

THE POSITIVE SIDE

HEALTH INFORMATION & VIEWS

WINTER 2008
VOLUME 10 ISSUE 2

SPLISH SPLASH

Create your own winter
spa getaway (therapeutic
bath recipes included!)

GESUNDHEIT!

Fending off the flu

RISKY BUSINESS

Rethinking safer sex

BLUES NOTES

Dealing with depression



Canadian AIDS Treatment Information Exchange
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CATIE IN PRINT

CATIE's many free HIV treatment publications include *TreatmentUpdate* and a series of informative Practical Guides. The guides deal with topics ranging from treatment side effects to complementary therapies to nutrition. CATIE also offers the new *Living with HIV: Starting Points* brochure developed with the Toronto People With AIDS Foundation. All CATIE publications are available through our website, which also offers a wide array of resources produced by AIDS organizations across Canada.



CATIE ONLINE WWW.CATIE.CA

The CATIE website offers a wide variety of online resources and links, downloadable PDFs and, through our new online ordering centre, free access to over 550 English and French publications produced by organizations across Canada. CATIE and partners also offer multilingual HIV treatment information at www.treatHIVglobally.ca. Or, if you have a specific HIV or hepatitis C question, you can send it to our Educators at questions@catie.ca.



CATIE BY PHONE 1-800-263-1638

CATIE Educators offer a free, anonymous, one-on-one phone service. They can answer your HIV and hepatitis C questions and connect you with resources near you.

Phone Service Hours	Monday	Tuesday to Thursday
British Columbia	7 am - 6 pm	7 am - 3 pm
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Atlantic Canada	11 am - 10 pm	11 am - 7 pm
Newfoundland	11:30 am - 10:30 pm	11:30 am - 7:30 pm



EDITOR'S LETTER

Winter is a dark time, and in this issue of *The Positive Side* we hope to brighten your long nights by highlighting just a few of the things that bring winter brilliantly to life.

Winter is...

...a time of rejuvenation. And what better way to rejuvenate than a do-it-yourself spa. In our cover feature, Darien Taylor shows you how to pamper yourself on those dreary winter days.

...a passionate time. While the mercury dips outside, the temperature soars in the bedroom (and backroom). To help keep things safe, CATIE analyzes the ongoing debate around viral load and infectivity.

...a time to stay inside. Bad weather may leave people with HIV stuck at home, but they can still stay connected. In creating www.frequencevih.ca, Albert Martin has ensured that HIV-positive francophones stay in touch with each other and the world.

...a dark time. Winter can bring on a case of the blues. Our Ask the Experts column explores depression—how to recognize it and how to cope. As well, David Nelson shares a hopeful story of his journey with HIV and depression.

...a migratory time. Birds flying south are on a journey to a warmer place. In Art Posi+ive, Don Short uses brushstrokes along his journey in accepting his diagnosis with HIV.

...cold and flu season. It is said that prevention is the best medicine, and so we provide the latest advice on how to ward off the bug.

...a gathering time. When it's cold outside, many find warmth in the company of friends and family. In From the Front Lines we showcase social programs from across the country.

...a time to share stories. In Chatty CATIE, five people with HIV talk about one of the most important treatment decisions they faced—how they chose their anti-HIV meds.

...a time of reflection. In an interview held after AIDS2008, Canadian Craig McClure, executive director of the International AIDS Society, shares his thoughts on the state of the global epidemic.

We'd love to hear what you think about anything you read in *The Positive Side*. Send your stars and cherry bombs to dmclay@catie.ca.

—David McLay

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socialize v. [so·cial·ize] 1. to interact with others...

Sometimes it's nice just to hang out, but meeting other HIV-positive folks to socialize with can be like finding a needle in a haystack. **Alex McClelland** highlights five unique and creative programs to satisfy social butterflies from coast to coast.



ATLANTIC

The PHA Learning Club

School's in for people with HIV in Halifax, and they don't mind one bit. The PHA Learning Club is less like math class, with its smell of chalk dust and agony of mind-twisting algebra equations, and more like everyone's favourite period—lunch. There's talking and eating and eating and talking, but hopefully no talking with a full mouth!

The PHA Learning Club was started in 2006 as a public-speaking training program for people living with HIV in and around Halifax. Initially the club was set up to help speakers prepare for presenting their personal stories to public health professionals and medical students across the province. However, it quickly grew beyond the traditional sense of a speakers' bureau and became a sort of social network for participants.

The group meets regularly in downtown Halifax for a potluck supper followed by a meeting and training activities. Mealtime is a great chance to make connections, learn about upcoming events and share practical advice about living with HIV. During the meeting portion, members practise public speaking and build confidence. A recent session included training from Toastmasters, the famed public-speaking program. Don't fret, there's no need to be an aspiring orator—quieter folk from the back of the class are more than welcome to join.

Looking ahead, the club sees plenty more courses in its calendar. "We are planning on expanding and doing more. This is just the beginning," says club member Marg.

"Meeting, sharing food and supporting each other is empowering, as it can be very isolating being positive."

For directions to the cafeteria, contact Larry Baxter at larrybaxter@ns.sympatico.ca or call 902.454.5158.

ONTARIO



Toronto's Pozitive Hetero Socials

In the HIV community of Canada's largest city, it can be hard to be straight. Toronto has a flourishing gay community, which, after facing the epidemic for more than 20 years, has a well-established HIV/AIDS support network. Not so much for the heteros.

Karl Jennrich knows from experience how hard it can be to connect with other HIV-positive heteros. In 2002, he took matters into his own hands and started Toronto's Pozitive Hetero Socials. As its name suggests, the group aims to bring HIV-positive hetero people together to hang out in a relaxed social setting, share food, gossip and make new friends. Along the way Karl met Angela (on a poz dating site), and the two newlyweds now host the group together.

About 10 to 20 people show up to each event, and there are always a few new faces each time the group meets (every six to eight weeks). These socials take it well beyond the standard venues of coffee shops and bars—there's a summer BBQ at Centre Island and a Halloween house party (extra points awarded for not losing your Sarah Palin wig while bobbing for apples!).

Though most of the members are already connected to the multiple services available in the city, Pozitive Hetero Socials fills a void by creating a place to meet socially. "Many laughs are shared and a good time is had by all," Jennrich says. "And although the group's basis isn't support, it does give people a chance to talk about health, meds, personal issues and, most importantly, life."

For a good time contact [pozitiveheterosocials@gmail.com!](mailto:pozitiveheterosocials@gmail.com)

QUEBEC

Jeunes Adultes Séropositifs Ensemble (JASE)

In French *jaser* means to chat, and once a month HIV-positive youth in Montreal get together to do just that. While there's a lot of talk of the movie they watched last weekend or who was seen bumpin' and grindin' on the dance floor, there's also a serious side to the group. "The youth get to meet other people in their situation and share how they feel, create a social network and understand what HIV is and what the treatment options are," says Pascal, who has facilitated the group for the past five years.

Discussions revolve around important questions like relationships (and heartbreak), sex (however you like it) and HIV treatment information (now there's a sexy topic!). The get-togethers are led by an HIV-positive youth so that participants are as comfortable as possible, and the information is always geared specifically toward young people. This is particularly important, says Pascal, given the lack of HIV resources for this demographic. The evenings often include guest doctors and experts, giving participants a chance to get the 411 about the latest hot topics.

➤ If you're under 30 and you wanna *jaser*, contact jase1629@hotmail.com.



PRAIRIES

AIDS Calgary Nutrition Program: Positive Living Lunches

"People always bond better when breaking bread," says Capri Rasmussen, an AIDS Calgary staffer. That might explain why the agency's nutrition program, which started as a way to help people with HIV get a healthy meal, has become much more. "The program addresses nutritional needs and also builds peer and social connections."

The program's cornerstone is its Positive Living Lunches. "We have two Friday lunches per month, during which people with HIV get together to visit and share a meal. They also volunteer as cooks or kitchen helpers if they like," Rasmussen says. "It's an empowering experience for them and helps build a community." So get out your apron, make some friends and fill your belly with something nutritious.

AIDS Calgary's nutrition program also includes an annual Calgary Stampede BBQ (don your Stetson hat!) and Coffee Connection, a relaxed social event where people meet over snacks and coffee.

➤ Jacket and tie not required. Call 403.508.2500 or e-mail info@aidscalgary.ca to make a reservation.



PACIFIC

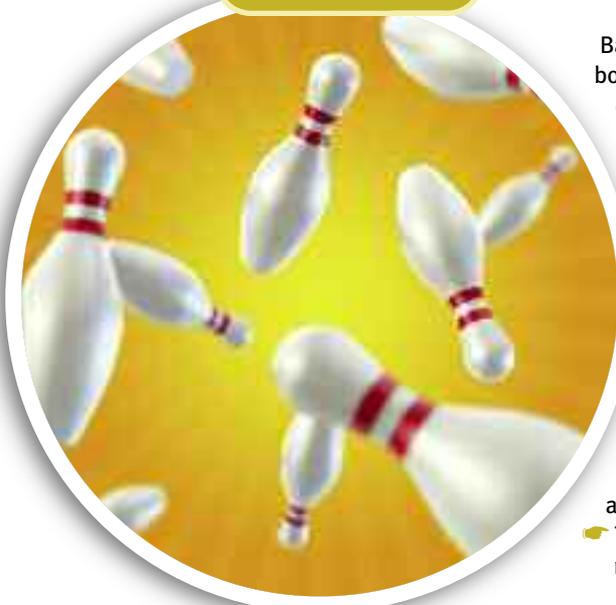
Average Joes

Bar scene not for you? Prefer an invigorating hike or a friendly game of bowling? (Or not so friendly if you're playing with my friend Mark—he's cutthroat and has the shoes to match!)

If so, you might want to check out Average Joes, a group for gay and bisexual men living with HIV in Vancouver and area. "Average Joes started as a way to meet and socialize in an atmosphere where being HIV positive is not an issue," says Richard Harrison of the British Columbia Persons with AIDS Society (BCPWA), which supports the group.

Every Wednesday, members gather to play pool and eat pizza. If that isn't enough to draw you out, there are weekly prizes. When you feel you've had one more slice than perhaps necessary, sign up for one of the many physical activities on the roster. Last September about 30 members hiked North Vancouver's Lynn Canyon and took in the spectacular views from the suspension bridge. Afraid of heights? Average Joes also puts on a bowling tournament, a Christmas party and a summer event.

➤ Think you're up to being an Average Joe? Contact Richard Harrison at richard@bcpwa.org or call 604.893.2258.





One pill, two pill. Red pill, blue pill. How did you choose your meds?

RonniLyn Pustil asks five PHAs how they chose their current combination of anti-HIV meds (or, as the smarty-pants call it, highly active antiretroviral therapy—HAART for short).

KEN BRISTOW, 49

Winnipeg

Diagnosed with HIV in 2003

CD4 count: 317

Viral load: 42 (“I consider myself undetectable”)

I’ve been on Sustiva (efavirenz) and Kivexa (abacavir + 3TC) since December 2007. It’s my second regimen. The only reason I switched is because I was on Sustiva and Combivir (AZT + 3TC) before and I was having issues with the Combivir—some noticeable lipodystrophy around my shoulder area and a bit in my cheeks.

It was my choice to switch and my doctor was more than willing to look at it. She

thought Kivexa would be a good drug for me. She put me on it after we did the hypersensitivity test and found out that it was safe for me to take abacavir.

Knowing a number of other people who’ve had issues with their drugs, I’ve had it pretty easy. My drugs are working and I’m happy, and that’s all that matters.

Considering where I was five years ago, I have to think positively. I was diagnosed in the hospital. I was really sick and didn’t know what was going on. At first they thought I had tuberculosis. Then they did an HIV test and I tested positive. I was in really bad shape. My CD4 count was 33 and my viral load was half a million. I had pneumonia (PCP). I also was diagnosed with hepatitis C.

Within a week I was on HIV medications. It took between four and six months before I started to feel almost normal again. My viral load dropped

quickly and dramatically—I’ve been undetectable for about four years now—but it was a struggle to get my CD4 count back up. I’ve been a slow climber... slow and steady.

DANIÈLE, 44

Montreal

Diagnosed with HIV in 1984

CD4 count: 169

Viral load: 150–200

I refused to start HAART for many years. I made several attempts but the diarrhea, headaches and fatigue made me give up. I was skeptical that the treatments would work, and I also didn’t feel like I really had to start because I had never come down with an opportunistic infection.

I made the decision to really start after attending a workshop at Maison Plein Coeur. It explored the meds through different discussions and through art. Everyone had different opinions and experiences about HAART. I came away with a different take on the meds. I stopped seeing only the negative side of HAART.

I’ve been seeing the same doctor for several years and he always respected and supported my right not to take meds. When I did start, I didn’t feel forced in any way because I made the decision myself. We agreed that I would start HAART and not stop for one year.

The decision about which combination to take was made on the advice of my doctor. He was aware of my concerns about adherence, so he was careful to prescribe a combination that can be taken just twice a

day. In January 2008, I started taking etravirine (Intelligence), Truvada (FTC + tenofovir) and Norvir (ritonavir). I was part of a clinical trial, but I didn’t feel like a research guinea pig. Instead, I felt more like I had achieved a personal victory through all the work I did in accepting to start treatment and making a contract with my doctor.

Many people might find that a CD4 count of 169 is pretty low, but I lived with between 0 and 4 CD4 cells for 13 years, so I see my combination as a great success. I have no regrets about waiting so long to start HAART, as I have the hope of living for many more years.

JAKE HILLS, 45

Vancouver

Diagnosed with HIV in 2000

CD4 count: 540

Viral load: undetectable

May 1, 2000: I tested positive. My virus was at very low levels and I was healthy and active. For the next few years I had regular tests and check-ups. Everything was going great.

2005: I could feel a change taking place. I was becoming doubtful of the most basic things, and I wasn’t able to complete thoughts. By 2006, I started getting terrible pains in my legs. Sometimes my neuropathy was so painful that I couldn’t walk.

December 2006: I had a near-collapse at work. I had no energy and felt mentally and physically empty. I wasn’t on HIV meds and I felt like the HIV was taking over my system. My advocate at BCPWA told me to go to my doctor, who immediately sent me for blood work. My CD4 count was 50 and my viral load was over 100,000. I was very sick with many infections.



I met with my doctor and pharmacist to discuss the immediate need for drug therapy. **The side effect issue was very high on my list. I didn't want to be sick from taking drugs that were supposed to help me.** I also suffered terribly from anxiety and depression, and I wanted meds that wouldn't make those issues worse.

Given how sick I was, my doctor and pharmacist wanted an aggressive approach against the virus. We discussed all the treatment options and decided on a combination of Kaletra (lopinavir/ritonavir) and Truvada. I was wary of Kaletra because of concerns about heart problems as a possible side effect. However, I'd heard that in combination with Truvada the drugs worked well against HIV.

February 2007: I started HAART. Initially I had strong side effects, but I never stopped taking the meds (the side effects only lasted one month). I rested a lot as my system repaired itself.

Today: I've added relaxation therapies and fitness to my health regimen. They've helped me gain weight and improve my mental state. I've also learned the value of talking to my peers at BCPWA about their experiences.



GORDON SINCLAIR, 48

Regina

Diagnosed with HIV in 2000

CD4 count: 312

Viral load: 25,000

I never really chose my meds; it was the doctor who did the choosing. I wasn't even given any options.

When I was first diagnosed they put me on meds right away—Viracept (nelfinavir) and Combivir. I was on that combination for about two years. Then I went through a bad time in my life, and every day that I took those meds I was reminded of what I had, so I stopped taking them completely. I avoided going to the clinic and I put HIV in the background.

I didn't go back on the meds until about two years ago. A change in lifestyle made me do it: I had my 13th grandchild and decided I wanted to live a little longer. Also, I got a job as Outreach Coordinator at All Nations Hope AIDS Network. (Even though I didn't want to deal with my own problems, I still wanted to help other people.)

When I went to see the doctor, she put me on Kivexa and Sustiva. Basically, she left the room, wrote out the prescription and put it in my hand. I didn't ask questions—I figured the doctor knows what she's doing. I think I put too much faith in the doctor. **I was never given the opportunity to discuss the medications.** There could be something out there that's better for me, but nobody's ever given me the chance to talk about it.

Plus, nobody has ever discussed with me the side effects of any of the meds I've been on. The only way I know about side effects is from the information package that comes with the meds. I've found out more about my meds and their side effects from that package than from my doctor. I get more help from my pharmacist than from anybody else. I'm also on methadone, and nobody's ever talked to me about drug interactions.

I'm fortunate because I get the education I need about HIV from the field I work in. What about the people out there who don't have that opportunity?

MICHAEL CONNIDIS, 54

Vancouver

Diagnosed with HIV in 1985

CD4 count: 570

Viral load: <40 ("the new undetectable")

How I chose my HAART regimen, or, life in the default lane: My choice was pretty limited in the early days, as it

was for everyone else. It wasn't just that there weren't many drugs to choose from, but the ones that were available were harsh, although fortunately they proved to be effective.

Thanks to the arrival of protease inhibitors, I was pulled back from the brink. Initially, I was on a dual therapy of saquinavir (Invirase) and d4T (Zerit), and in 1998 I stepped into the world of HAART when a third drug, nelfinavir, was added.

Since then, there have been changes to my regimen in attempts to minimize side effects and take advantage of newer and hopefully less-toxic drugs. My choice of antiretrovirals has been limited due to my intolerance of ritonavir. The side effects of my regimen have been constant and chronic, and I am now eyeing drugs from new classes, such as the integrase inhibitor raltegravir (Isentress), that seem to be very well tolerated.

I recently went through four months of test-driving several new combos in an attempt to switch to a regimen that's less toxic. New classes of drugs, new drugs in old classes and drugs combined into one pill—I tried them all. It was a rough ride and at the end I was left taking the same old meds—saquinavir and nelfinavir.

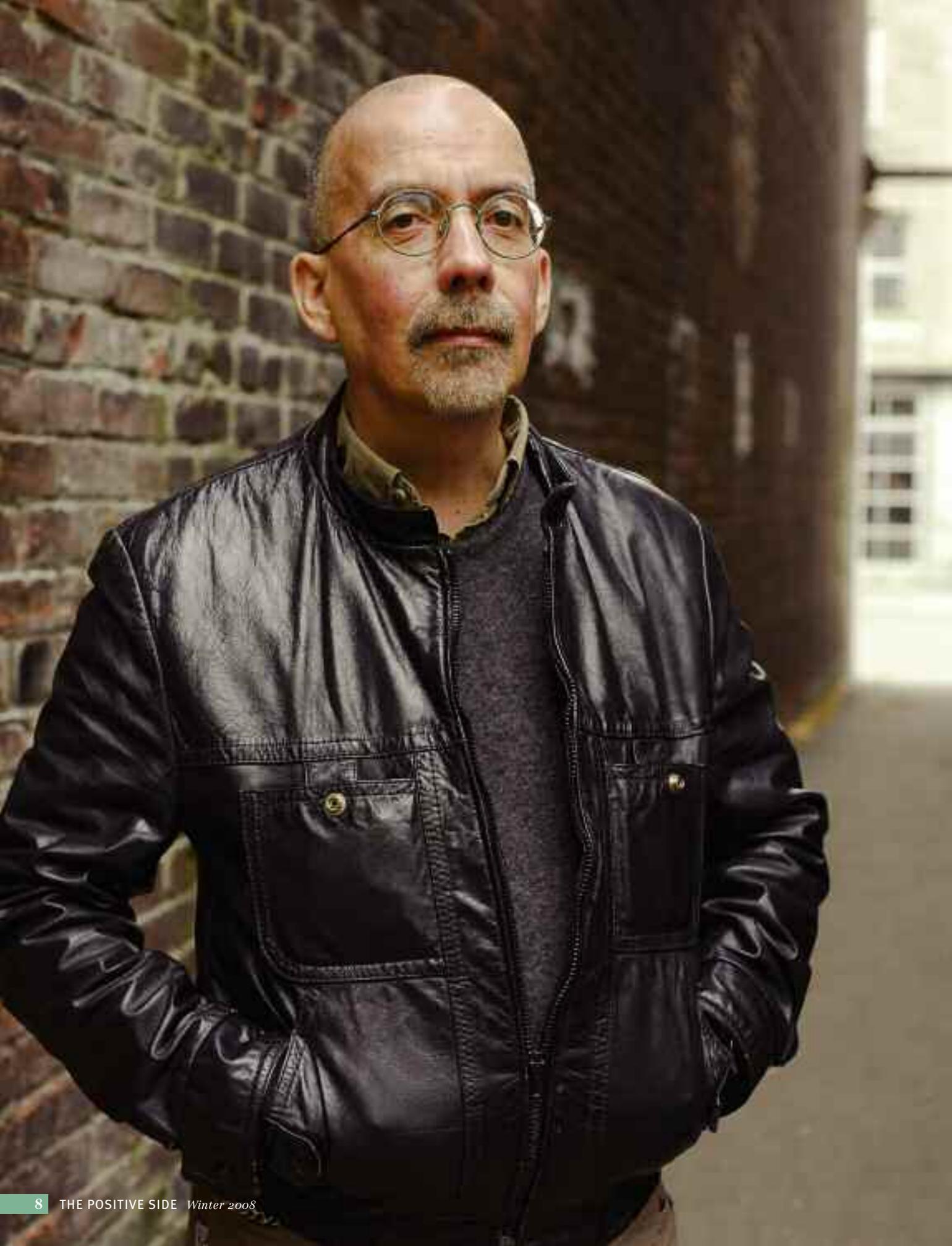


Tenofovir (Viread), the third member of my HAART team, was signed on because it's a less toxic non-nuke than the older but still potent d4T.

While my choices at first were pretty much by default and made by my doctors, 20 years on it is a different story. Now I learn about

the drugs that are available. I review the literature and talk with people who are taking the drugs, trying to weigh the benefits and potential side effects before I meet with my HIV doc. My doctor is open to discussing my options and considering possible combinations of antiretrovirals.

So, it's been through a combination of consultation and elimination that I've ended up on my current HAART regimen. +



A Voice for All

During the 13 years that **Albert Martin** has had HIV, he has learned that the voices of people living with HIV have a unique resonance. By creating **Fréquence VIH** and its website www.frequencevih.ca he has made certain that these voices can be heard loud and clear.

When I learned I was HIV positive, I had already developed AIDS. I had Kaposi's sarcoma and my life expectancy was only a few months. It was one year before the combination-therapy revolution. HAART arrived just in time to pull my head above water.

In the beginning, when I spoke to my friends and family about what I was feeling physically and emotionally, their reactions often began with words like "You should..." or "If I were you..." Inside I was thinking: "How clueless!" How could they truly feel what I was feeling? I knew their intention was to reassure and encourage me, but how could anyone who isn't infected truly understand what it is like to live with HIV?

Several months went by before I joined my first support group. By the end of the first session, I left with the feeling that I was now part of a secret society—the society of people living with HIV. In a way I was proud to be part of it, proud to have been accepted into it. It's far from an ideal society—a fact I continue to discover year after year—but it's the only one that fits us. It's a society that is prey to

upheaval and internal fighting that is, in my opinion, the expression of the contradictions we carry within us.

My participation in support groups taught me the importance of listening to people with HIV/AIDS (PHAS), including those with points of view different from my own. I discovered how important it was to pay attention to experiences that I had not lived myself, as well as the stages of denial and acceptance that varied from one person to the next. There is no single experience of being HIV positive. There is, however, only one way to listen to these experiences: by imposing silence on one's own experiences and listening without judgment or comparison.

Eventually I became involved in community work. I sat for several years on the board of CPAVIH (Comité des personnes atteintes du VIH du Québec), an AIDS service organization (ASO) in Quebec that officially closed in 2008 amid widespread indifference. It was

during my time at CPAVIH that I came to understand how important HIV information is to people living with the virus and that they prefer to receive this information from ASOs.

There is no single experience of being HIV positive.

For many years CPAVIH was the only ASO in Quebec and it gave a voice to PHAS through its many accomplishments, including its treatment and legal information services and its magazine, *Le Point de VIH*, which I contributed to. With CPAVIH gone, I believe we will come to realize—hopefully sooner rather than later—that HIV activism must find new ways to express itself.

I truly believe that HIV is here to stay for many years and we must collectively acknowledge who we are and affirm it. When I say affirm, I don't simply mean stating who we are in the public arena, but also among ourselves as HIV-positive people. We must establish relationships and build bridges between ourselves and the groups we represent. In my opinion, we will have a better chance of being heard if we speak with a single voice. This is the only way to get our message across and it is urgent that we do so.

It was this realization and my longtime experience as a journalist, scriptwriter and novelist that led me to create Fréquence VIH, a network whose main face is its website www.frequencevih.ca.

The site is a mix of current news and in-depth reporting on HIV/AIDS, all in French. When the site was launched in 2005, there was no Internet site that focused on the reality of Quebec PHAS. Now, every week from Monday to Friday, there are stories about HIV/AIDS from around the world. This daily press review of general news about HIV/AIDS is unique in the French-speaking world.

We provide information and allow all PHAS to make their voices heard, regardless of where they live or where they come from. I am always surprised and moved to receive the feedback of forgotten PHAS living in villages in Quebec, Guyana or Lebanon—people seeking comfort in front of an anonymous computer screen. Fréquence VIH has become a place where people with HIV can feel at ease, can feel at home.

I find it atrocious that the section dealing with lipodystrophy places third on the list of the site's most visited pages—more than 10,000 visitors during the past six months! I imagine the pain of these no-doubt isolated people who visit the site day after day in the hope of learning about a treatment that will free them from the ostracism they face.

I am quite proud of the fact that “Diane” (not her real name)—

the HIV-positive Quebec woman accused and convicted of aggravated sexual assault for not disclosing her status before having sex with her ex-partner—agreed to share her story in an exclusive interview with Fréquence VIH. The organization supports Diane and COCQ-Sida in their appeal of the judgment. It is a major case for all HIV-positive people in Canada.

A year ago, Fréquence VIH started producing videos and, to date, has completed seven in partnership with other HIV groups—and more are coming. We have also produced more than 40 radio shows, presenting interviews with workers from Quebec and French HIV organizations and reports on pressing subjects such as lipodystrophy or criminalization. There are also numerous personal accounts from PHAs.

We have plans to open Fréquence VIH to other languages, for example, with a series of stories titled *Si d'aventures en aventures* (From One Adventure to the Next) written by HIV-positive Quebec youth and translated into Spanish. We will also have interviews in English (with French transcripts).

Fréquence VIH wishes to continue its role as spokesperson for those without a voice in the HIV community. We want the voice of HIV-positive people to be heard and to find its place in society. We wish to build bridges between the HIV community and society in general. Despite the empathetic ear of many HIV-negative people, PHA voices remain misunderstood and often incomprehensible for the majority of people who are not living this reality. They do not know what we are talking about and often do not want to know.

Every day I am outraged by this lack of understanding and openness, and it is one of the reasons why I never tire of fighting, either through my work with Fréquence VIH or my work as a writer. I doubt my most recent novel will ever find a publisher. The story of a doctor who is fascinated by patients who actively search to be infected by HIV will never be a best-seller—it is too taboo. But such behaviour exists, and we should talk about it. Why is there resistance to talking about all the realities of HIV, even within the HIV community? As long as these realities are suppressed or denied, Fréquence VIH will remind us of their existence. It is my hope that Fréquence VIH will continue to reflect the experiences of all people living with HIV, even long after my departure. +



frequencevih.ca
has become a
place where
people with HIV
can feel at ease,
can feel at home.

Nothing to

Sneeze at



For many PHAs, an annual flu shot is part of the strategy to beat the bug each winter.

Suzanne MacCarthy investigates how Canadian researchers are working to make the vaccine even more effective.

with contributions from
Jennifer Chung



Whether it's your mother's chicken soup or a double dose of vitamin C, everyone has a "prescription" for keeping the flu at bay. When these tactics fail and the sniffles, chills and aches invade, most people treat the flu as an unwelcome and uncomfortable nuisance. But for people with weakened immune systems, influenza can be much more than a nasty bug.

According to Dr. Curtis Cooper, an infectious disease specialist at The Ottawa Hospital, influenza is responsible for an average of 20,000 hospitalizations and 4,000 deaths each year in Canada—primarily among the elderly, young children and people with compromised immune systems. He explains that for people with HIV/AIDS (PHAs), the flu can lead to complications like pneumonia and even death. It can also last longer and result in more heart- and lung-related hospitalizations.



With flu season upon us, Cooper's medical advice is: "Prevention, prevention, prevention."

José Sousa, who was diagnosed with HIV in 1985, says he takes "lots of vitamin C in order to prevent or shorten the duration of the flu." As a waiter who works closely with the public, Sousa is aware that he may be exposed to all kinds of contagious illnesses, so he tries to take good care of himself. Sousa knows the flu shot is an important part of his health strategy, and this year he'll be making extra efforts to get one.

Cooper agrees that vaccination is one of the best ways to prevent specific strains of the flu virus. PHAS are especially encouraged to get a flu shot every year. "If [your viral load] is undetectable, usually you won't experience the more severe symptoms," says Sousa, who also chairs the committee at the Canadian HIV Trials Network (CTN) that reviews HIV/AIDS clinical research from a community perspective. "But if you have a weakened immune system, chances are the flu is going to be worse no matter how old you are."

The influenza vaccine is considered the standard of care to protect PHAS from the flu, and overall its benefits outweigh its costs. Side effects associated with the vaccination include local injection-site pain, swelling and redness. Some people may experience brief periods of fevers and aches. However,

Cooper and his physician colleagues have observed over time that the vaccine does not always ward off the bug and that the number of cases of influenza among PHAS remains quite high in Canada.

Two shots at the flu

Aware that one flu shot a year isn't foolproof, Cooper and a team of Canadian researchers are currently investigating an innovative approach to maximize the effectiveness of the influenza vaccine in PHAS. Their study examines whether receiving multiple doses of the vaccine results in improved protection from the flu.

This past fall, eligible HIV-positive volunteers from across the country enrolled in the study and were randomly assigned to receive varying doses of Fluviral vaccine to help researchers find the most effective treatment strategy. Study CTN 237 set out to recruit 285 people at clinics in British Columbia, Alberta, Ontario, Quebec and Nova Scotia.

"There are not that many studies that examine flu vaccination strategies and HIV-positive people," says Sousa. "This study will help determine whether a double dose of the vaccine or booster shot will produce enough antibodies in the body to fight the flu."

In addition to potentially benefiting PHAS, Cooper explains that findings from this study could also help other people with compromised immune systems. "We're eager to see if results from this study might be applicable to other populations, including those on corticosteroids as well as people living with autoimmune disease, organ transplantation and cancer," he says.

Until one single strategy exists to avoid the flu entirely, Cooper will continue to advise his patients to take precautions in addition to getting their shot. Frequent hand-washing with soap and warm water is a must, he says. If soap and water are not available, alcohol-based hand sanitizers or hand wipes containing 60 to 90 percent ethyl alcohol or isopropanol can be very effective. Washing or sanitizing is particularly important if you touch your hands to your eyes, nose or mouth.

Whether testing new strategies for vaccination or providing advice for his patients, Cooper remains concerned that PHAS take the necessary precautions to protect themselves from the perils of influenza. "The first step to avoiding the nasty flu bug is to get a free flu vaccination from your healthcare professional." +

To learn more about the flu vaccination study (CTN 237) visit www.hivnet.ubc.ca or call 1.800.661.4664. For general info on the flu and annual flu vaccination clinics near you, visit the Public Health Agency of Canada at www.phac-aspc.gc.ca or speak to your healthcare provider.

Suzanne MacCarthy is Communications and Information Coordinator at the CIHR Canadian HIV Trials Network in Vancouver. Her adventures in HIV have taken her from Swaziland to British Columbia, with a stop in beautiful Cape Breton, Nova Scotia along the way.



Doctor's orders

If you do get sidelined by the flu bug, Dr. Curtis Cooper shares some helpful tips to get you back in the game.

- Stay home and get enough rest.
- Drink plenty of fluids like water and fruit juices, and avoid alcoholic beverages. Fluids are important if you have a fever because a fever can lead to dehydration.
- For a stuffy nose, breathing moist air from a hot shower can help. Chicken noodle soup also helps loosen mucus.
- Hot tea with lemon and honey soothes a sore throat.
- A cough drop or plain hard candy can provide some relief from coughing.
- Contact your healthcare provider as needed.



Positively Pampered

Cover girl and CATIE staffer **Darien Taylor** divulges her tips for transforming your bath into a sanctuary of peace and healing (do-it-yourself recipes included!)



It's

been one of those exhausting, living-with-HIV kind of days. You know the kind. Maybe you just spent hours at your local AIDS service organization in a meeting where you could have cut the tension with a knife. Or you're anxiously waiting to find out if your last viral load test was just a blip or whether it shows that your meds are starting to fail. Or you're feeling weak and depleted by the various gastrointestinal side effects from your new drug combination.

We all have these days, and they call for some tender, loving self-care. With a little effort and next to no cost, you can create a spa-like oasis of calm and tranquility in your very own bathroom.

For centuries, people have turned to the restorative powers of the bath to soothe body and soul. Ancient Roman bathhouses featured communal steam baths, stimulating

cold baths and relaxing warm baths. Islamic societies value the *hammam* for hygienic and religious purposes. Scandinavians and Russians are renowned for their saunas, which they finish off with a dip in icy water or snow. Canadians have the thermal waters of Banff Springs as part of our national heritage.

Bath-time self-care doesn't depend on pricey lotions and potions. There are many options available straight from your garden or cupboard—with the added bonus that they won't damage the environment. Bypass the products that cost a small fortune. Many of us are living on a fixed income and have little spare change for such luxuries. Besides,

some bath products, especially some bubble baths, can be harsh on the skin or even aggravate yeast infections.

A simple bath recipe is to mix Epsom salts (which cost a few dollars for a big bag and can be found at any pharmacy or grocery store) with a few drops of your favourite essential oil. Epsom salts are rich in magnesium; simply soaking in a bath with them can boost our levels of this element,

which eliminates toxins and helps with muscle, nerve and enzyme function.

The key to using your bath as a therapeutic tool is to be mindful and intentional in nurturing your body *and* soul. Enter the water with the intention to be cleansed, purified and relieved of your pains and stresses—be they emotional, physical or spiritual.

A banquet for the body

Make your bath a feast for your senses. Put on some relaxing background music, dim the lights and burn some beeswax candles or incense. Treat yourself with something special to eat (maybe some berries or chocolate) or drink (a glass of wine, mineral water or a soothing herbal tea). A warm bath is very calming, and an inflatable neck pillow or rolled towel behind your head will help you truly relax. It's also a good time for a facial mask or hot oil treatment for your hair. And just in case you get a little too relaxed and start to drift off, set a timer for 20 to 30 minutes.



SIMPLICITY ITSELF FACE MASK

- 1 tbsp natural yogurt, room temperature (not low fat or non-fat)
- 1 tsp runny honey (if necessary, put it in the microwave for a few seconds to soften)

Combine mixture and apply to your face. Let it sit for 15 minutes, and then wash your face with a steaming washcloth. For dry skin, use an extra teaspoon of honey. For oily skin, add a few drops of fresh lime juice.

HOT OIL HAIR TREATMENT

- 3 tbsp olive oil
- 3 tbsp canola oil
- 1 tsp honey or 5 drops of your favourite essential oil (both optional)

Combine mixture in a microwaveable bowl. Heat in microwave until warm. Remove and let set for a few minutes. Place some of the oily mixture on your hands and start applying it to your hair, starting at the ends and working up to the scalp. Wrap your hair in a warm towel or plastic shower cap and leave on for 20 to 30 minutes. Rinse and shampoo.

Rise like a phoenix

Use your bath as a time to regenerate. While relaxing in the tub, breathe deeply and mindfully, paying attention to your breathing as you inhale and exhale—the extra oxygen will nourish your cells. Try to visualize your body as a temple of health and healing. Or visualize yourself being successful at your goals: being loved and appreciated, triumphing over adversity, laughing.

If you want to do a little exfoliation while you're at it, bring along your loofah, pumice stone or scrubbie. Exfoliation can help stimulate the blood's circulation. But be gentle with your skin—it's very delicate and easily damaged! Our recipes for body scrubs are made from natural ingredients that are literally good enough to eat.

SEA SALT SCRUB

1 cup fine-grained sea salt
 ½ cup natural carrier oil
 (olive, sesame, sweet almond
 or grape seed)
 10 to 15 drops essential oil
 clean jar for storage

Use 10 to 15 drops of your favourite essential oil for each cup of finely ground sea salt. Blend your essential oil with the carrier oil, add to the salt and stir well. Store in a clean, sealed jar.

For use, apply the salt scrub to damp, clean skin. Massage your body, focusing on rough spots like elbows and knees and avoiding the face. Rinse off in a warm bath.

SUGAR AND SPICE BODY POLISH

1 cup brown sugar
 1 cup white granulated sugar
 ¾ cup natural carrier oil (such as sweet almond oil)
 2 tsp cinnamon, powdered
 2 tsp ginger, powdered
 2 tsp nutmeg, powdered
 10 drops cardamom essential oil
 clean jar for storage

Combine all ingredients except the essential oil. Using a whisk, blend thoroughly, making sure to break up any lumps of brown sugar or spice. Add the essential oil drop by drop, blending after each addition. Spoon into a jar with a tight-fitting lid.

For use, massage approximately ¼ to ½ cup of scrub onto damp skin using circular motions. Rinse in a warm bath. The stimulating aroma of the spices lingers long after the sugar has been rinsed away and is wonderful for both women and men. After your bath, apply a moisturizer. Cocoa butter smells marvellous, nourishes the skin and is cheap.

D-I-Y therapeutic baths

Therapeutic baths make such good use of natural ingredients to promote health that you are bound to feel lighter, happier and more in touch with your environment afterwards. Here are some hints to help these good feelings last. If you share the bathroom with others, be conscious of their needs. Nothing is more guaranteed to wake you out of your reveries than a sharp knock on the door from a roommate or family member who needs the bathroom for a more practical purpose. And remember that water is a precious resource—use only what you need. Finally, lay back...exhale...enjoy! You deserve it.

DRIFT OFF ON A CLOUD: A BATH TO HELP YOU SLEEP

Many people who are living with HIV have trouble sleeping due to stress, night sweats or side effects. A warm bath before bed can do wonders in terms of preparing you for a good night's sleep.

- **Add some dried chamomile flowers** (often available in health food or bulk food stores). Using this





herb in your bath calms your body and mind, dispels restlessness and promotes a relaxing sleep. To prevent the chamomile from plugging your drain, create a bath bag by placing a handful of chamomile in the centre of a square of cheesecloth (approximately 20 cm by 20 cm) and tie securely with string. Hang the bag around the faucet while running a warm bath. You can dry and reuse the bag (and its contents) again for another two or three baths.

- **Be a flower child.** Wrap equal parts lavender flowers, rose petals and chamomile in a cheesecloth bag, according to the method above, and scent your bath water with this sedative bouquet.
- **Sip sleepy-time tea.** Make a cup of sleepy-time tea from 1 teaspoon of linden blossoms and 1 teaspoon of lemon balm steeped for five minutes in boiling water and strained.
- **Prepare for bed.** Before your bath, make up your bed with clean sheets so that after the bath you can slip into a nice fresh bed, ready for a restful night of sweet dreams. Put your pyjamas, bathrobe and some fluffy towels by the bath so you can dry yourself and put on something warm and cozy.

REV YOUR ENGINE: A BATH TO GIVE YOU ENERGY

Fatigue is a common symptom of HIV and a side effect of some of the medications. Visit the spice cupboard or garden for the ingredients to make a sensuous, energizing bath experience. Any mixture of basil, bay leaves, fennel, marjoram, rosemary, sage, savoury, thyme, mint, pine needles, geranium or lemon verbena can be combined in a cheesecloth bag and immersed in the tub for a stimulating bath. Or tie together sprigs of lemon, basil, rosemary and lavender, and then hang them over the faucet while you fill your bath. You'll emerge renewed and invigorated.

SAY HASTA LUEGO TO HSV: A BATH TO SOOTHE A HERPES OUTBREAK

In addition to promoting relaxation, lemon balm also inhibits some viruses. When applied to herpes sores, it has been shown to speed healing, prevent spreading and decrease pain and swelling. Added to the bath in a bath bag, lemon balm can reduce muscle tension and soothe the irritation of a herpes outbreak.

CALM THAT ITCH: BATHS FOR SKIN PROBLEMS

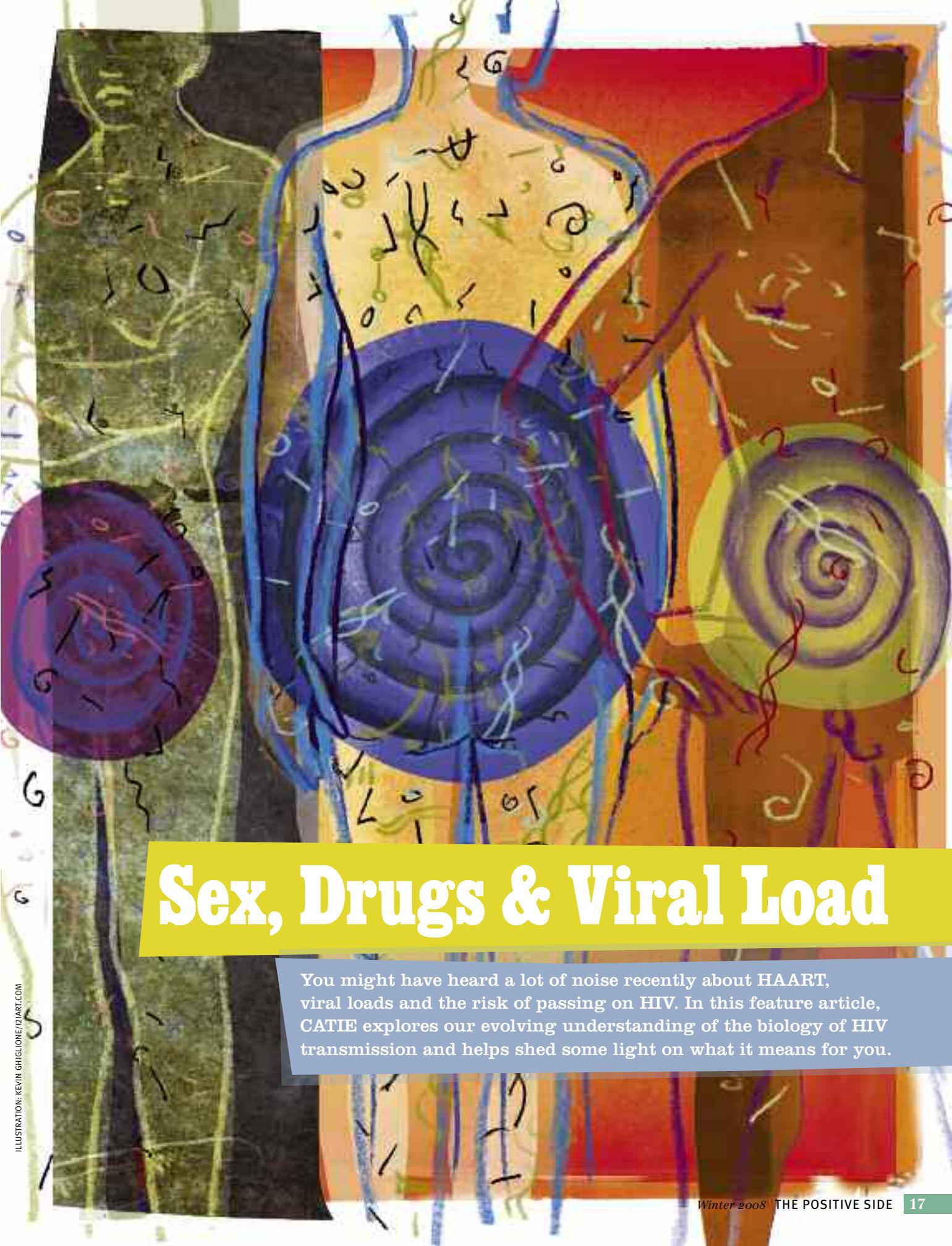
For many people with HIV, dry skin, eczema, shingles or rashes are common health issues. Treat your skin by pouring a cup or so of quick or instant oats into a cheesecloth bath bag and immersing it in the tub. As you relax for about 20 minutes in this silky bath, lightly rub the bag over your skin to make the most of the soothing colloidal properties of the oatmeal. Powdered milk added to the bath will soften your skin, as will honey.

BREATHE DEEPLY: BATHS FOR COLDS, FLU AND RESPIRATORY PROBLEMS

The warmth and steam of a bath can ease breathing and help with respiratory problems. Herbs or essential oils that are effective to use in the bath when you have a cold or flu include eucalyptus, thyme, lemon and rosemary. +

Darien Taylor is Director of Program Delivery at CATIE and a woman living with HIV. Given the laziness of her virus, which (thankfully! thankfully!) has accomplished little in the way of immune system destruction over the 20 years she has been infected, she suspects that her virus spends much of its day dozing in a warm bath or between the sheets.



An abstract, colorful illustration featuring three large, concentric spirals in shades of purple, blue, and green. The background is a mix of warm colors like orange, red, and yellow, with various lines and shapes scattered throughout, suggesting a complex biological or molecular structure.

Sex, Drugs & Viral Load

You might have heard a lot of noise recently about HAART, viral loads and the risk of passing on HIV. In this feature article, CATIE explores our evolving understanding of the biology of HIV transmission and helps shed some light on what it means for you.

E

arlier this year, the Swiss National AIDS Commission sparked a global controversy when it released a provocative statement about viral load and HIV transmission. The Swiss commission said that a person with HIV/AIDS (PHA) would be sexually non-infectious if that person: a) is taking highly active antiretroviral therapy (HAART) with excellent adherence, b) has an undetectable viral load for the past six consecutive months, c) is in a stable and monogamous relationship *and* d) neither partner has a sexually transmitted infection (STI). The statement was an expert opinion based on a small number of studies in heterosexual people, but the implications were huge. If true, the statement seemed to say that some people with HIV might not need to use condoms every time they have sex.

The Swiss statement came in response to a growing climate of criminalization, in which PHAs are being accused of endangering the lives of others through unprotected sexual relations. If scientific evidence showed that people with an undetectable viral load were not infectious, they would no longer be a “threat” to their sex partners and arguments that support HIV criminalization laws would be weakened.

Evidence of being non-infectious could also go a long way toward reducing stigma and discrimination. PHAs might find it easier to disclose their HIV status to sex partners, friends and family. Serodiscordant couples might become less fearful of sexual intimacy with the knowledge that HIV transmission is less likely. Heterosexual couples could find it easier to try having children without resorting to the often unaffordable or unavailable services of a fertility clinic. And sex could regain more joy and carry less stress than it did before.

On the other hand, HIV prevention advocates noted that the conditions laid out by the Swiss statement are very specific. There is a concern that the message will reach a broader audience than it was intended for. People who don’t meet all the conditions may mistakenly assume they are safe and then change their sex habits,

**Viral load,
by itself,
may not be
an accurate
indicator
of risk for
any one
person at
any one
particular
time.**

which could put themselves and others at risk for HIV and other STIs. There are other potential negative consequences as well, such as PHAs feeling pressured to start treatment before it is medically necessary.

The Swiss statement has been refuted by many national and international organizations on the basis that there is not yet sufficient evidence for such a bold and potentially misleading conclusion. (For an in-depth analysis of the evidence behind the statement, read *Treatment-Update #166*, March 2008, available at www.catie.ca/tu.nsf.) Unfortunately, there is currently no consensus among the global research community about how to interpret what little evidence there is. That’s because the transmission of HIV can depend dramatically on several factors, and all of these factors can play out differently in different people.

One of the more important biological factors for HIV transmission is viral load. There is mounting evidence that reduced viral load can mean reduced risk of HIV transmission for some people. The Swiss commission went so far as to say that PHAs with an undetectable viral load can be “non-infectious” in some circumstances. Recently, however, there have been several anecdotal reports and one published case study of HIV transmission in male couples who meet the criteria set out in the Swiss statement. So there is still a risk of HIV transmission with an undetectable viral load.

We know from existing research that, *on average*, undetectable viral load results in a low risk of HIV transmission—less virus, less chance of transmission. But we also have good reason to believe that this reduced risk does not happen all the time and does not apply to everyone, as the Swiss commission originally claimed. Many studies have indicated that viral load, by itself, may not be an accurate indicator of risk for any one person at any one particular time.

Viral load tests look only at the amount of virus in the blood, which accounts for less than 2% of the virus

CATIE offers *Beyond the Banana*, a workshop for service providers that covers the biology of HIV transmission. Contact us at www.catie.ca or 1.800.263.1638 for more information.

A PHA perspective

DARIEN TAYLOR has lived with HIV for more than 20 years and has been active in the community and the cause for just as long.

For most of us, most of the time, the new information that we have about viral load and other factors affecting HIV transmissibility won't make a huge "operational" difference in the way that we have sex. Given the yet-to-be-answered questions about such things as the link between viral load in blood, semen, vaginal and rectal secretions and the contribution of inflammation and STIs to HIV transmissibility, it is difficult to see this new information as a clear go-ahead to abandon condoms. For now and into the foreseeable future, condoms will continue to be our main way of keeping sex safer.

Serodiscordant couples who are trying to conceive will definitely benefit from the Swiss commission's announcement, which is reassuring about the risk of transmitting HIV through unprotected sex, particularly when the positive partner has an undetectable viral load and when the period of unprotected sex is limited. As well, people with HIV who have an undetectable viral load (and our partners) will no longer need to spend sleepless post-coital nights tossing and turning in worry about when the condom happened to break accidentally during the evening's amorous activities. But for many of us, our sex life will probably look much the same as it has throughout this epidemic. We have become attached to the security of condoms and, strange though it seems, to the freedom that they offer us to safely have several sex partners, if we so choose.

What is undergoing a significant change, though—and the impact of this new way of thinking will undoubtedly take some time to sink in—is our way of thinking of ourselves, our bodies and our acts of intimacy. We are no longer dangerously infectious. The stigma, shame and fear of infecting others with HIV are deeply ingrained in even those of us with the healthiest self-esteem. But by making sure that we see our physician regularly, monitor our health and intervene with HIV drugs when needed (something that many of us do as a matter of course), we can dramatically reduce our infectiousness. What's good for our health turns out to be good for our partner's health, too. To (re)conceive of our sexuality as non-threatening, healthy, affirming, powerful and loving is an opportunity second only in significance to HAART's transformation of HIV from a death sentence to a more manageable illness.

in the body. Even in people with undetectable viral load in the blood, virus can still sometimes be detected in the semen and genital fluids. Also, from time to time people on HAART with undetectable viral load can experience short bursts of viral activity, which cause a temporary detectable viral load (these are called blips). Viral load may also increase when a person does not take their HAART regimen faithfully on time and as directed. Any of these scenarios could lead to the transmission of HIV during unprotected vaginal or anal sex.

By nature, estimates of HIV risk are not very accurate because the risk of transmission is very difficult to measure. Since the Swiss statement, a group of American HIV researchers has conducted a systematic review of published data and found that current estimates of risk might be too low. More importantly, the review found that HIV risk is extremely dependent on circumstances, so there is no single measure of risk that applies to everyone. For example, studies have found that unprotected anal sex may be more than 30 times more risky than unprotected vaginal sex. Researchers have also pointed out that the cumulative risk of transmitting HIV increases with the number of sexual exposures. Over time, small risks can add up to a significant overall chance of transmission.

The picture that appears to be emerging is that HIV risk is dynamic. Over the course of time, PHAs may experience periods of heightened infectivity, while at other times their infectivity may be quite low. Likewise, the susceptibility of people who are negative can vary over time. Having a better understanding of how HIV is transmitted can help us make safer decisions about sex. Unfortunately, we don't yet know all of the factors involved in accurately predicting risk.

Until recently, we had two ways to stop the spread of the virus: using condoms and choosing what kind of sex we have. The Canadian AIDS Society (CAS) publishes guidelines (titled *HIV Transmission Guidelines for Assessing Risk*, available at www.cdnaids.ca) that categorize different sex activities as being high, low, negligible, or no risk. You know

“What’s good for our health turns out to be good for our partner’s health, too.”

What the doctors are saying

MARK YUDIN MD

Obstetrician and gynecologist
at St. Michael's Hospital, Toronto

I see HIV-positive women for many reasons, including those looking to have a baby. Foremost, I do not advocate having unprotected intercourse to get pregnant. Options then depend on who in the couple is positive.

I am most cautious in cases where the woman is negative and the man is positive and has an undetectable viral load. Sperm washing and intra-uterine insemination is the safest option. I would never tell them to have unprotected sex. I would re-iterate what we know—and don't know—about viral load and transmission, but ultimately, they decide how they want to proceed. Some couples do decide to try to conceive by having sex. They often do as much as they can to increase their chance of conceiving, especially monitoring the woman's cycle, because they don't want to be putting the woman at repeated risk of exposure.

In cases where both partners are positive, I counsel them that sperm washing and intra-uterine insemination is still the safest thing to do. With these couples, we usually have a discussion about the risk of re-infection during unprotected sex. I mention that we know that HIV can still be present in the semen and vaginal fluids, even with an undetectable viral load.

Usually when a couple comes to me for this sort of counselling, they are doing fairly well. They are healthy, their HIV disease is under control and often they are on meds. So, their risks are probably lower than someone who is not on meds and has a high viral load, but I can't use the word *negligible* to describe the risk of transmission because I don't think we know enough to say that.

Over the years, I've seen more and more couples and women who are thinking about this, because HIV has changed a lot. People are healthy and expecting to have a long life, and so, many consider having children. I'm very supportive of this. These women are no different from other women and deserve to have the same opportunities.

the ones: anal or vaginal sex without a condom is high risk; kissing, with no blood, is no risk.

People continue to use the CAS guidelines as a starting point for making decisions around how to keep themselves and their partners safe, but they are beginning to include in their decisions other factors that increase or decrease risk. Viral load is one such factor; stage of HIV infection is another. During the first five to six months of HIV infection, the risk of passing on HIV is very high. During this time, levels of virus in the body are very high, but there may also be other reasons for the increased risk.

Sexually transmitted infections (STIs), in either partner, can also heighten the risk. STIs can raise the amount of HIV in genital and rectal fluids. In HIV-negative people, an STI can make it easier for HIV to enter the body. STIs also cause activated immune cells to collect near the infection, and HIV loves to infect activated immune cells.

Some other factors that can make it easier for HIV-negative partners to contract HIV are imbalances in the bacteria that live in the vagina (bacterial vaginosis) or rectum, inflammation, cuts or lesions, variations in the levels of sex hormones, and dryness of the fragile barriers that line the inside of the body. Young women who are just entering puberty and older women who have entered menopause might also be at higher risk because the barriers in their vagina and cervix are not as strong as in other women.

While we don't yet know all of the factors involved in accurately predicting risk, there are some things we do know. Condoms dramatically reduce risk—when they are used properly and don't break. High viral load can increase the risk, as can STIs in either partner. Circumcision can reduce the risk for an HIV-negative man who has unprotected sex with women, but not enough to make sex safe.

The good news is that the things that we already do to manage our health—like treating STIs, starting meds when it is time and sticking to our pill-taking schedule—also reduce the chances that HIV will be transmitted. How much this can contribute to HIV prevention is still an open question. But it is a question that we are now talking about more openly. +

HIV risk is extremely dependent on circumstances, so there is no single measure of risk that applies to everyone.

MARK TYNDALL MD ScD

Clinician in Vancouver's Downtown East Side and researcher at the University of British Columbia

If I see somebody in clinic who is HIV positive, I ask whether or not they have a regular partner. If they do and the partner is HIV negative, I push antiretrovirals very strongly, no matter what their CD4 count is, because the chance of transmitting to their partner is much reduced if they achieve an undetectable viral load. Although I think they should still practise the safer sex they've been practising, this is not as important as getting them on antiretroviral therapy.

Clearly, this message of reduced infectiousness with undetectable viral load needs to be combined with other prevention messages. People don't always know if they have a concurrent sexually transmitted infection, which might make them more susceptible. There are different forms of penetrative sex and some may be more risky than others, and the data from heterosexual sex may not translate exactly into anal sex among men, but certainly the same principles hold. There are some caveats to the Swiss statement, and the message shouldn't be all or nothing.

But, as a physician, if somebody asks me about the Swiss statement, I don't want to tell them, "Well, it looks like you might be less infectious, but I really wouldn't trust that information." I think that the information I have in front of me says that if you are undetectable, you're not very infectious. If you're having anonymous sex, I think you should use a condom and practise what you've been practising. The safer-sex messages shouldn't be undermined.

There's the very educated person you can sit down with and say, "Your CD4 count is 500, you're in a serodiscordant relationship, and I strongly recommend you get on treatment." And we can have this conversation. But my practice is around marginalized people who have a lot of trouble taking these drugs. For somebody who is on a cocaine run and their CD4 count is 10, that conversation isn't going to occur very easily.

Clearly, we have to deal with other issues that person is facing before they can be successfully treated. It's much more than getting people on treatment—it's an addiction issue and a housing issue and a poverty issue. I think that the Swiss statement gives even more impetus to supporting comprehensive solutions to these challenges because by getting more people on treatment we can really make an impact on reducing HIV transmission.

"While we know that people on therapy can transmit HIV, we have precious little data on the level of risk."

PAUL MACPHERSON

MD PhD
Clinician and researcher at the Ottawa Hospital

When patients ask me whether or not they can infect their sex partners if they have an undetectable viral load, I point to the data showing that people are still potentially infectious even when their virus is successfully controlled in the blood. Many studies have now demonstrated that people on therapy with an undetectable viral load in the blood can still have significant levels of free virus in their genital fluids, be it semen, vaginal fluids or rectal secretions. This alone should indicate transmission on therapy is possible.

I have heard of several such cases, and recently a well documented report was published in the medical literature. So, passing on HIV through sex while the blood viral load is undetectable can definitely happen. The risk is not eliminated.

While we know that people on therapy can transmit HIV, we have precious little data on the level of risk. The chance of transmitting may well be lower but we have no idea by how much. Lots of numbers are generated, but these numbers are estimates and vary greatly depending on many factors. HAART is just one more variable added to a very

complex mix influencing HIV transmission.

Frankly, we don't understand even the most basic issues, such as why, how or to what extent viral loads change over time and in different tissues of the body either on or off HAART. To think we actually know to what extent therapy may reduce transmission is naïve.

How are we going to find out if and to what extent transmission is reduced by HAART? We can't ethically tell one group of people on HAART to stop using condoms and a second group on therapy to continue using condoms and then count how many people get infected in each group. What will happen is people will stop using condoms. Why would they put on a condom if you just told them the chance of transmitting HIV has virtually been eliminated? Sadly, I believe the gay community will likely become the testing ground for this debate. We will get an answer, but at the cost of new infections.

Reflections on a Epidemic

Global



An interview with
International AIDS Society
executive director, and
Canadian, **Craig McClure**

BY ANN SILVERSIDES



“Dealing with this disease
is really about dealing
with human rights.”

While we all have our personal relationship with the virus, HIV affects people around the globe, and the biennial International AIDS Conference (IAC) is a chance for the world to gather and reflect on the bigger issues. After the hubbub of the most recent IAC in Mexico City settled, journalist and author Ann Silversides chatted with Craig McClure, executive director of the International AIDS Society (IAS), the conference organizer. McClure, a proud Canadian who once worked at CATIE, shared his views on where we are and where we're going.

Ann Silversides: You've been to eight other International AIDS conferences. How did AIDS2008 compare?

Craig McClure: For me, there were a couple of differences. One was the emphasis on human rights and concentrated epidemics. It has never been emphasized so clearly that in order to scale up treatment and prevention services we have to make some progress on HIV-specific stigma and discrimination as well as other forms of discrimination against communities at risk of HIV infection. Homosexuality is illegal in, I think, more than 80 countries, as one example, and it is difficult for a community to access services if its identity is criminalized or ignored.

Another difference was the clear recognition of the need to strengthen overall health systems in developing countries. We've hit a wall in terms of expanding HIV services in these countries until health services are strengthened. We need to pay close attention to the links between systems broadly and to the integration of HIV services with other services—primary care, maternal health, tuberculosis testing and treatment, and sexual and reproductive health.

What was most memorable for you about the conference?

Meeting with the youth coalitions in the Global Village and seeing so much energy among young people. I don't think many of us realized 20 years ago or more when we got involved that this was going to be a multigenerational fight. But I am now moving through middle age and it is that much more evident to me that it is going to be the next generation of advocates and researchers and healthcare workers that carries the torch. It is their ideas and creativity that will take us into the next phase of the epidemic. I was impressed by their forthrightness, assertiveness and demand to be at the table. That strikes me as very powerful indeed.

What did you hear or learn about the epidemic that made a big impression on you?

That the idea of eradication [that is, curing HIV] is back on the table. It was a presentation by Bob Siliciano at a basic science plenary session. It is the first time that eradication has been on the table publicly since 1998.

Also, the new guidelines from IAS-USA that recommend going back to earlier treatment—to start at 350 CD4s, and in the small print the guidelines talk about starting even earlier on an individualized basis, such as if someone has an HIV-negative partner or an underlying propensity for heart disease.

The reason for this shift is the confirmation that HIV disease is really a chronic inflammatory disease, and that even before the immune system starts to be damaged, right from the beginning of infection the virus is

causing inflammation that is putting pressure on the heart, kidney and lungs. So, with gentler, more forgiving drugs now, the argument to start treatment earlier is even stronger, to prevent damage to the body even before the immune system starts to weaken.

What did you learn or realize that might change the way you do your work?

From where I sit, the conference is still grounded in HIV/AIDS but is moving more and more toward a conference about global health and human rights. This is an issue for the IAS board to think about—how far do we want this to go?

The more we respond to AIDS, the more we all realize that dealing with this disease is really about dealing with human rights, including the right to health, and the lack of protection of human rights among the most marginalized people in communities around the world. HIV has always exposed the ugly underbelly of our societies. +

To read the perspectives of four other Canadian delegates who attended AIDS2008, check out *A uniquely Canadian look at AIDS2008* (2008 Sept 17), available at www.catie.ca/catieneews.nsf.

Ann Silversides is the author of *AIDS Activist: Michael Lynch and the Politics of Community* (Between the Lines, 2003), a history of the early days of AIDS activism in Toronto and Canada. She recently moved to a log house in the Ottawa Valley and spends her spare time (and money) at country auctions.

ASK THE EXPERTS

Get answers to your treatment questions

Dark Days

The short days, the grey skies, the gusting winds—it all makes me feel dreary, like the weather has moved into my head. I often get a case of the blues this time of year, but I can't tell whether this is normal or something more serious. What are the signs of genuine depression and what can I do to make it through? – C.B., Vancouver



DR. JULIE MAGGI

Psychiatrist

St. Michael's Hospital and
Women's College Hospital
Toronto

The symptoms of depression are when someone feels—for at least two weeks—that their mood is low, or they feel that they're losing interest in things they enjoy doing. This is accompanied by a combination of the following: a change in appetite, problems sleeping, low energy, feeling slowed down, difficulty concentrating, feeling worthless, and maybe thoughts of suicide or that life is not worth living.

We know from studies that people with HIV are at higher risk of developing depression. Biological factors, such as the effects of a chronic illness, may be one reason for this increased risk. Living with HIV can also present certain stresses, including coping with stigma and coping with a chronic illness. As well, some anti-HIV medications can cause side effects such as depression.

The first thing I do when I suspect someone is depressed is to learn as much as I can about the person and their symptoms of depression: How long has the person had symptoms? Are there any stressful events that trig-

We know from studies that people with HIV are at higher risk of developing depression.

gered them? If there's a history of depression, how was it treated? Are there any medical causes for their symptoms? Is there a family history of depression? What supports does the person have in place to help them cope? I then try to create, with the person, an individualized treatment plan, usually a combination of therapy and medication.

After I make a diagnosis of depression, I may start someone's treatment with one of the SSRIs (selective serotonin reuptake inhibitors, such as Paxil, Zoloft and Celexa), primarily because they may be better tolerated

than some older medications. Cognitive-behavioural therapy (generally speaking, learning to understand the connection between your feelings, thoughts and actions) and interpersonal therapy (helping someone work through grief, transitions, relationship disputes) are short-term treatments for depression. One or the other might be the best fit for someone dealing with depression.

People can talk with their family doctor, who can assist in diagnosis, treatment planning and referral to a psychiatrist if necessary. AIDS service organizations can be helpful when looking for resources in the community. Many SSRIs are covered by extended health plans and provincial formularies, but it's best to check with your pharmacist for the details in your province or territory.

JOHN MONTAGUE

MSW M.Div RSW

Individual, Couple and Family Therapist
Toronto

Talk therapy, or "therapeutic conversation," is telling your story and feeling that your voice is being heard.

People know quickly if their therapist seems to understand their emotional pain. Empathy is either there or it's lacking.

When helping people who are depressed, I am first interested in hearing about when they began feeling depressed, and I ask them to describe

what it was like before that in order to get a baseline for how they see their normal functioning.

I help people understand that they are not the problem—the problem is the problem. I help them to take control back from depression by externalizing it and seeing it as separate from themselves. This can involve not accepting the identity that others put on them, which may be making them feel down. By objectifying the problem, clients can begin to form their own sense of self that is separate from the expectations that others, including society in general, have placed on them. It is easier to

question and address the depression once it is separated.

I remind people that they are the experts on themselves, and rather than give advice I try to offer questions for people to ponder. For example: What is depression telling you about yourself that is not true? What is depression stealing from you? Do you talk back to depression and what do you tell it? I would also ask people about their support networks and who in their life is helpful. Are there people who are not helpful, and, if so, how can they be handled differently? I would ask about their exercise habits and talk about the need

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to take power back from depression by being more active rather than passive.

Unlike anti-depressant medication, talk therapy helps people reflect on how they can be an active participant in their healing and not let depression take power away from them. This can involve journaling or any form of artistic expression that is life-giving. Above all, people living with HIV who start to address their depression often embrace new goals that become important to making constructive changes in their lives.

DR. TASLEEM KASSAM

Naturopathic Doctor, Clinic Director,
Effective Health Solutions
Calgary

I diagnose depression using the Hamilton Depression Scale, which rates appetite, sleep, motivation and more. Based on that I develop a plan. In naturopathy, we do very individualized care. I see it as I'm treating a person who happens to be depressed.

I personally favour a more homeopathic approach because a) I've seen it work, b) it's not tedious to take the therapy (with nutritional supplements it sometimes can be) and c) there's

*We do very individualized care.
I'm treating a person who
happens to be depressed.*

no interaction with the range of pharmaceuticals someone can be on, as there can be with some supplements. People with HIV should know that St. John's wort, a supplement often taken to counter depression, can interact with many anti-HIV drugs, so tell your doctor if you are on meds and are taking St. John's wort or thinking of doing so.

The idea behind homeopathy, put succinctly, is that small doses of

certain herbs or minerals exaggerate symptoms and force the body's defence mechanisms to kick in. The body's defences, sometimes called PNEI [psycho- neuro- endocrine immunology], are affected by homeopathic treatments and respond to them by trying to come back to equilibrium.

I'll check the person's hormone balance and also make sure he or she is getting enough of the right nutrients: vitamin B₆, melatonin, vitamin D₃, vitamin B₁₂, folate and omega-3s. Because of the virus, people with HIV can sometimes have mineral or vitamin deficiencies and not know it. It's amazing how tweaking some of those small things can help.

In the end, the goal is to get to a place of balance where you're not dependent on any substance.

For more information about homeopathy and other complementary therapies, check out CATIE's *Practical Guide to Complementary Therapies* and *Practical Guide to Herbal Therapies*, both available at www.catie.ca.

BLAIR PELLETIER

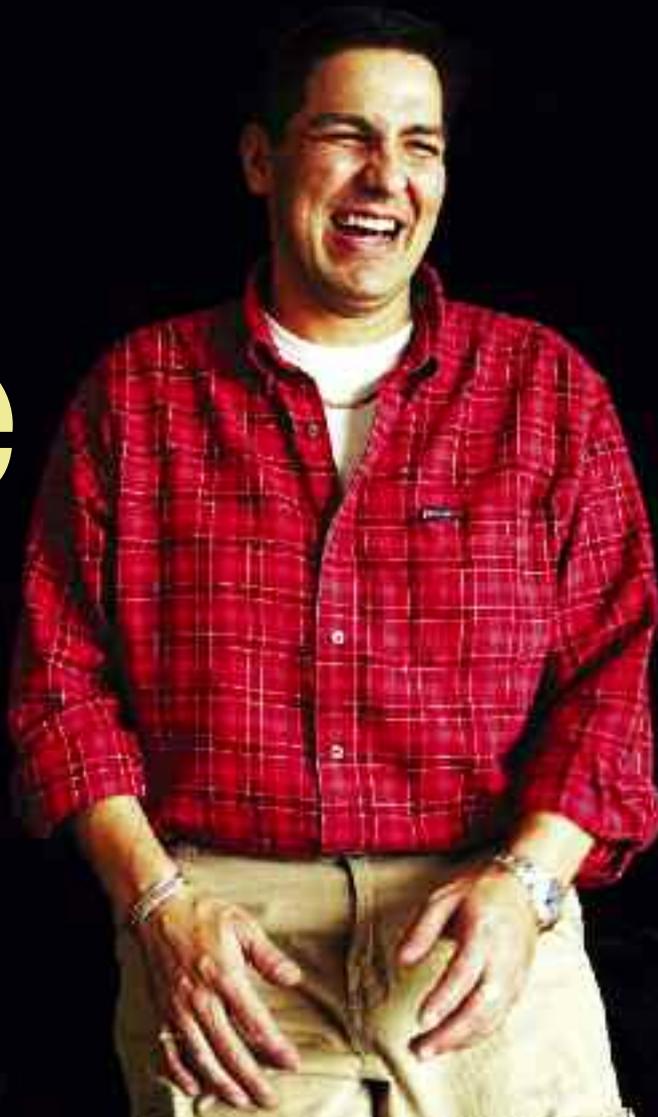
Cultural Mentor

All Nations Hope AIDS Network
Regina

In the programs we run, we have one-on-one counselling and we also have wellness circles. We had a well-

Road to Hope

David Nelson of Edmonton has often travelled the road of HIV and depression. But each time he grows more adept at letting his experiences and his friends guide him back to a stronger place.



ness circle just for people who have HIV and we'll be starting one up again soon.

The wellness circle is traditional. You sit in a circle and talk about the

I think that once you restore spirituality you're on the road to restoration of your identity.

things that are bothering you, and I think the importance of it is that everybody is on the same page and they support each other. It's nice to sit in a circle and realize "I'm not the

only one who's facing this." People tell their stories. They cry sometimes. It gives them an opportunity to get rid of some of that garbage they're carrying around, a place to vent some of the stored-up emotions. Other times we just sit around and drink coffee.

We have ceremonies we go to. There's a sacred area that's just on the outskirts of Regina, and we have a sweat lodge there. I do sweat lodge ceremonies. I bring people out there and it's really beneficial for them. Whether you're HIV positive or not, it helps to get back to our traditional way of life.

I think the element that's often missing in anything that Aboriginal people face is spirituality. We're a spir-

itual people, and if you look at anything that's wrong in our lives and struggles that we go through as a people, as a nation, spirituality is one of the things that's missing. I think that once you restore spirituality you're on the road to restoration of your identity. Anything culturally based or traditionally based has a spiritual essence; it has meaning to it. Without spirit, you're basically going through the motions. +

For more information about dealing with depression, read "Lady Sings the Blues" in the Spring/Summer 2003 issue of *The Positive Side* (available at www.positiveside.ca).

It begins with wanting to close the curtains, to sleep all day. The feeling that he can't take control like he's "supposed" to, can't think about anything positive at all. Having dealt with depression since he was a teenager, David Nelson can tell when those feelings are coming on again.

On Sept 20, 1996, when he was 31, he found out he was HIV positive. "It changed depression for me," he says. "At first, I allowed myself to fall into that hopelessness. But since then I have done my best to address these emotions."

These days, Nelson speaks publicly, but his AIDS activism began organically back in 1982 when he was 17. He was a runaway living near Washington, DC, and he and some friends found a newspaper article that described the symptoms of AIDS. That article inspired him to action, and he began warning friends and acquaintances to choose their sexual partners carefully. He wasn't afraid to take a public stance either, pointedly hugging someone who was being shunned in church one day for being HIV positive.

Eventually, in 1989–90 when he had gone on to study social work, he co-founded Feather of Hope—an organization in Edmonton for Aboriginal people with HIV—along with two nursing students and a mutual friend living with HIV. Nelson was only 24 at the time: "It was so hard and overwhelming, because I didn't

have the background, but I saw the need was there," he recalls. Feather of Hope went on to operate for more than 10 years. During the same period, Nelson was also the first Aboriginal outreach worker at the AIDS Network of Edmonton.

Learning to cope

All of these experiences would later serve to help Nelson with the depression he sank into after his diagnosis in 1996. He drew on the strength and hopefulness of the many positive role models he'd met: "I asked myself, 'What did they do to cope with those feelings?'"

Other supports have proved useful, too, such as the 12-step programs he had attended when he was in his twenties. Back then he wasn't willing to give up alcohol and drugs, but after the tailspin following his diagnosis, the perspectives he had gained in the program resurfaced to help him realize that "drinking and drugging" weren't helping—instead they were feeding the depression.

More recently, he tried bodymapping, a form of art therapy, to refocus himself after a difficult bout with hepatitis C medication side effects. "When I'm lost, rather than letting it go into a depression, I intentionally look for things like bodymapping or a retreat of some kind to go to and reconnect spiritually—anything that might be useful toward helping my spirit."

As well, Nelson takes part in a peer support group where he has met people who have reinforced his belief that you can get through the rough times. Of course, having an understanding partner helps, and there's also his cat, Spice, who is a source of unconditional love.

Despite all the hard-earned self-awareness and support, there are still times when Nelson feels down: when his arthritis acts up and he has to stay inside, for instance, or when one of the people he counts on for health care is rude. Acknowledging the feelings helps—he

"The further I let myself go down the road of depression, the longer it takes me to get back."

tries to allow himself to feel bad for about half an hour, and then move on. "The further I let myself go down the road of depression," he says, "the longer it takes me to get back."

Nelson's journey has taken him to a healthier space within himself. "I've stuck around," he says. "I waited for the miracle that would lift my depression even when I felt I was in hell... and because I hung in there I get to be here today. The world is not a better place. I've changed inside myself." +

—Jennifer O'Connor



Migrations

Don Short embarks on a healing journey across the rugged landscape of Newfoundland

AS TOLD TO RONNILYN PUSTIL



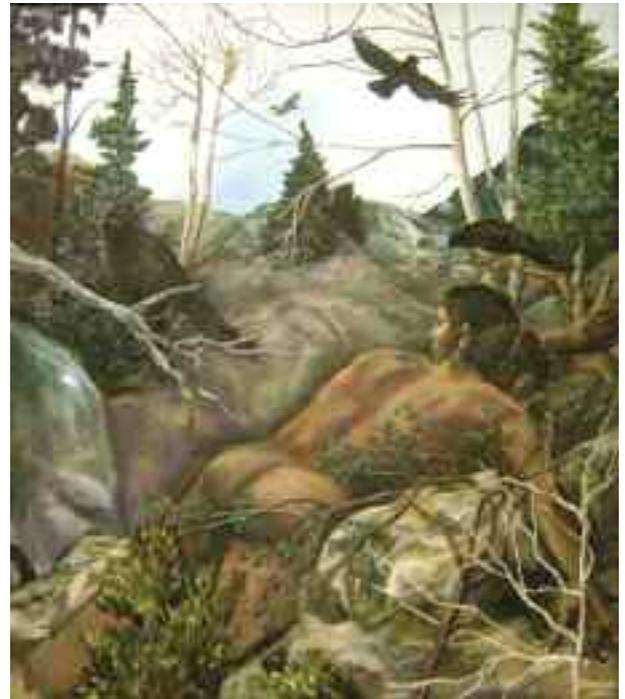
Crash

“The unexpected: You don’t know what’s coming, and there it is—and you have to deal with it.”



The Red Cloak

“Covering yourself to brace for the unexpected—using what you know or what you believe to protect who you are when it happens.”



The Turning

“When the feeling of being buried alive leaves you and a new outlook comes. That decision time where you say to yourself: Whatever it takes, I’m doing it.”

Don Short, 44
Visual artist
Mount Pearl, Newfoundland
Diagnosed with HIV in 2006
 Migrations series, 2006
 Acrylic on canvas

MIGRATIONS OCCUR WHEN BIRDS relocate to avoid harsh conditions. What I wanted to do in the Migrations series was show that when you are diagnosed with HIV you become temporarily immobilized in your thinking, knowing it’s a long journey ahead. For me, the whole experience after diagnosis was about how the landscape around me kept shifting and changing while I learned to stabilize. My life had to adjust in so many ways to being HIV positive.

The five large-scale paintings in this series cover my experience during my first year post-diagnosis and identify distinct transitions in acknowledging and accepting being HIV positive. The order of the paintings is *Crash*, *Red Cloak*, *The Turning*, *Stirring the Waters* and *Resolve*. They were painted over one year at intervals when I was ready to explore each part of my personal recovery. Recovery, to me, has been the process of accepting the imposition of the virus and preparing myself emotionally, mentally and physically for each hurdle or setback that has presented itself along the journey.

When I first received my diagnosis, I was frozen by the shock of it and not feeling able to even deal with it. Over time, I realized I had to make the decision to get my head and my heart right. The paintings show the process of how

I became grounded and overcame obstacles as I moved forward, while opening up to support from those around me.

WHEN NATURE CALLS

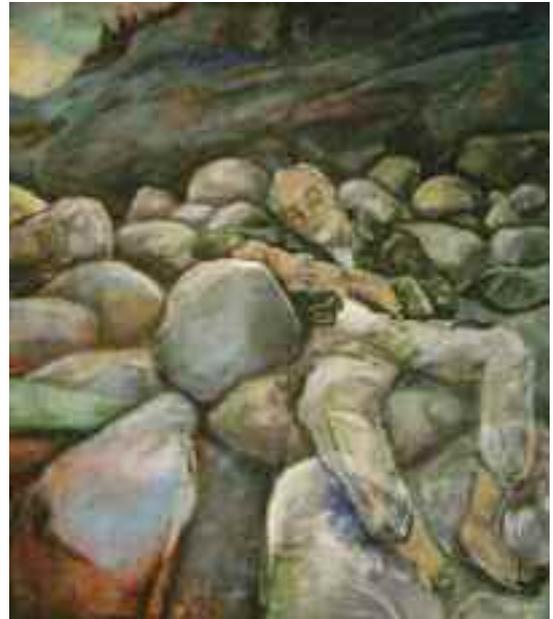
There is a lot of symbolism in the work but it’s subtle. The paintings are a visual poem in which the landscape is very interpretive. Each one contains varied elements of coastline (rock, water, trees), and because I’m from the East Coast, I use seabirds. They represent the outside forces that you either embrace or resist. Though there is a bit of me in each of the paintings, the male form in each one is not necessarily my form.

The AIDS Committee of Newfoundland and Labrador (ACNL) housed the series for World AIDS Day 2007, and the paintings have remained in the lobby of our centre as an educational tool. They have opened the door for a lot of conversations here. Art has been an integral component of the activity of ACNL’s peer support project PIERS (PHAS Interacting and Engaging in Real Support). The Tommy Sexton Centre, which houses the offices of ACNL, also has on display three large murals painted by people with HIV (PHAS) and children of PHAS.



Stirring the Waters

“Contemplation. For me that means gaining confidence in who you are and what you use to stay focused. It’s everything—support, what you think about, what goals you’ve created to move to the next level. It’s a time alone for reflection.”



Resolve

“This is the ultimate goal of rest and recovery. By recovery, I mean the process that someone goes through to bounce back. The older man in the painting represents the time and lifespan that is given to people with HIV as a result of the medications and information that are available.”

A FAMILY AFFAIR

As part of the Migrations series, my children and I painted five small paintings of birds that connected to the theme. As an artist, I’ve always included my children (ages 10, 12 and 13) in the creative process. They also participate with me in my HIV journey and recovery in every way. We’ve always had an open relationship, and they know about my peer support work at ACNL. They’re a great support and are right there for me. The reason I want to fight the virus is for them, to show them that you have to fight. My children are my biggest motivation because they are my heartbeat—I eat, sleep and breathe them. I can’t imagine keeping my personal experience with HIV from them, as they will benefit from the strength, strategies and skills I have acquired from it.



Don Short coordinates a peer support project called PIERS (PHAS Interacting and Engaging in Real Support) at ACNL and teaches private art classes.

Disclosure to children is a big issue. A lot of people avoid it and wait too long to tell their children, which can cause conflicts and mistrust further along life’s journey. It’s a personal choice for any parent when to disclose, but I chose to reveal my HIV status a few months after my diagnosis, which opened the door for honesty and discussion. My happiest memory after hospitalization was my kids actively participating in cleaning my house. They heard about the importance of sterilizing surfaces so they had fun putting on rubber gloves and using spray bottles. This demonstrated their care and concern for me. +

This column is part of art posi+ive, an initiative enabling HIV-positive artists to share their experiences of living with HIV through their artwork. The program was launched in 2005 by CATIE in partnership with Gilead Sciences Canada, Inc.

PHOTOGRAPH: COURTESY OF DON SHORT

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IMPORTANT: Decisions about particular medical treatments should always be made in consultation with a qualified medical practitioner knowledgeable about HIV-related illness and the treatments in question.

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