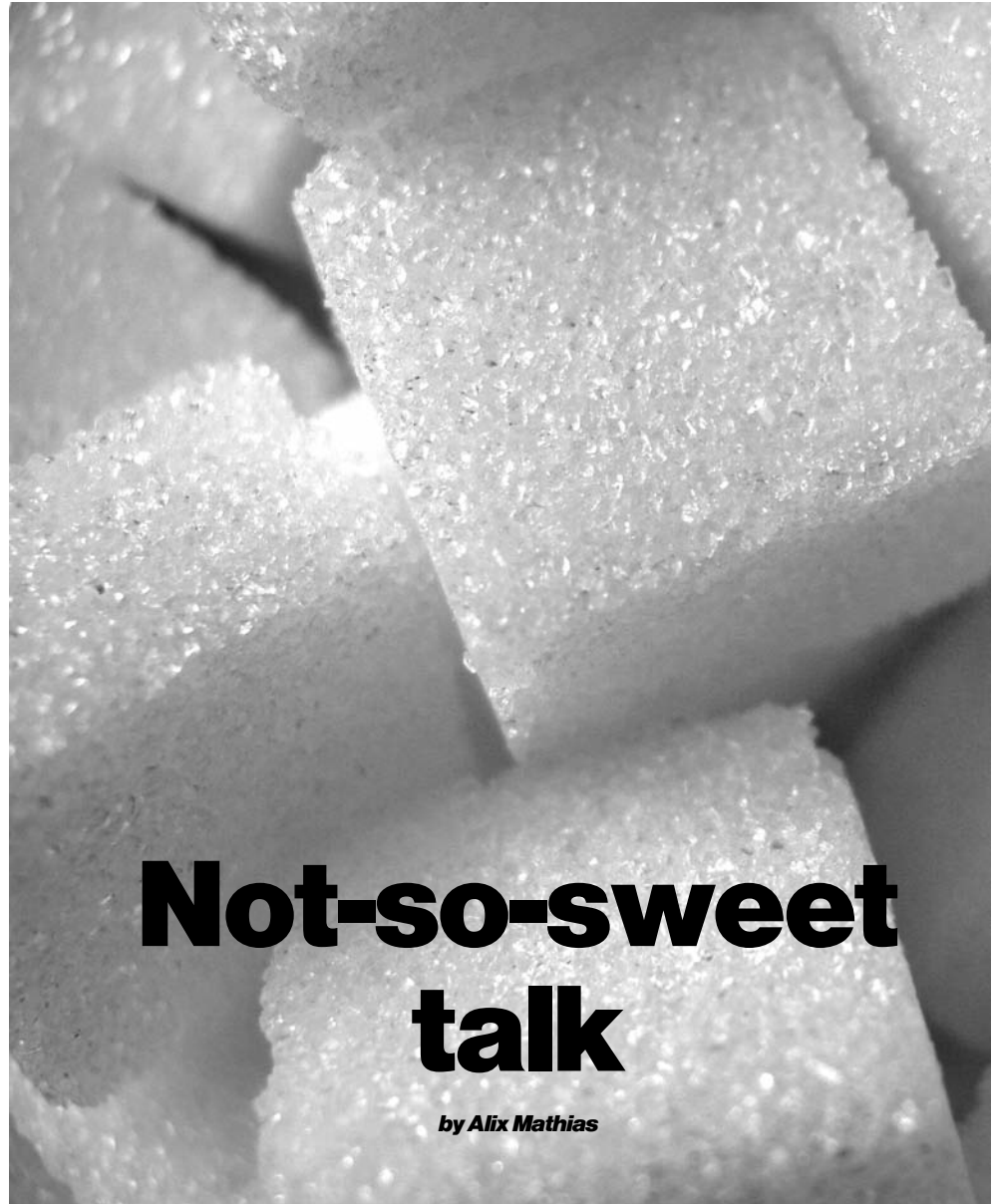


# treatment. information

## TREATMENT INFORMATION PROGRAM MANDATE & DISCLAIMER

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

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



**L**et me be perfectly clear: I love the sweet stuff as much as the next person. I believe that the perfect chocolate chip cookie, hot from the oven, is part of a complete childhood. And, while I stopped drinking pop and eating waxy chocolate bars many years ago, I'm the first

one to crave a good gelato when the sun comes out and I could eat an entire chocolate babka if I found myself alone with one on a Saturday night.

But, at one point, I had to admit to myself that I was eating way too much sugar. If you are too, you're not alone.

## Nutrition

Until 800 years ago, refined sugar didn't exist in the human diet. For unknown thousands of years, the experience of sweetness was found almost entirely in fruits, vegetables, and complex starches. The sweet flavour was early man's way of detecting a safe, high-energy food source. In nature, poison is never sweet.

Then someone figured out how to refine cane and beets. In an evolutionary blink of an eye, we began consuming mass amounts of sugar. It was the dietary equivalent of someone setting off a bomb in the human body. Whereas the natural sources of sweet turn into glucose slowly, sucrose is broken down by saliva, explodes on the tongue, and sends blood-sugar levels sky-high in seconds.

### **Sugar in virtually all our meals**

Sugar was cheap, thanks to slavery, and before long, entire populations were literally hooked on the taste sensation. The candy man has now created so many ways to deliver the sweet stuff that it's almost impossible for the average consumer to eat even one meal—ever—that doesn't contain refined sugar.

It just keeps adding up. Today, the average North American consumes about 25 teaspoons of refined sugar every day. That's over 150 pounds of sugar per person each year.

The problem is, our bodies aren't equipped to handle the rush from pure glucose. The pancreas starts to pump out large amounts of insulin in order to restore balance. The adrenal glands become exhausted and start to produce more of the hormone cortisol and less of the hormone DHEA.

### **Sugar can damage your immune system**

This isn't good news for your immune system if you're HIV-positive. There is strong evidence that naturally

occurring DHEA is an inhibitor of HIV and that cortisol accelerates HIV replication. Cortisol is very hard on the body and plays a role in everything from accelerated aging to diabetes to osteoporosis. In fact, a growing body of research suggests that the speed of HIV replication is determined by a tug-of-war between the hormones. Under this theory, more cortisol equals more virus; more DHEA means less virus.

**Our bodies aren't equipped to handle the rush from pure glucose. The adrenal glands become exhausted and start to produce more cortisol and less DHEA. This isn't good news for your immune system if you're HIV-positive.**

If that doesn't get your attention, perhaps this will: sugar consumption contributes to sagging skin, weak muscles, and erectile dysfunction. It attacks all the proteins of the body, including collagen. According to collagen expert Dr. Nicholas Perricone, "sugar is responsible for nearly half of all skin aging because it inhibits the effectiveness of collagen within your skin cells."

When you're young, collagen is elastic, flexible, and springy, giving you a literal bounce in your step and a fresh, young face. But it's not just about vanity. Collagen is also in your joints, bones, muscles, arteries, and, there's a whole lot of it in the penis. If it makes your cheeks sag, you can bet it's not helping the rest of you.

### **Eat wisely, while still enjoying your meals**

It's unlikely any of us will give up sweet treats completely. Joy is also an aspect of wellness. The trick is to become strategic. Your goal is to continually minimize the amount of sugar you eat and maximize the pleasure you get from what you do eat. Here are a few pointers:

- ▷ Dump the energy drinks, they're filled with caffeine and sugar stimulants—a few added herbs doesn't make them healthy
- ▷ Gradually cut down on the amount of sugar in your coffee and tea
- ▷ Look for peanut butter, jam, and salad dressings with no sugar
- ▷ Give up daily snacks in exchange for one or two awesome desserts on the weekend
- ▷ Buy 70 percent dark, organic chocolate.—it has less sugar than a banana and a few small squares will satisfy your cravings ⊕

*Alix is a wellness maven, yoga teacher, and co-owner of Catalyst Wellness Services. She lives in Ironman City, otherwise known as Penticton, BC.*



# Dousing the fire

*How to beat heartburn  
before it develops into  
something more serious*

*by Rani Wangsawidjaya*

**A**lmost everyone experiences heartburn on occasion—that burning sensation behind your breastbone, which is caused by acids backing up from the stomach into your esophagus. However, if you experience heartburn frequently, it can cause a more serious medical condition called gastroesophageal reflux disease (GERD). At this stage, the reflux is happening so often that the acid damages your esophagus.

If you're experiencing heartburn more than three times a week, you may have GERD and should consult your doctor. However, heartburn is only one of the major symptoms of GERD. Other symptoms of GERD include regurgitation of stomach acids into the mouth, difficult or painful swallowing, and chest pain.

**If you're experiencing  
heartburn more than three  
times a week, you may  
have GERD and should  
consult your doctor.**

Many factors can contribute to developing GERD, including the use of antiretrovirals and other medications. However, you can manage and treat mild symptoms through diet and lifestyle choices.

One of the most effective ways of avoiding heartburn and other GERD symptoms is to avoid the foods that cause you to react. While everyone reacts differently to various food items, there are certain foods that are known to trigger heartburn:

- ▷ Fatty and fried foods
- ▷ Citrus fruits
- ▷ Tomato products
- ▷ Spices
- ▷ Peppermint

- ▷ Chocolate
- ▷ Garlic
- ▷ Onions

You may need to go through a trial and error period before finding out which foods cause discomfort. Keep a seven-day journal of what you ate, when you ate it, and any symptoms you experienced. This will help you and your doctor or dietitian determine which foods are causing you reflux.

Avoid caffeine, alcohol, citrus juices, and carbonated drinks that are irritants to the stomach. Alcohol may relax the muscle between the esophagus and stomach (lower esophageal sphincter) and allow stomach acids to reflux into the esophagus.

Modifying your lifestyle can also reduce heartburn and GERD:

- ▷ Eat frequent smaller meals and snacks—large meals take more time to digest and may cause reflux
- ▷ Stop smoking—cigarette smoking relaxes the lower esophageal sphincter
- ▷ Maintain a healthy weight
- ▷ Sit upright during meals and for 30 minutes after eating.
- ▷ Avoid eating two to three hours before going to bed
- ▷ When sleeping, raise your head (for example, with pillows) at least a few inches above your stomach
- ▷ Avoid tight-fitting clothes

Finally, talk to your doctor about over-the-counter and prescribed medications if GERD symptoms continue to bother you. Be wary that some acid-reducing drugs, which are often used to treat heartburn, can interact with certain antiretroviral drugs. ⊕

*Rani Wangsawidjaya, RD, is a community  
nutritionist with Vancouver Coastal Health,  
as well as the dietitian at  
A Loving Spoonful in Vancouver.*



**Dr. David Burdge****Dr. Susan Burgess****Dr. Joss De Wet**

# Doctor, doctor, give me the news

***As HIV treatment evolves, what are the emerging trends in physician practices? Living Positive spoke to three physicians***

*by Zoran Stjepanovic and R. Paul Kerston*

**HIV** treatment isn't the same as it was 10 years ago, or even five years ago. It's a different era now, so how have physicians changed their practices? What health issues are coming up these days for people with HIV? *Living Positive* magazine spoke to three physicians in Vancouver: Dr. Susan Burgess, who works in the Downtown Eastside; Dr. David Burdge from Oaktree Clinic, which serves women and children; and Dr. Joss De Wet from Spectrum Health Clinic, which has a large

proportion of gay male patients. (Attempts to interview HIV-knowledgeable physicians in other regions of BC were unsuccessful.)

## **Changing demographics at clinics**

All three doctors noted a shift in the patients they see. Dr. Burgess is seeing an increasing number of young HIV-positive women in the Downtown Eastside (DTES), and it's difficult to stabilize their HIV care. These young

women face enormous challenges: homelessness, fetal alcohol syndrome, drug use, physical assault, and mental health issues. There's another segment in DTES clinics composed of HIV-positive men who have been HIV-positive for over 10 years and are now receiving hepatitis C treatment due to liver failure.

At the Oaktree Clinic, Dr. Burdge is seeing an increasing number of immigrant women and families in the last few years. Seventy-five percent of Dr. Burdge's patients are HIV-positive women and of those, 20 percent are African Canadian, around 11 percent are South Asians and South East Asians, and 30 percent are aboriginal and First Nations. In his practice, he finds some families may be multiply infected—children, mothers, and fathers.

The most striking difference that Dr. De Wet has seen in the last five years is that 99.9 percent of patients on antiretroviral regimens are now fully suppressed. In 2004, this wasn't the case, despite optimal treatments at the time. Dr. De Wet sees this high success rate arising from more potent regimens, particularly using etravirine (Intelence), raltegravir (Isentress), and darunavir (Prezista), which seem to overcome previously seen resistance patterns. Even raltegravir, with its more fragile resistance profile, is working very well in combination with other antiretrovirals. The era of "mega-HAART"—a laborious regimen of multiple highly active antiretroviral therapies—is now gone and has been replaced with fewer and better medications offering virological control.

### Health issues

HIV-positive individuals in the DTES face numerous health issues, including chronic obstructive pulmonary disease, poor nutrition (pre-diabetes conditions), metabolic syndrome, addiction, depression, and posttraumatic stress disorder. Dr. Burgess notes that many patients at her clinic are also afflicted with sudden overwhelming infections, especially respiratory infections, which hit PWAs in the DTES very hard. They're doing well virologically, with undetectable viral loads, but suddenly are weakened by cocaine and crystal meth inhalation, as well as cigarette smoking, and then hit by pneumonias that can be fatal. There are increasing numbers of PWAs with lung cancer in the DTES, likely due to high amounts of smoking. So even when HIV is under control, there remain many other health issues.

At Oaktree Clinic, pulmonary and extrapulmonary tuberculosis (TB) are very common in immigrant women and families. TB is also still common with Aboriginal individuals. Immigrants seeing a physician for the first time tend to have very low CD4 counts, possibly due to late diagnosis. They also face language barriers when

accessing healthcare, so Oaktree Clinic often needs to provide interpreters for these patients. However, the patients are extremely concerned about stigma and discrimination and reluctant to have anyone interpret, since they believe the interpreter is likely from their own community and that they will risk the negative consequences of disclosure.

### Starting HIV treatment and barriers to adherence

In the DTES, Dr. Burgess rarely expects individuals to take medications without a supportive team or system customized for them. PWAs in the DTES are also using methadone or heroin, so physicians need to modify HIV treatment. There are teams, such as the MAT DOT program, to support PWAs in sticking to their drug regimen. This supportive team must understand they're in it for the long term and that circumstances can suddenly change in a PWA's life that will affect adherence. It thus requires continual problem solving to maintain medication efficacy. These care teams work with people in many different situations—some don't have adequate shelter and/or are entrenched in addictions. Methadone maintenance can help someone take his or her medications, but the physician's priority must be HIV care, not solely addiction management.

At Oaktree Clinic, initialization of treatment is individualized. Dr. Burdge notes that Africans and South Asians/South East Asians tend to show more openness to starting therapy. As for adherence challenges, he feels the same social determinants that make women vulnerable—sex and gender-based power imbalances—affect their ability to access care and adhere to HIV treatment. As women play caregiver roles, they may put children and partners first, or they may be in vulnerable situations or economically dependant, which can be barriers to adherence.

Dr. De Wet aptly notes that a key barrier to starting treatment continues to be concerns about lipoatrophy and lipodystrophy. Treatment-naïve patients may be reluctant to start taking antiretrovirals, worried that they'll get the same physical side effects that they see in other PWAs in the community—even though those side effects are almost unseen in new regimens. Psychiatric illness and addictions can also be a barrier to starting treatment, affecting attitudes toward treatment and HIV as well as support systems.

Poor adherence isn't an issue in Dr. De Wet's practice. Ninety to 95 percent of his patients, most of who are gay men, take their medications as prescribed and on schedule, with no change over recent history. Simple regimens with twice- and once-daily dosing have helped keep adherence rates high.

*continued on next page*

## Treatment Feature

In the past five years, there's been a radical paradigm shift in when to start treatment. In the past, people would wait until their CD4 counts dropped to 200 to begin antiretrovirals. However, studies have indicated co-morbidities and mortalities with lower CD4 counts, and many experts recommend starting treatment "the earlier, the better." In Dr. De Wet's practice, that often means starting at CD4 counts of 400 or even higher. He notes that it can be challenging to tell a patient that starting a regimen is wise, whereas a year ago under the same circumstances, it wasn't time to start the same treatment.

### Side effects from antiretrovirals

In the DTES, the side effects of antiretrovirals aren't as apparent, but that could be because people there are used to physical discomfort, and they also self-medicate with substances.

At the Oaktree Clinic, women are more likely than men to experience higher rash and liver toxicities from nevirapine (Viramune)—between 15 – 20 percent of women may experience a rash. Women on tenofovir/emtricitabine (Truvada) experience more nausea and vomiting as well as more instances of rash than men do. Women of childbearing age also need to avoid certain antiretrovirals such as efavirenz (Sustiva), which is associated with a higher risk of central nervous system issues.

Medical knowledge has provided a greater understanding of the toxicities associated with particular medications. Thus, regimens are not only more potent but less toxic than in the past. Changing regimens was more common five years ago because of side effects, and because virological failure was also higher; now, virological failure is a very rare occurrence.

### Other co-infections

HIV and hepatitis C co-infection is quite high in the DTES. There are also increasing rates of lung cancer in the DTES.

Hepatitis C co-infection is also common among patients at Oaktree Clinic, as is TB among immigrant women. Bacterial vaginosis is also common among patients at Oaktree Clinic.

At Spectrum, Dr. De Wet confirms the rise in hepatitis C infections, particularly among gay men. He finds it troubling to see this disease is now being sexually transmitted. He states that increases in unsafe sexual practices, including fisting, as well as sharing needles and snorting drugs, have fuelled this rise in hepatitis C infections. This creates serious complications because of interactions between medications used for treating both hepatitis C and HIV.

Syphilis infections are also on the rise. Syphilis rates have been high among gay men for a while, and now they're high among women as well.

### Other notable trends

Dr. Burdge says that HIV-positive women are surviving longer than before, and has noted an increase in older, post menopausal women living with HIV—some even in their seventies and eighties, which brings up other aging-related health issues. Dr. Burdge is also seeing more HIV-positive women choosing to become pregnant. There are ongoing disproportionate numbers of young Aboriginal women, as well as more women with mental health and addiction issues.

While there are newer, less toxic therapies these days, other health issues such as lung cancer—due to heavy smoking among HIV-positive individuals—and osteoporosis have emerged. Cardiovascular concerns aren't as big an issue for women as for men.

Dr. Burgess says that if we want people in the DTES to be healthy, there must be adequate funding to give people real choices to leave addiction and poverty in that community. There needs to be on-demand detox options and many more professional recovery sites.

While the newer medications have fewer and often controllable side effects, there's a disturbing incidence of increased syphilis, along with rises in TB and other lung conditions, as well as continuing barriers to adherence in the form of untreated addictions and mental health issues.

Ultimately, there's a need for treatment teams to sometimes seek HIV-positive individuals and work with them, rather than follow older, unworkable care-centred approaches. ⊕



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



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

# Made to measure

**Therapeutic drug monitoring can help you determine the best dosage for you** *by Kristin de Girolamo*

Drugs aren't a one-size-fits-all proposition. Everybody absorbs and metabolizes drugs at a different rate. That's why there's therapeutic drug monitoring (TDM). TDM measures drug levels in the bloodstream to determine the most effective drug dosage with the least amount of toxicity.

Think of your body as a conveyor belt for drugs. First, the drugs enter your system through your mouth and you swallow them down to your stomach. Once the medication reaches the stomach, enzymes and acid begin to break down the drug and digest it before it moves to the small intestine, your bowels.

In the bowel, many drugs get absorbed into the blood. There are more enzymes and molecules here, which can change the drug or even pump it back out of the intestine, so that not much of the drug gets absorbed to your blood. Once in the blood, the liver further reduces the bioavailability of the drug by absorbing some of it—this is known as the “first-pass effect.”

The liver contains many enzymes, notably the CYP450 group, which is responsible for almost all drug metabolism. Once this process is complete, the remaining free drug is left in the blood, and the product at the end of the conveyor belt is what goes on to help fight HIV.

The active component of the drug is what also remains to cause side effects such as lipodystrophy and diarrhea. Other drugs in your system can also join the conveyor belt at various steps, binding with your HIV medications to stop them from achieving their active form or possibly enhancing them, increasing the active component and possibly increasing side effects.

Not everyone has the same amounts of liver enzymes, digestive enzymes, or time it takes for the drug to start at your mouth and end up in its active form in your blood. Factors such as age, race, body weight, hormone levels, and the food you eat all affect these processes and change how much active drug you absorb.

Before a drug reaches the market, research is conducted to determine an effective dosage. However, this is determined

using an average group of study participants, and not every PWA will fit into that average group. That would be like going to a clothing store and buying clothes in a size designed for the average Canadian; most of us wouldn't fit one-size-fits-all clothing!

That's where TDM fits in. In Vancouver, TDM is conducted in the Immunodeficiency Clinic at St. Paul's Hospital in Vancouver. Here's how it works: Several blood samples are taken from your arm throughout the day. The first level is typically drawn just before you take your next dose; this is called the trough, or lowest blood level. Then blood is drawn at various points after the dose is given, to determine the peak levels and how quickly the drug makes it through your body's conveyor belt. Combined with the knowledge of how much active drug is needed to keep the HIV virus suppressed, the inhibitory quotient—how much drug is needed to suppress the virus by 50 percent—is determined, which then helps healthcare professionals determine what dosage is appropriate for you.

TDM can only be used for protease inhibitors and non-nucleoside reverse transcriptase inhibitors. Nucleoside reverse transcriptase inhibitors are converted to their active form within blood cells, and TDM still can't accurately measure these levels.

TDM can help to maximize the amount of active drug in your system while minimizing side effects, but it can be difficult to conduct because it's labour intensive—for the person and in the lab. If the process could be streamlined, it would be easier for everyone involved. Hopefully, when combined with genotyping, all PWAs will be able to find a suitable, effective, and safe drug regimen. ⊕

*Kristin DeGirolamo is a fourth-year pharmacy student at the University of British Columbia.*



# CROI 2009

16th Conference on Retroviruses  
and Opportunistic Infections

The 16th Conference on Retroviruses and Opportunistic Infections (CROI) was held for the first time in Canada at Montreal on February 8 - 11, 2009. Over 4,000 leading international researchers and clinicians from 92 countries attended.

CROI focuses on the scientific research and clinical studies that have advanced our understanding and treatment of HIV and other associated concomitant and opportunistic infections. Activism, social-political debate, and pharmaceutical company representation weren't evident at the conference.

This year, there was more emphasis on opportunistic infections, which was a welcome shift for some. Relative to previous years, there was very little on drug trials and new treatments. While this could lead to a gap in effective antiretrovirals to treat drug resistant virus, the growing knowledge of HIV pathogenesis shared at CROI promised new direction in treatment.

The first morning of the conference, new trainees, young investigators, and community educators attended a compulsory workshop hosted by the Program Committee. Six presentations covered some of the key issues in HIV research and treatment: host restriction factors, pathogenesis, vaccines, immunology, deployment of highly active antiretroviral therapy (HAART), treatment as prevention, and HIV transmission prevention strategies. Each speaker provided an overview of current research and discussed what they considered were key issues in their field for continued and future research.

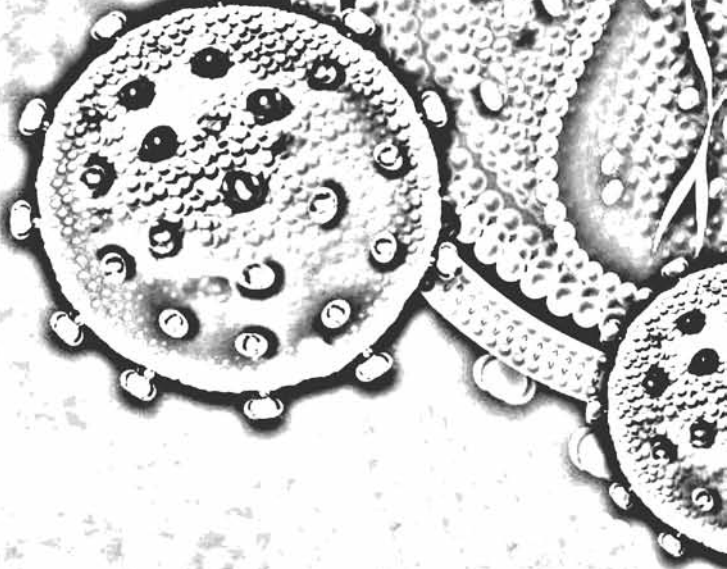
## Host restriction factors and viral escape mechanisms

Michael Malim, head of the Department of Infectious Diseases at King's College London School of Medicine, talked about host restriction factors and how retroviruses manage to evade them. The human immune system is capable of adapting and fighting a wide range of infectious agents through the production of antibodies and T-lymphocytes. The body also has an innate immunity, whereby physical and chemical barriers such as the skin, tears, and mucous prevent infection.

A third line of defence, intrinsic resistance, is achieved through intrinsic resistance factors or proteins that are capable of inhibiting retrovirus replication. They provide an early line of intracellular defence and are targets for the HIV accessory proteins that inhibit them. One family of intrinsic factors, the APOBEC3 proteins, arrests HIV replication by altering the sequencing of the viral genome, disrupting reverse transcription. Research into this family of proteins may give rise to new approaches for defeating HIV.

## Revisiting unanswered questions

Jon Cohen, a correspondent with *Science Magazine*, spoke of the social, political, and scientific issues that were prevalent early in the HIV epidemic. While much has changed for the better since the first CROI meeting in 1994, some of the issues that were challenging then continue to be so now. In the early



## Report on the 16th Conference on Retroviruses and Opportunistic Infections

by Michael Connidis



1990s, the epidemic was still young and HIV was rapidly spreading through the regions that are hardest hit today.

Sub-Saharan Africa had an estimated 14 million people living with HIV at the time. By 1999, over 30 million people were infected with the virus; almost six percent of the adult population was HIV infected, up from 2.5 percent 10 years earlier. In comparison, globally the percentage of HIV-infected adults rose from less than 0.5 percent up to one percent during the same time period.

The HIV pandemic continues, disproportionately affecting women and children in developing countries. Treatment and prevention efforts have not yet stemmed the tide of infection worldwide. While HAART has proven to be very effective in stopping HIV, delivering medications and treating co-infections present huge challenges, especially in resource-restricted settings.

The limits and realities of scaling up HAART are many but must be overcome. The scale-up needs to continue to grow exponentially. The delivery of treatment must keep pace with new infections, must maintain those who have already started on HAART, and must be capable of providing for those who currently have a CD4 count greater than 350 and will eventually need treatment.

### **New approaches to understanding and evaluating the efficacy of antiretrovirals**

Dr. Robert Siliciano, an investigator at Howard Hughes Medical Institute and a professor of medicine at Johns Hopkins University School of Medicine, spoke about new approaches to understanding and evaluating the efficacy of antiretrovirals. After 12 years of HAART, we know it can lower the viral load to undetectable levels, yet the virus is still able to replicate. While antiretroviral drugs protect cells against infection, latently infected CD4 cells—long-lived memory T-cells that are infected with HIV—persist longer than other HIV-infected cells and can produce virus when activated. The ratio of these proviruses to uninfected resting T-cells is one in one million. The rate at which these cells decay and leave the body is extremely slow, taking decades.

This reservoir of latently infected cells maintains a low-level viremia (virus in the blood), between one to 10 copies per ml of blood. This viremia may be behind blips in viral load readings seen with people who are on HAART and have good viral suppression.

Low-level viremia occurs even with effective viral suppression, but without viral evolution or the development of resistance. Intensifying HAART using different combinations of drugs to which the virus is sensitive in treatment-naïve and adherent people doesn't result in any change in this low-level viremia. Most of the residual viremia is coming from ongoing cycles of replication, due to the release of virus from at least two stable reservoirs. It would seem that, to the extent that detection is possible, HAART effectively stops the virus from replicating and evolving in adherent people, but it doesn't clear the latent virus reservoirs.

A change in the methodology for determining the inhibitory potential of antiretrovirals has led to an improved approach for choosing drug combinations for people with multi-drug resistance. There is considerable variation in the ability of different drugs to reduce viral load. This has to do in part with the point at which the life cycle of the virus is being disrupted.

The protease inhibitors and non-nucleoside reverse transcriptase inhibitors are very potent relative to the integrase inhibitor raltegravir (Isentress) in reducing viral load. However, they're all equally effective in treating HIV because within an infected cell, the disruption of protease or reverse transcriptase will initially generate a much greater drop in the number of virions (virus particles) than blocking integrase will.

Choosing effective drug combinations that will impact multi-drug-resistant HIV is based on four factors: the genotype of the resistant virus, the inhibitory potential of the different antiretrovirals to the resistant virus, the inhibitory potential of the combination of drugs used, and how well the regimen is tolerated.

### **A heartwarming musical performance**

The presentation that won hearts, captured minds, and moved people out of their seats was delivered by musician and activist Oliver Mtukudzi and the Black Spirits, dressed all in white, from Harare, Zimbabwe. Mtukudzi's broad smile, enhanced by the high arch of his cheekbones, warmed the room and lifted people's spirits. He talked about the impact of HIV disease on himself, his family, and his community. His tall, lipoatrophy-lean body moved gracefully about the stage as he spoke and sang. He said he didn't want to teach people, but rather wanted to tell a story and make people laugh while they looked at their lives.

His first song encouraged people to be careful with their life, respect themselves, and appreciate their worthiness. His message was delivered in the lyric, "don't collect dust and garbage as you go along through your life." In another song, he urged people to remember that one day we will all pass on and that in spite of the devastation and loss we may encounter, we must hold onto the joy of life and celebrate it. ☺

### **CROI online**

There's a wealth of accessible information on the CROI website. A majority of the conference materials, including abstracts, posters, webcasts of plenary sessions, symposia, and oral abstract sessions, can be viewed and listened to online at [www.retroconference.org](http://www.retroconference.org). It's a site worth exploring.



**Michael Connidis** is a BCPWA member and a member of the Living Positive editorial Board.

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# Women and cancer

## **The latest studies on HPV and HIV-positive women**

by Nicole Lewis

**The** human papillomavirus (HPV) is a sexually transmitted infection (STI) that causes warts in or around the genitals and anus. HPV can also cause abnormal growths—on the cervix, vulva, and penis or inside the anus—that can sometimes transform into pre-cancerous or cancerous tumours. HPV infections can be especially difficult to eliminate when HIV has weakened a person's immune system, making HPV of special concern to researchers studying HIV. Some recent studies have shed further light on the relationship between antiretrovirals and cancer among HIV-positive women.

In one study published in the January 2009 issue of *Obstetrics and Gynecology*, US researchers found a link between the use of highly active antiretroviral therapy (HAART) and an increased ability for the immune system to control HPV. By closely monitoring the gynecologic health of HIV-positive women (for up to seven years), the study found that the use of HAART in women with moderately abnormal Papanicolaou (Pap) test results did help to clear HPV cervical infections. Overall, 30 percent of women taking HAART were less likely to have worsened Pap test results and 30 percent were more likely to have improved Pap test results. The study seems to indicate that although HPV can be more prevalent in women with HIV, HAART can help to manage HPV infections and reduce the risk of pre-cancerous or cancerous tumours from developing.

**In one study,  
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system to control HPV.**

In addition to increased risk of cervical cancer, a research team from the Women's Interagency HIV Study at the Department of Clinical Pharmacy at the University of California has drawn a connection between HPV infection in the anus and anal cancer in women. Comparing a group of HIV-positive women to a similar group of HIV-negative women, researchers found that the HIV-positive women were three times more likely to have HPV in the anus,

cervix, or in both places at once. On top of that, the HIV-positive women were also more likely to have abnormal anal and cervical growths, a symptom that can sometimes lead to anal or cervical cancer.

Women with high-risk HPV strains—strains that commonly develop into cancer—were between seven and 10 times more likely to have pre-cancerous lesions. As well, 80 percent of HIV-positive women had HPV. Anal HPV was even more common than cervical HPV, with 50 percent more cases of anal HPV. A number of studies have been conducted to explore the link between HPV and anal cancer in men, but the results of this study demonstrate that anal cancer is also a cause for concern in women with HPV.

Smoking cigarettes, already known as a risk factor for abnormal cervical growths, also seems to increase the chances of developing pre-cancerous growths in the anus. In the study, 64 percent of women who smoked had pre-cancerous growths in the anus—regardless of HIV status—as the cancer-causing compounds in cigarette smoke concentrate in the mucus of the anus and genitals.

Both of these studies illustrate the importance of regular vaginal and anal Pap tests for both men and women with HIV, to ensure HPV and any growths are caught early. Although HPV vaccines have recently come onto the market, there isn't enough information yet to determine if these vaccines are safe and effective in HIV-positive women. In British Columbia, the HPV vaccine (Gardasil) is already being provided free to girls in grades six and nine.

Researchers are already investigating how HPV vaccines affect HIV-positive women. The good news is that researchers across Canada and the US are starting to recognize the relationships between HIV and HPV and are working to take action against this troubling STI to ensure dual infection can be treated quickly and HIV-positive women can avoid cancer entirely. With routine Pap tests, especially when combined with HAART therapy, HPV can be managed in women with HIV. ☺

**Nicole** is a recent graduate of the University of Victoria Writing Department and a volunteer with BCPWA's Treatment Information Program.





# Cover all the bases

**The catastrophe of unequal drug coverage across Canada and how to fix it** *by Louise Binder and Ron Rosenes*

**W**hy is it that access to many HIV drugs is a function of your address in Canada? Why is it that federal prisoners have different drug coverage than the RCMP? Why do people have to move from one province to another in order to get a drug they need because they are denied in their home province?

The answer is easy and well understood by chronic disease and disability insiders, those of us who rely on public drug reimbursement plans for our medications. Simply put, we don't have equal access to drugs across this country. Each province and territory sets its own drug budget and works within it to create the formulary or list of what it will pay for. Provinces with larger populations and those with a large number of people with particular types of diseases have larger budgets and will decide to pay for certain drugs, relative to provinces with smaller populations and different disease demographics. In addition, some public plans force the substitution of generic drugs over brand name drugs that may not work for you and may not be what you and your doctor ordered.

It all started with the Canadian Fathers of Confederation who were basically silent in the 1867 *Constitution Act* when it came to health care. In that document, it was left up to the provinces. Today, however, it's not just the provinces and territories that perpetuate this inequality for Canadians. The federal government doesn't have its act together, either. It manages separate plans for groups over which it has jurisdiction, including civil servants, RCMP, the military, federal prisoners, and Aboriginal people on reserve, but it has set different lists or formularies for these various federal plans. We have no idea why.

You have drug coverage while in the hospital, as mandated by the *Canada Health Act*, but only those that are available and

on the formulary list at that hospital. In some cases, patients in hospitals will ask a friend or relative to bring in a prescription for them from their doctor because the hospital won't provide it or may demand they take a substitute which is at best ineffective or at worst, harmful.

## **An uneven patchwork of drug coverage**

The result is a patchwork quilt that is far from keeping us warm. Private insurance plans cover some drug costs for some people, although they tend to be for people who are working, younger, and generally healthier. The public drug programs of the provinces and territories fill in the gaps in different ways. While most offer coverage for seniors and people on social assistance, often the working person without private insurance is the most vulnerable when it comes to paying out-of-pocket.

Canadians are catching on to this inequality across our land as we age and as more drugs for life-threatening and chronic illnesses and conditions are discovered. The Fathers of Confederation couldn't foresee a time when the second largest cost to the healthcare system would result from the use of drugs, or pharmacotherapy.

The problem is that innovation costs money—lots of money for research, development, and regulatory approvals. As a result, the drug companies argue that innovative drugs are generally more expensive. Thus, the provinces and territories, with healthcare budgets already stretched to the limit, are often reluctant to add costly new drugs to their formularies unless convinced they offer a tangible benefit. For people living with HIV, access to newer, less toxic medications is essential, not just because we can develop resistance, but because we take our medications in combination, so it only makes sense to evaluate

their cost that way. And as we all know, PWAs take a lot of other drugs to deal with side effects.

### Canadians want a catastrophic drug plan

Canadians have come to expect drug coverage as part of our social safety net. We expect the right drug for the right person at the right time, regardless of cost, ability to pay, and where we live. We have told this to commissions and task forces, including both the Romanow Commission and Kirby Commission when hearings on healthcare were held across Canada in 2006. They both recommended a catastrophic drug plan for Canadians. (The term catastrophic coverage refers to the financial burden that some people face when diagnosed with a serious medical condition.) The formula for running it and the way to finance it in each report is different, but the principle is the same: no one should be bankrupted to pay for drugs they need, nor should they be denied access to the drugs.

The federal government has a role along with the provincial and territorial governments to ensure that money is transferred into health budgets to ensure that this happens. Some believe that lower-income people should get all drugs for free, some believe that there should be affordable cost sharing between Canadians and their governments, and others argue it should all come out of taxes. Even the federal-provincial-territorial task force set up to look at this issue wasn't sure how it should be financed according to an interim report in 2007, but it was clear that it supported the concept.

For all the information and recommendations our governments have about the fact that Canadians want a catastrophic drug plan, with equal access and best practices in prescribing drugs, nothing has come to fruition.

### Lots of questions about how to address the issue

So let's get down to business. What are the main decisions to be made? First, we need to decide what we mean by "catastrophic." Does it refer to the type of illness the person has—a life-threatening, serious, chronic illness that has an impact on health and quality of life? Some say yes, that anyone with such an illness should get free drugs, period. Or does it refer to ability to pay? Others feel that if the out-of-pocket costs for drugs will be a financial catastrophe for you, then the drugs should be covered, whatever the illness. Does it include a mix of both serious illness and financial hardship? A third group says yes it does. And a fourth group would say either/or: if it's a serious illness or a financial catastrophe no matter the illness, drug costs should be covered.

Once we decide what we mean by a catastrophic drug plan, our second question is how should it be funded? Some say we should raise taxes and fund it directly through the tax system. Others say that users should pay with the exception of people below the poverty line. Some say there should be a deductible based on a sliding scale with a maximum ceiling depending on income.

If it's based on income, then the third question is, do we create a scale that is different for single people than couples, or for people with dependents and those without dependents?

Fourthly, if there's a sliding scale to determine co-payments, at what income levels should that scale increase? And should there be a ceiling or maximum contribution regardless of income?

Fifth, who will administer it? The federal or provincial/territorial governments?

Last but not least, how will it be integrated into existing public plans to ensure that it covers the broadest choice and spectrum of treatments and doesn't result in a race to the bottom where everyone will have catastrophic drug coverage but based on an unacceptably low common denominator?

### Next steps by CTAC

The Canadian Treatment Action Council (CTAC) has decided that the best people to determine the substance of a catastrophic drug program are the people who will use the system. In order to start the process, CTAC has drafted a White Paper that offers suggestions to define who should be covered as well as different formulae for funding and administering the program. The paper has now been presented across the country in a series of consultations to gather input from the HIV community and other disability and disease groups. Input has also been sought via an online survey. Once it's complete, CTAC will invite partners to sign on to this Paper.

The White Paper will then provide advice to health policy-makers based on the research.

Canadians in many parts of the country, particularly those in the Atlantic provinces, where public drug reimbursement programs are weak or non-existent, have told the government that this issue is a priority. It has never been more of a necessity than in this economic crisis, when so many are losing their jobs, their benefits or are taking wage cuts. Keeping people healthy will keep our economy healthy. It's change that Canadians can believe in. ☺



**Louise Binder** is chair of the Canadian Treatment Action Council, Steering Committee member of the Coalition for a Blueprint for Action on Women and Girls and HIV/AIDS, vice-chair of Voices of Positive Women, North American representative on the International Steering Committee of the International Community of Women Living with HIV, and member of the Global Coalition on Women and AIDS Leadership Council.



**Ron Rosenes** is chair of the Community Network Advisory Committee at the Ontario HIV Treatment Network, vice chair of the Canadian Treatment Action Council, and sits on the Ontario Advisory Committee on HIV/AIDS that advises the Ontario Minister of Health.

# The P-spot

**Men tend to get squeamish talking to their doctors about their prostate**

by Lorne Berkowitz

For various reasons—including its location, size, and invisibility—the prostate can be the most mysterious part of male genitalia. And unfortunately, sometimes it's the last thing that men will talk about with their doctor.

The prostate is an exocrine gland just like sweat glands—a gland that secretes to the outside of the body. It's the size of a walnut and is found beneath the bladder, in the front of the rectum and surrounding the urethra. It contributes to the fluid that mixes with the sperm to form semen. Specifically, prostate fluid helps stabilize the sperm and keeps them healthy, aiding in fertility. When a man climaxes, muscle contractions in the perineum enable the prostate to secrete the semen into the urethra and then expel it through the penis.

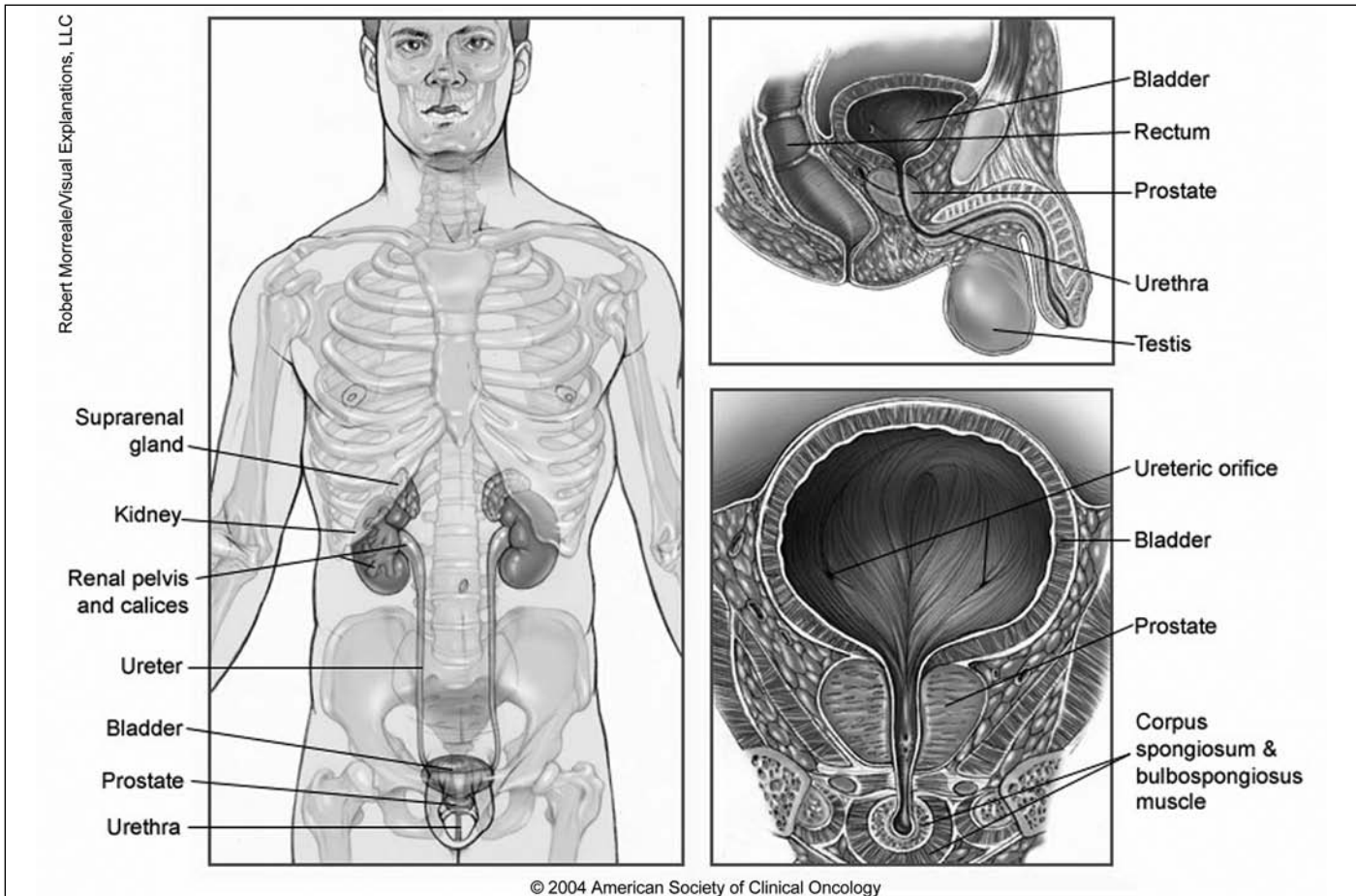
Besides its specific role as part of a man's reproductive organs, it's also referred to as a man's G-spot, or rather his

P-spot. The specific massaging of the prostate during anal intercourse can often create great physical pleasure. And the stimulation of the prostate during sexual activity has been known to increase the intensity of the male orgasm and often the strength of ejaculation.

## Enlargement of the prostate

After the age of 50, however, half of men will experience benign prostatic hyperplasia (BPH). BPH is the enlargement of the prostate. Because the prostate surrounds the urethra, an enlarged prostate may constrict the urethra and interrupt the flow of urine.

Symptoms of BPH may be a delay in urinating, a weak or interrupted stream, and a need to urinate more often. BPH can also get in the way of a good night's sleep. BPH symptoms can range from mild to severe. Often, mild



cases will improve on their own. If your symptoms are severe, doctors will often prescribe hormone therapy, alpha-blockers to relax the urethral sphincter, and surgery in some severe cases.

### Inflammation of the prostate

Another condition of the prostate is prostatitis, the inflammation of the prostate, which can happen at any age. There are three main types of prostatitis: chronic non-bacterial, acute bacterial, and chronic bacterial. The symptoms of all are pretty much the same and only a doctor's exam will be able to differentiate them. These symptoms may include difficulty urinating, frequency of urination, pain upon urination and ejaculation, as well as chronic back and pelvic malaise. Inflammation of the prostate may also negatively affect erectile function.

### Foods for a healthy prostate

Below is a list of the foods that will promote a healthy prostate.

- ▶ Selenium-rich foods: fish, shellfish, Brazil nuts, and garlic
- ▶ Lycopene-rich foods: cooked tomatoes, watermelon, grapefruit, berries, and any bright red food
- ▶ Cruciferous vegetables: cabbage, broccoli, and broccoli sprouts
- ▶ Polyphenols: pomegranate, cranberries, red wine, and soy products
- ▶ Anti-inflammatory foods: ginger, oregano, cinnamon, turmeric, onions, berries, apples, flax, and pumpkin seed (best if ground)

Chronic non-bacterial is the most common type of prostatitis. Most experts are still unclear about the cause. Researchers are currently exploring a connection between candidiasis and prostatitis in immuno-compromised men. Treatment for the non-bacterial strain includes warm baths, plenty of fluids, and—best of all—regular ejaculation. The fluids and the ejaculation will help flush out the prostate.

The bacterial strains are usually more severe and are treated with antibiotics. Sometimes you'll need to take the antibiotics for up to three months, especially in the chronic varieties.

### Prostate cancer

You should also be aware of prostate cancer. It's the third most common cancer among men. Fortunately, men with HIV are no more likely to experience it than their HIV-negative counterparts. As well, the survival rate now is 87 percent. Since the symptoms of this cancer are very similar to prostatitis and BPH, it's important to put aside any squeamishness and get your prostate checked if you're experiencing any of the symptoms mentioned above.

Early detection of prostate cancer is key. If you're over 50, make sure you get an annual digital rectal examination from your doctor. It's simple and quick.

As important as the prostate is to the sexual reproduction of the species, it's also an important part of a man's sense of sexual confidence and pleasure. A healthy prostate will ensure not only a strong, steady urine flow, but also will affect the strength and length of your ejaculation, as well as the amount of pleasure you feel during anal intercourse.

While most men will experience some prostate health issues, there are things you can do to ensure your prostate remains healthy and robust. The best intervention is prevention. The best ways to prevent prostate issues are through exercise and good nutrition—especially foods that are high in antioxidants or have anti-inflammatory properties.

Don't underestimate the role of exercise. Stretches and yogic poses such as spinal twists and sitting fingers to toes stretches will help promote blood flow to your mid-section, which can help keep your prostate healthy. Some studies indicate that direct massaging of the prostate can be beneficial, but remember to be gentle, not massaging your prostate if there is sign of bacterial infection—that may make matters worse.

However humble and invisible your prostate may be, it plays an important role in your life. Take good care of it. ⊕



**Lorne Berkowitz** is a BCPWA board member and a volunteer in the Treatment Information Program.

# Save your skin

**If you're HIV-positive, you're more susceptible to skin cancers from the sun**

by Mark Abbott

**W**ith the cold winter months behind us and the warm summer months almost here, the urge for sun-worshippers to hit the beaches and parks wearing minimal clothing is too much to resist. The usual warnings about the dangers of overexposure to the sun often go unheeded. If you're HIV-positive, you're at even greater risk than HIV-negative people to develop various forms of skin cancer if you don't take proper precautions. If you subject yourself to too much sun and don't employ a skincare regimen, you're susceptible to Kaposi's sarcoma, basal cell carcinoma, malignant melanoma, and squamous cell carcinoma.

According to findings reported by the Fourth International AIDS Society Conference, people with immune suppression are more susceptible to skin cancers. In the early 1980s, Kaposi's sarcoma started showing up in people with HIV/AIDS. Before the introduction of highly active antiretroviral therapy (HAART), up to 80 percent of PWAs suffered from the disease.

In the HAART era, that number has dropped dramatically, and today about 30 percent are susceptible to Kaposi's sarcoma.

However, studies are now showing that other types of skin cancers are common in PWAs. Rates of basal cell carcinoma are higher in PWAs than in HIV-negative people. According to recent research, basal cell carcinoma accounted for 200 cases per 100,000 person years and was 2.3-fold higher for PWAs. Malignant melanoma, the most severe type of skin cancer, had higher rates by 3.1-fold among PWAs compared to those who are HIV-negative. By contrast, rates of squamous cell carcinoma—the second most common type of skin cancer—are the same among PWAs and HIV-negative people.

CD4 cell counts don't correlate with skin cancer. High CD4 cell counts don't protect against skin cancer and low CD4 cell counts don't necessarily help predict skin cancer development.

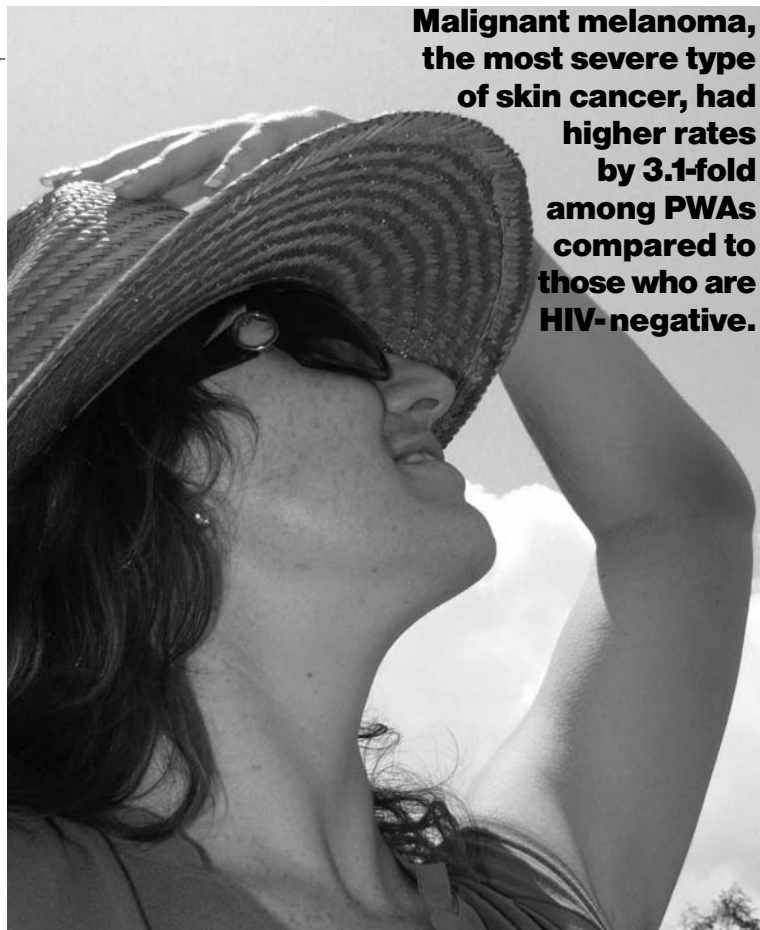
Since the risk of skin cancer is greater for PWAs, it's especially important to protect yourself by adhering to a skincare regimen. Regular cancer screenings are imperative. There are also daily procedures you can do to minimize risks: avoid excessive tanning (including tanning lamps), stay in shaded areas as much as possible, wear a hat, and keep your skin covered—especially your extremities.

If you can't cover up, use a sunscreen lotion with a sun protection factor (SPF) of at least 15 or higher. Apply the sunscreen 15 to 30 minutes before going outside, and reapply the lotion regularly. Also, the sunscreen should have both UVA and UVB protection. The sun is hottest between 11:00 am and 4:00 pm, so skin protection is especially necessary during this time.

Certain medications can make your skin more sensitive to UV rays, so consult with your doctor about your medications before venturing out in the sunshine.

For most of us, summer is the best time of the year. After months of cold weather and darkness, the desire to soak up the sun's rays is tempting. For HIV-positive people, this desire can lead to unfortunate results. Because PWAs are at higher risk for developing skin cancer, staying informed, educated, and protected can greatly reduce the risks—while still enjoying the summer season. ☺

**Malignant melanoma, the most severe type of skin cancer, had higher rates by 3.1-fold among PWAs compared to those who are HIV-negative.**



**Mark Abbott** is a volunteer with BCPWA's Treatment Information Program and an aspiring writer. He lives in Vancouver.





the CTN  
CIHR Canadian  
HIV Trials Network

# Opposites attract: HSV-2 and HIV

by Suzanne McCarthy

The herpes simplex virus 2 (HSV-2) and HIV have been deemed the odd couple—an unfortunate combination of two vastly different viruses that co-infect 52 - 95 percent of HIV-positive individuals. As the rules of attraction tell us: opposites not only attract, they often collide.

Studies show that herpes raises HIV's viral load while HIV increases the symptoms and reoccurrences of genital herpes. Herpes infection has also been strongly linked with HIV transmission.

"There is one opportunity arising from this synergy," says Dr. Darrell Tan of the University of Toronto. "HSV-2 medications have been proven to reduce HIV viral load."

A past CTN postdoctoral fellow, Dr. Tan is an emerging investigator in HIV research. Along with his mentor, Dr. Sharon Walmsley from the Immunodeficiency Clinic and the Infectious Diseases Unit at Toronto General Hospital, Dr. Tan is leading a new clinical trial investigating the use of oral valacyclovir. The study will examine this anti-HSV-2 medication to slow the rate of CD4 count decline and ultimately delay the need to start highly active antiretroviral therapy (HAART) in adults with HIV and infrequent recurrences of herpes, who aren't currently needing or taking HAART (CTN 240).

Dr. Tan says that further studies are needed to examine the impact of HSV-2 treatment on HIV transmission and on CD4 counts—the fundamental marker of HIV disease stage.

HAART has proven to reduce morbidity and increase the quality of life for PWAs. But HAART's potential toxicities and

significant risk of HIV drug resistance means it may be more desirable to postpone starting therapy.

Valacyclovir is a safe, well-tolerated HSV-2 medication with over 10 years of public use. Anti-HSV-2 medications such as valacyclovir are associated with decreased HIV viral loads, yet the use of this treatment to slow the rate of CD4 count decline in HIV co-infected adults hasn't been adequately studied.

Trial enrolment will begin September 2009 and will last two years. Eligible participants will be randomly assigned to either a valacyclovir group or a placebo group. Both groups will receive one pill twice a day. Follow-up for all participants will include standard-of-care medical assessments and blood tests for three to five years following study enrolment or until the primary endpoint is reached (for example, the need to start HAART).

Knowledge gained from this study could lead to the introduction of chronic suppressive valacyclovir as a therapeutic strategy used to slow the rate at which HIV damages the immune system, and delay the start of HAART in HIV and HSV-2 co-infected adults.

This is a multi-centre, randomized, placebo-controlled trial recruiting 480 participants over two years at 24 sites across Canada and Brazil. ☺



*Suzanne MacCarthy is the communications and information coordinator at the CIHR Canadian HIV Trials Network in Vancouver.*

## Studies enrolling in BC

- |  |   |
|--|---|
| <p><b>CTN 239—</b> Phase II study of AGS-004 an immunotherapeutic agent in combination with ART followed by ART interruption<br/><i>BC sites:</i> St. Paul's Hospital, Vancouver</p> | <p><b>CTN 218—</b> Effect of rosuvastatin (Crestor) on blood vessels<br/><i>BC sites:</i> St. Paul's Hospital, Vancouver</p>                                    |
| <p><b>CTN 238—</b> The MAINTAIN study<br/><i>BC sites:</i> Downtown Infectious Diseases Clinic (DIDC), Vancouver; St. Paul's Hospital, Vancouver</p>                                 | <p><b>CTN 214—</b> Effect of a one-year course of HAART in acute/early HIV<br/><i>BC sites:</i> DIDC, Vancouver; Cool Aid Community Health Clinic, Victoria</p> |
| <p><b>CTN 236—</b> HPV vaccine in HIV-positive girls and women<br/><i>BC sites:</i> Oak Tree Clinic, Vancouver</p>   | <p><b>CTN 194—</b> Peg-Interferon and citalopram in co-infection (PICCO)<br/><i>BC sites:</i> St. Paul's Hospital, Vancouver; DIDC, Vancouver</p>               |
| <p><b>CTN 222—</b> Canadian Co-infection Cohort<br/><i>BC sites:</i> DIDC, Vancouver; St. Paul's Hospital, Vancouver</p>   |   |

To find out more about these and other CTN studies, visit the CIHR Canadian HIV Trials Network database at [www.hivnet.ubc.ca](http://www.hivnet.ubc.ca) or call 1.800.661.4664.

# Measuring up

## Part 3 in our series of understanding blood test results *by Ashley Smith*

**S**ome HIV treatments can affect your blood work results, such as elevated cholesterol and triglyceride levels. Blood tests are part of your routine HIV care. The following tables explain different tests you might typically get when you have blood work done, the importance of each test, and where normal values may fall.

Serum electrolytes are minerals in your blood that control things like cardiac function and muscle contraction. Lipids are fat-like compounds and one of their primary roles is energy storage; cholesterol and triglycerides tests help determine the quality of your diet.

If you have any questions, contact BCPWA's treatment information

program at 604.893.2243 to discuss your results with a peer treatment volunteer. This can give you the tools to be better prepared to discuss your lab results with your doctor. ☺

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

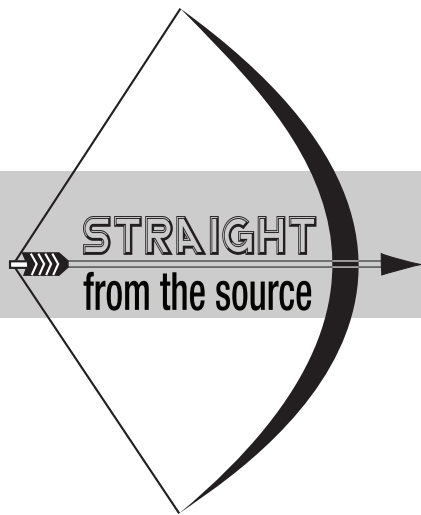
Test	Importance	Normal values
Sodium	<ul style="list-style-type: none"> <li>• Nerve impulse &amp; maintaining normal cell function</li> <li>• Helps with fluid balance</li> <li>• Excess sodium (hypernatremia) is normally due to dehydration during periods of vomiting &amp; diarrhea</li> <li>• Low sodium (hyponatremia) related to hormone dysregulation; also seen with hepatitis C (HCV) co-infection</li> </ul>	135 – 145 mmol/L
Potassium	<ul style="list-style-type: none"> <li>• Nerve impulses &amp; normal cell function</li> <li>• Excess potassium (hyperkalemia) can be due to kidney problems, non-HIV medication, &amp; hormone dysregulation</li> <li>• Loss of potassium (hypokalemia) can be due to insufficient intake, loss of fluid (vomiting &amp; diarrhea), &amp; hormonal dysregulation</li> </ul>	3.5 – 5.0 mmol/L
Chloride	<ul style="list-style-type: none"> <li>• Neurotransmitter release</li> <li>• Hyperchloremia associated with some kidney disorders, hormone dysregulation, &amp; dehydration</li> <li>• Hypochloremia is very rare but may be associated with vomiting</li> </ul>	95 – 105 mmol/L
Bicarbonate	<ul style="list-style-type: none"> <li>• Regulates the pH of the blood</li> <li>• Low bicarbonate can be response to increase in acid production (lactate), decrease in acid removal (kidney problems/hormonal dysregulation), &amp; loss of bicarb (diarrhea)</li> <li>• High bicarbonate can be response to bicarb (antacids), loss of stomach acid (vomiting), or loss of acid through kidneys (e.g., water pills, high potassium, or hormone deficiency)</li> </ul>	22 – 30 mmol/L

**Table 2. Lipid profile**

Test	Importance	Normal values
Cholesterol	<ul style="list-style-type: none"> <li>• Associated with hormone production, cell membrane constituent, &amp; a known factor in heart &amp; vessel diseases</li> <li>• HIV can cause infected cells to expel cholesterol, leading to hypercholesterolemia (high cholesterol in the blood)</li> <li>• Genetics and diet also factor in cholesterol level</li> </ul>	Less than 5.2 mmol/L
LDL (low density lipoprotein)	<ul style="list-style-type: none"> <li>• “Bad” cholesterol causing damage to blood vessels</li> <li>• Genetics &amp; diet affect LDL</li> <li>• Increased in some HAART therapy, notably certain PIs</li> </ul>	1.5 – 3.4 mmol/L
HDL (high density lipoprotein)	<ul style="list-style-type: none"> <li>• “Good” cholesterol</li> <li>• Genetics &amp; diet affect HDL</li> <li>• Decreased HDL levels seen with HAART therapy, most notably protease inhibitors &amp; NNRTIs</li> </ul>	Greater than 0.9 mmol/L
Triglycerides	<ul style="list-style-type: none"> <li>• Associated with increased risk of heart &amp; pancreatic diseases</li> <li>• Increased in PWAs on HAART, mostly PIs &amp; NNRTIs</li> </ul>	Less than 1.5 mmol/L

**Table 3. Other tests**

Test	Importance	Normal values
Glucose	<ul style="list-style-type: none"> <li>• The body’s main source of energy &amp; the only source of energy for the brain</li> <li>• Hyperglycemia is the increase in blood glucose &amp; can be caused by diabetes, eating disorders (bulimia) &amp; medications</li> <li>• In HIV-positive individuals, PI, HCV co-infection, &amp; dyslipidemia are known to be associated with hyperglycemia due to insulin resistance</li> <li>• Hypoglycemia can be caused by a decreased intake associated with poor appetite</li> </ul>	3.9 – 6.0 mmol/L
Lactate	<ul style="list-style-type: none"> <li>• Normal product of “anaerobic” metabolism, or a physiologic stressed state, such as running, normally corrected for once stress has subsided</li> <li>• High lactate levels associated with higher acid in blood</li> <li>• Some NRTIs may increase lactate.</li> </ul>	0.5 – 2.1 mmol/L
Pap smear	<ul style="list-style-type: none"> <li>• Tests presence of HPV, the virus that causes cervical cancer in women; or anal cancer in men &amp; women</li> </ul>	



what's new in research

## The Antiretroviral Cohort Collaboration

by Dr. Marianne Harris

**The** Antiretroviral Cohort Collaboration (ART-CC) is a large collaborative effort including 19 cohorts of HIV-positive people from Europe and North America. The BC Centre for Excellence in HIV/AIDS (BC-CfE) was a founding member of this collaboration, which also includes the Southern Alberta Clinic as well as groups throughout Europe (France, Germany, Italy, Switzerland, Spain, the UK, and others), and four groups in the US.

The collaboration was formed in 2001 to look at the outcomes of PWAs starting highly active antiretroviral therapy (HAART), as well as at factors influencing those outcomes and how they're changing over time. The ART-CC database now includes information on more than 60,000 PWAs.

Dr. Bob Hogg at the BC-CfE was the lead author on a recent ART-CC paper published in the British medical journal *Lancet* last year, which looked at changes in life expectancy over time for people who start HAART in industrialized high-income countries such as Canada. The study looked at people who started HAART during the following time periods: 1996 - 1999, 18,587 people; 2000 - 2002, 13,914 people; and 2003 - 2005, 10,854 people.

During the study period, 2,050 study participants died, representing 4.7 percent of the study population. The good news is that death rates among people 20 years of age and older have decreased steadily over time:

- ▷ 1996 - 1999: 16.3 deaths per 1,000 person-years
- ▷ 2000 - 2002: 12.4 deaths per 1,000 person-years
- ▷ 2003 - 2005: 10.0 deaths per 1,000 person-years

(Person-years of followup is the number of people followed in the study multiplied by the number of years each person is followed, i.e., the length of time the person has been in the study.)

For people starting HAART between the ages of 20 and 44 years, death rates are even lower:

- ▷ 1996 - 1999: 13.1 deaths per 1000 person-years
- ▷ 2000 - 2002: 10.3 deaths per 1000 person-years
- ▷ 2003 - 2005: 7.5 deaths per 1000 person-years

Looked at another way, a 20-year-old starting HAART between 2003 and 2005 could expect to live about 13 years

longer than his or her counterpart who started HAART between 1996 and 1999, while a 35-year-old would gain about 12 years in life expectancy over the same time. These results indicate that in high-income countries where treatment is readily available, life expectancy for HIV-positive people has improved significantly over time, mainly as a result of more effective, well tolerated, and simplified HAART regimens.

The ART-CC investigators noticed that life expectancy varied quite a bit between different groups of people. For example, women had longer life expectancies than men, by about one year overall. Also, people who acquired HIV through injection drug use had shorter life expectancies by about 10 years than people in other risk groups.

Not surprisingly, life expectancies were shorter for people who started HAART with a lower CD4 cell count. In line with these CD4 findings, more recent work from the ART-CC, which was recently presented at the 2009 Conference for Retroviruses and Opportunistic Infections in Montreal, confirmed the advantages of starting HAART at higher CD4 thresholds, as recommended in current guidelines. The risk of AIDS and death is lower when HAART is started immediately as opposed to delayed until the CD4 cell count falls, for all levels of starting CD4 counts up to 350-450 cells/mm<sup>3</sup>.

The ART-CC is ongoing, with continuing input from the BC-CfE, and other issues of interest are being studied. The investigators are also comparing their findings with those of similar international groups in Africa and elsewhere, to allow comparisons of HAART outcomes between industrialized and resource-limited settings. Further information and updates on the ART-CC can be found at [www.art-cohort-collaboration.org](http://www.art-cohort-collaboration.org). ☉



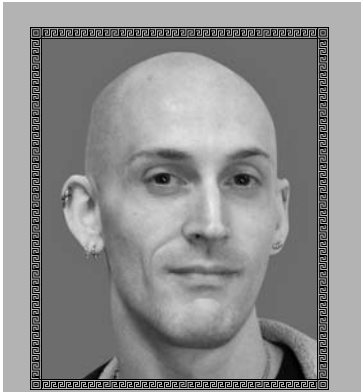
**Dr. Marianne Harris** is a family doctor with the AIDS Research Program at St. Paul's Hospital in Vancouver.



# Volunteering at BCPWA

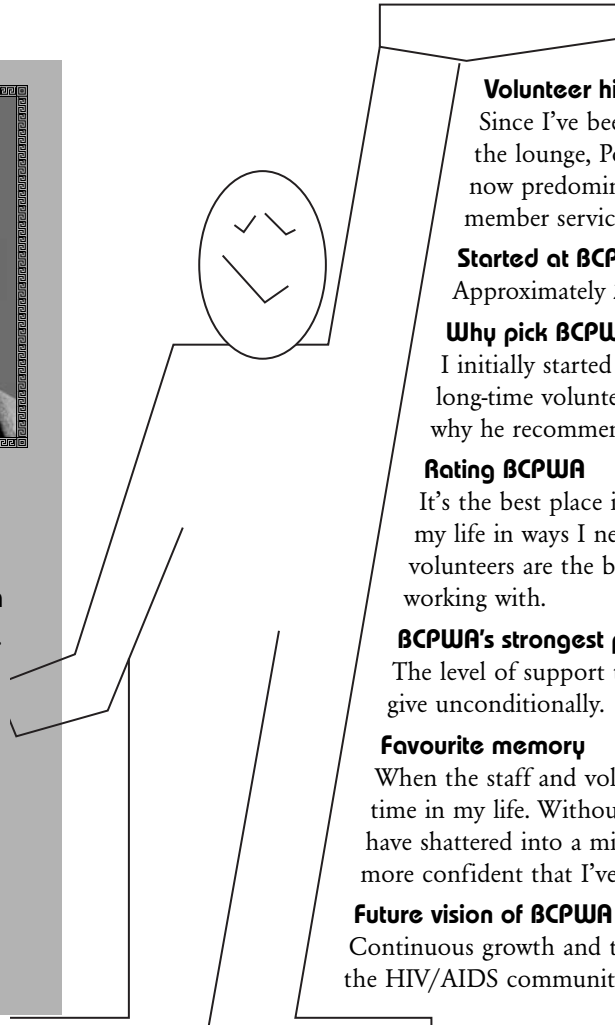
Profile of a volunteer:

## Jason Henriksen



Jason is extremely diligent and thorough. Anything he's tasked with he carries out with a cheerful countenance. What a wonderful volunteer to have as a member of our team!

**Ruth Marzetti,**  
Co-director,  
Support Services



### Volunteer history

Since I've been at BCPWA, I've worked at the front desk, the lounge, Polli & Esther's, CHF, the mailroom, and I'm now predominately an assistant to Richard Harrison, the member services coordinator.

### Started at BCPWA

Approximately 2 years ago.

### Why pick BCPWA?

I initially started at the suggestion of my partner who is a long-time volunteer here. It didn't take me long to discover why he recommended it.

### Rating BCPWA

It's the best place in the world to work. It has changed me and my life in ways I never thought imaginable. The staff and other volunteers are the best group of people I've had the privilege of working with.

### BCPWA's strongest point

The level of support that the people of this organization give unconditionally.

### Favourite memory

When the staff and volunteers helped me through the most difficult time in my life. Without this support and guidance, my life would have shattered into a million pieces. Instead, I came out stronger and more confident than I've ever been. I'm very grateful!

### Future vision of BCPWA

Continuous growth and transformation to better serve and empower the HIV/AIDS community.



## Polli & Esther's Closet

Your peer-run, second time around store!

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

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



Great selection!



# where to find help

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

## A Loving Spoonful

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

## AIDS Memorial Vancouver

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

## AIDS Society of Kamloops

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

## AIDS Vancouver

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

## AIDS Vancouver Island (Victoria)

1601 Blanshard St, Victoria, BC V8W 2J5  
t 250.384.2366 or 1.800.665.2437  
e info@avi.org www.avi.org

## AIDS Vancouver Island

(Cowichan Valley Mobile Needle Exchange)  
t 250.701.3667

## AIDS Vancouver Island (Campbell River)

t 250.830.0787 or 1.877.650.8787

## AIDS Vancouver Island (Port Hardy)

t 250.949.0432

## AIDS Vancouver Island (Nanaimo)

t 250.753.2437

## AIDS Vancouver Island (Courtenay)

t 250.338.7400 or 1.877.311.7400

## ANKORS (Nelson)

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

## ANKORS (Cranbrook)

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

## Asian Society for the Intervention of AIDS (ASIA)

210 – 119 West Pender St,  
Vancouver, BC V6B 1S5  
t 604.669.5567 f 604.669.7756  
e asia@asia.bc.ca www.asia.bc.ca

## BC Persons With AIDS Society

1107 Seymour St, Vancouver BC V6B 5S8  
604.893.2200 or 1.800.994.2437  
e info@bcpwa.org www.bcpwa.org

## Dr Peter Centre

1100 Comox St,  
Vancouver, BC V6E 1K5  
t 604.608.1874 f 604.608.4259  
e info@drpetercentre.ca www.dr-  
petercentre.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 VOJ 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](http://www.bcpwa.org)  
and click on "Links and Services" under the  
"Empower Yourself" drop-down menu.



<b>Upcoming BCPWA Society Board Meetings:</b>			
<b>Date</b>	<b>Time</b>	<b>Location</b>	<b>Reports to be presented</b>
May 6, 2009	1:00	Board Room	Director of APT
May 20, 2009	1:00	Board Room	Written Executive Director Report / Standing Committees Financial Statements—February / Director of Prevention
June 3, 2009	1:00	Board Room	Executive Committee / Director of Communications Strike ED Evaluation Committee
June 17, 2009	1:00	Board Room	Written Executive Director Report / Financial Statements—March Director of HR
July 1, 2009	1:00	Board Room	Standing Committees Quarterly Department Reports – 4th Quarter/Year End

**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.

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**Community Representation & Engagement**  
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**Education & Communications**  
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**IT Committee**  
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**living⊕ Magazine**  
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**Positive Gathering Committee**  
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# Boost in a tube

## The hard reality of flagging sexual interest

by **MT O'Shaughnessy**

Ikea is looking more and more appealing. Well, their instructions, anyway.

As I'm unfolding the instructions for a steroid goop I'm supposed to slather on, grabbing a magnifying glass to read them, it seems inevitable I consider the furniture store's instructions. You should see the restrictions on where and how to apply this stuff: only on your shoulders and upper arms, not on forearms, never on your chest, only for some brands on your stomach, never near your legs, avoid the genitals.

**I'm finding it wildly amusing that as I plaster myself with this clear gunk that is, in essence, my new best friend; it also makes it so that I can't do anything with my renewed and functioning libido.**

I'm not sure where the Allen wrench is supposed to go.

Over the last year, my energy level has been declining. The most recent round of doctor visits revealed that my testosterone levels are low. So I'm contorting myself around this piece of paper trying to see what I need to do with a steroid gel. Which apparently makes me untouchable for five hours a day, once applied.

Part of my energy decline has been below the belt. I'm finding it wildly amusing that as I plaster myself with this clear gunk that is, in essence, my new best friend; it also makes it so that I can't do anything with my renewed and functioning libido.

And they say *I'm* a masochist.

On this first day, I've noticed no major difference, other than how I stank of the alcohol that is mixed in—to help the goop absorb into the skin faster, I assume. Smoking presented another moment of fear that my shoulders would catch on fire. With my luck, I'd get a hot doctor at emergency wondering why I'm flaming.

I've decided to be open about this process. It has too many good lines for me to get to them all on my own. I need a hand or two—so to speak.

But the truth is that I'm looking forward to potentially having a return to a slightly more energetic Mike—in all areas. It's hard enough getting around the thorny issue of sex these days without having to overcome my own apathy on the subject. And really, it's not even apathy. That looks festive from here.

It would be nice to end a day not dragging myself back home after work, wondering if I could just nap on the sidewalk, or consider doing more than just walking home after work. Maybe a movie. Or a conversation. Some semblance of a pulse.

It's been hard to convince people that I'm dealing with any of this. It's a gradual fade of energy and interest in the world. It's not like one day I'm doing marathons, the next I'm under a blanket being pushed around by swarthy young nurses. It's a lot less dramatic than that.

Until you compare bigger gaps of time. A year ago, I could have walked around Stanley Park. Today, I need to take a lot of breaks or I simply can't do it. Never in my life have I had the experience of thinking, "oh hell, I'm going to get stuck out here because I can't make it back." That was the wake-up call.

It's like being betrayed by your body. Part of this is, yes, aging. And yes, part of this is that I've never actually done a marathon. But there is so much more to all this, which just adds to my frustration.

So while this gel—this lovely, stinky, sticky gel—might be treating something unrelated to all that, I'm willing to give it a shot.

If nothing else, it's revitalized my stock of jokes. ☺

**Mike O'Shaughnessy** is not allowed to sum himself up as "born in 1972, not dead yet." Instead, he describes himself as: a fairly average person, last seen in the presence of rather extraordinary people, living as best as he's able.

Send chocolate.

