NEWS AND TREATMENT INFORMATION FROM THE POSITIVE LIVING SOCIETY OF BRITISH COLUMBIA

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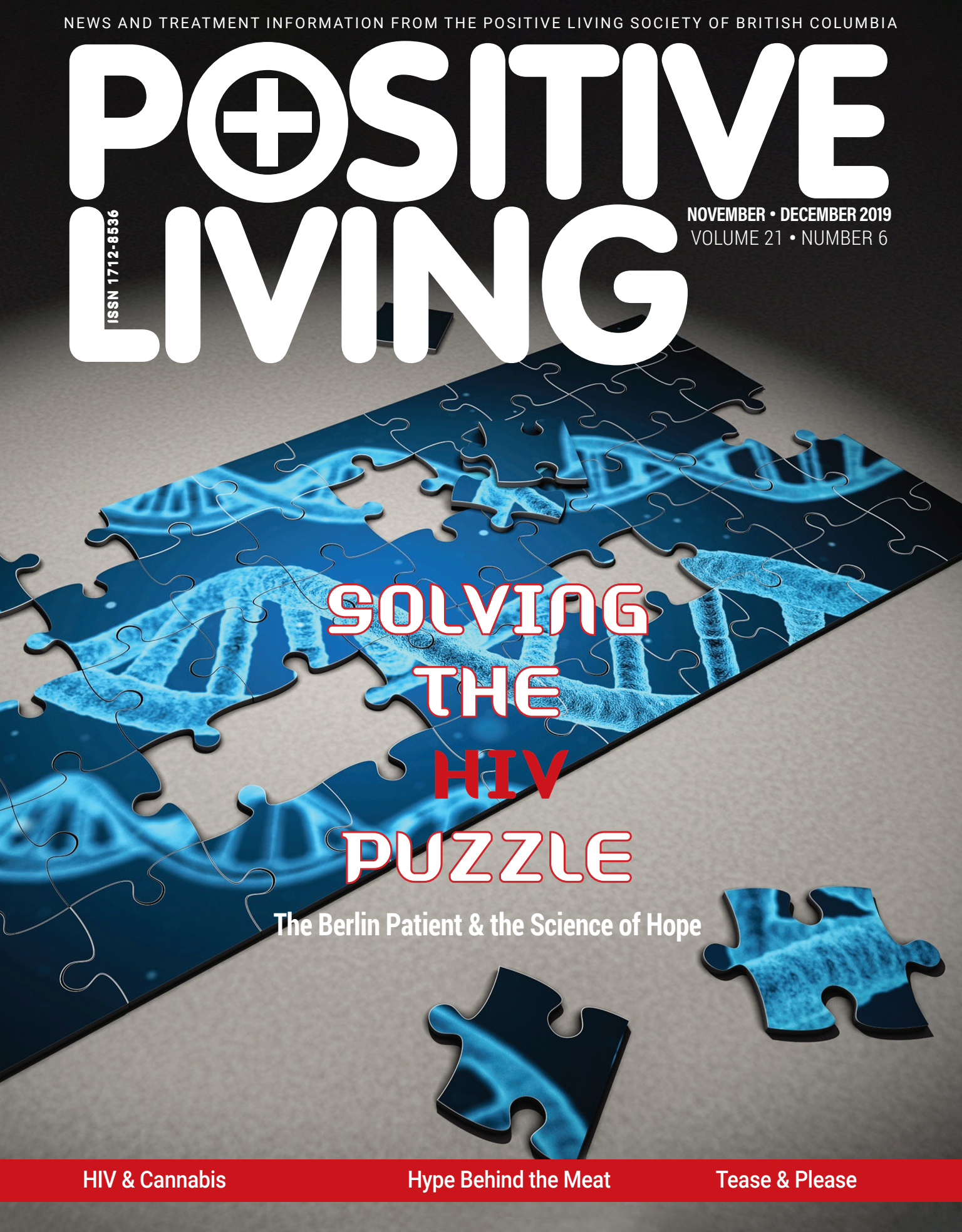

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POSITIVE LIVING SOCIETY OF BRITISH COLUMBIA

The Positive Living Society of British Columbia seeks to empower persons living with HIV disease and AIDS through mutual support and collective action. The Society has over 6,000 HIV+ members.

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A fresh take on an old idea

Welcome to the new Health Promotion & Activities Lounge! Our Members' Lounge and iCafe at 1101 Seymour Street have been re-imagined to build on our successful social activities with new, fun health promotion events in the afternoons and evenings.

Starting November 4th, on afternoons from Monday to Friday, the Members' Lounge and iCafe will be open only for specific programs and events such as Bingo, Crafts, Bridge Club, Cribbage, et cetera. And in the near future, computer skills training and new interactive health promotion events will also be offered. It's important for members to note that during these times:

- the Lounge will be open only to activity and event participants;
- refreshments will be provided only to these participants;
- the TV and computers will be shut off;
- Polli & Esther's Clothing will be closed.

Be sure that members who rely on our long-established operational standards aren't forgotten in this new plan. The Lounge, iCafe and Polli & Esther's Clothing will still be open for drop-ins Monday to Friday from 10am –1pm with refreshments and snacks provided as usual. The Women's Lounge will still be open Wednesday and Thursday afternoons.

The Lounge has always been an important part of the Society's approach to membership engagement. It is designed as a safe space where members can connect with each other socially, learn from each other on a peer-to-peer basis, and help each other live healthier and stronger with HIV. The changes we're making to Lounge operations are meant to enhance that design and they are evidence-based. Whereas the Lounge once flourished as a drop-in space self-directed by members, we've noticed that the Lounge is now at its busiest and best when members are offered planned activities. Please connect with www.positivelivingbc.org and our social media channels included there to keep up to date on the Lounge schedule as it develops.

We're excited to build on what we've learned–and we invite members to help guide us. If you have any suggestions for new programs and activities for the Lounge that interest you as a member and/or volunteer, please contact Ken Coolen (Peer Engagement Coordinator) at kenc@positivelivingbc.org.

realitybites ■ NEWS from home & around the world

Poor HIV control and sudden cardiac death

■ People living with HIV (PLHIV) who are hospitalized with heart failure are at an increased risk for subsequent sudden cardiac death (SCD), according to a study published online in *JACC: Heart Failure*.

Raza M. Alvi, M.D., from Massachusetts General Hospital in Boston, and colleagues retrospectively analyzed data from 2,578 patients hospitalized with heart failure from a single academic center; 344 of these patients were PLHIV. The incidence of SCD was evaluated by viral load.

The researchers found that 86 percent of included patients did not have an implantable cardioverter defibrillator (ICD; 344 PHIV and 1,805 uninfected controls). The vast majority of PHIV with heart failure were prescribed antiretroviral therapy, ART, (91 percent), and 64 percent were virally suppressed. During a median follow-up of 19 months, there were 191 SCDs. PHIV had a threefold increase in SCD (21 versus 6.4 percent; adjusted odds ratio, 3.0) compared with controls.

SCD predictors among PHIV included cocaine use, lower left ventricular ejection fraction (LVEF), absence of beta-blocker prescription, lower CD4 count, and higher viral load. PLHIV with an undetectable viral load had an SCD rate like that of HIV-uninfected individuals. The rate of SCD was 10 percent per year among PLHIV with heart failure without a conventional indication for an ICD.

"This study advances our understanding of SCD among PLHIV with heart failure, re-emphasizing the already recognized importance of disease control among PLHIV regardless of LVEF," the authors wrote.

Source: www.infectiousdiseaseadvisor.com

Prenatal HIV exposure and decreased infant immunity

■ In the August edition of *Nature Scientific Reports*, scientists at the University of Rhode Island provided concrete evidence linking the specific immune responses in HIV-negative babies to the HIV-positive status of their mothers.

To arrive at their conclusions, the researchers compared the T-cell receptor beta-chain repertoire of cord blood samples from HIV-exposed uninfected infants to samples collected from mother-child pairs unaffected by HIV, but who were living in the same communities.

Despite the success of ART in helping to suppress the risk of HIV being passed from mother to child, globally, HIV-exposed uninfected infants are a vulnerable population characterized by increased morbidity and mortality, as well as higher rates of hospitalizations and childhood infections with more severe outcomes.

The team was able to work with researchers that had established cohorts as part of their work in the 1990s and 2000s, prior to the wide introduction of ART in Kenya, in order to obtain samples for analysis.

The analysis revealed two clusters of HIV-exposed but uninfected babies: one cluster born like healthy infants without HIV exposure while the other was born with a significantly reduced immune repertoire.

The reduced immune repertoire in HIV-exposed but uninfected infants found in the study may help explain the increased risk of morbidity in this population and emphasizes the need for special care and attention to this group.

Source: https://www.nature.com/articles/s41598-019-48434-4

HIV patients and tuberculosis

■ Tuberculosis and HIV–two of the world's deadliest infectious diseases–are far worse when they occur together. Now, Texas Biomedical Research Institute researchers have pinpointed an important mechanism at work in this troubling health problem. And, their discovery could lead to a new mode of treatment for people at risk. The results were published in the *Journal of Clinical Investigation*, a top-tier venue for critical advances in biomedical research.

"We were a little surprised at the extent of clarity in our data," Professor and Southwest National Primate Research Center Director Deepak Kaushal, Ph.D., said. "I am actually very excited to move forward trying different treatment approaches on co-infected monkeys."

The scientific community has long assumed the reason PLHIV are more likely to develop TB is a depletion of immune cells called CD4+ T cells. However, Dr. Kaushal's team was able to show that other effects of viral co-infection play a crucial role in this process.

Using about 40 rhesus macaques, researchers determined that lung-specific chronic immune activation is responsible for the progression of disease. Chronic immune activation is a dysfunction of immune pathways that generate molecules (cytokines and chemokines) which fight off pathogens like bacteria, viruses, and fungi.

Dr. Kaushal used an analogy to explain what this dysfunction caused by HIV infection does in the body. "It's like all the taps and faucets in your house are turned on full blast all the time," he said. "You are going to lose a lot of water. With this dysfunction, all cytokines and chemokines are constantly being produced to the highest levels. This dysregulates the body's ability to fight off other infections."

Even with the gold standard ART for PLHIV, chronic immune activation persists. "We need to develop approaches to target chronic immune activation," perhaps with a drug that would be an additional therapy along with ART," said Dr. Kaushal.

The implications of a new method of treatment are huge. Up to a fourth of the world's population is infected with tuberculosis. Most of the time, the bacterial disease remains latent. In otherwise healthy people with latent TB, only five percent will go on to develop active tuberculosis. In HIV/AIDS patients, the risk of developing active TB increases ten-fold to 50 percent. TB and HIV co-infection is considered a global syndergistic epidemic meaning the diseases are pandemics infecting people all around the world, and they promote each other. In parts of Sub-Saharan Africa, the rate of TB/HIV co-infection is "astronomically high," said Dr. Kaushal, citing statistics that show it's 100 times higher than the rest of the world.

This discovery was 12 years in the making, starting with the creation of a nonhuman primate model for TB/HIV co-infection. Dr. Kaushal is hopeful new treatment strategies could reach the clinic within a decade.

Source: https://www.jci.org/articles/view/125810

Correctional institute AIDS Walk marches on

■ Mountain Institution, a medium security federal penitentiary near Agassiz BC, held its 21st Annual AIDS Walk Behind Bars in late August.

Persons currently incarcerated, correctional staff, and staff from Positive Living BC worked together to create an event-filled day. Over 70 people registered to participate in the walk. Indigenous drummers provided live music, and everyone enjoyed the fresh bannock and ice cream. Proceeds raised from the sale of ice cream and bannock benefits all HIV-positive incarcerated persons.

Each year the event organizers strive to exceed their fundraising goals of the previous years. In 2018, the group raised over $1,400.00. When incarcerated people, who frequently earn less than $2.00 per day, can be so generous, it is an inspiration for the rest of us. ⊕

From left to right: Mary Petty, Wayne Campbell, Elis Aubie

A Taste of Teasing

By Jaylene Acheson

Oh the art of seduction. It is a mass-produced ordeal where North Americans spend millions of dollars on books, classes, toys, etc. Yet, how come we still feel lost when it's time to create a buzz in our partner's veins? How do we create some static between skin? Turns out, it is not as simple as rubbing a balloon on your head, but requires a lighter approach called teasing.

Your body is full of mechanoreceptors, nerve endings that give the sensation of touch. Because our lives are so hectic, we do not always give our body a chance to re-sensitize itself. Meditation and other body movement practices (e.g. yoga) can help, but, for the bedroom, we have the lovely combination of breathing and touch.

The sexual response cycle starts by first climbing to the excitement stage, plateauing, then up to orgasm– we want to start our teasing just like that. Touch needn't be heavy to be lusty; skin can pick up the touch of a breath. Shivers happen just thinking about it. If your partner has trouble relaxing or focusing, remind them to take a breath. The tools to start are all within preparing your partners body to receive your touch.

Go light and slow. Do not be shy to seek out places with both hands and mouth–arms, legs, torso, and shoulders can be easily cast away as not needed, but nay I say. Most tender areas that produce a "ticklish" sensation, can also transfer easily into a sexy sensation, such as inner elbow, wrists, and if you like, feet. Because some people are more ticklish than others, I suggest applying more pressure to the skin if they start getting too giggly on the light touch (but not enough to dig into the ticklish nerve, please).

Some of you may wonder why we might want to cover more body area, when the real deal is between the legs. Touching the whole body warms up the entire self through blood flow, and warms up the genital area, which needs a lot of blood during this exciting time. Make a circuit of it–shoulder, arm, torso, legs on one side, then come up upon the other side. Hands, kissing, biting, and toys can all work. Sucking can provide an intense feeling as well but beware of giving hickeys! Eventually, you may start focusing on the pelvic region. Remember the foreplay hasn't even started yet, so jumping directly to sex, especially penetrative, may be too early in the play.

Visual and audio aides are also useful. Teasing may start before you even lock the bedroom, such as whispering in your partner's ear. Oh yes, the almighty dirty talk helps stimulate the imagination (i.e. the brain), which is the biggest sex organ of all when it comes to getting in the mood. Visual keys help as well, such as communicating via bodily cues (eye contact, lip licking, other gestures) that you are ready to play. The more extreme, but still great, side of things could be a strip tease, or even putting on porn that you both like. Either way, play into what senses you think your partner reacts best with and do not be afraid to ask them what they prefer. ⊕

Jaylene Acheson is a sex coach who works with individuals and couples towards a fulfilling sex life through sexuality empowerment workshops. Find her on Instagram and Facebook: @femmeforth.

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Are you HIV-positive and living in BC? Join Positive Living BC for free and access the benefits of membership.

Call 604.893.2262 or visit our website at www.positivelivingbc.org

Or join as an Associate Member if you support those living with HIV in BC.

The Beyond Meat hype

By Alena Spears

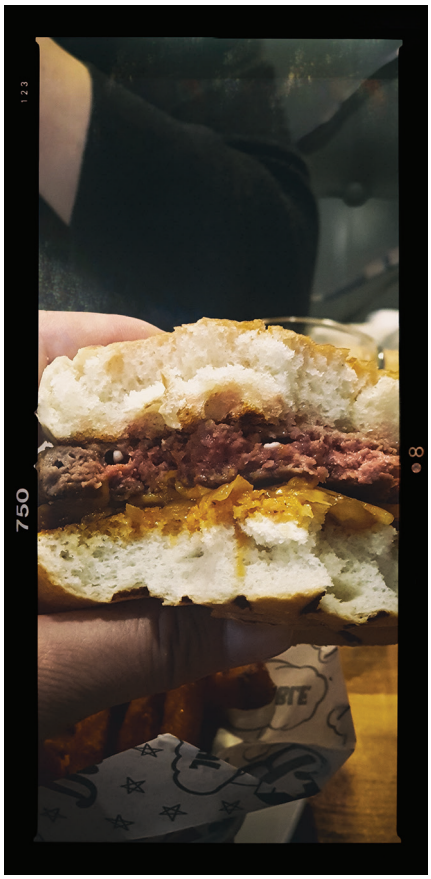
Meat substitute products are not new to the market. Soy-based 'chicken' nuggets or 'ground meat' have been grocery store staples for some time now; but they've never trended like Beyond Meat. You can now find Beyond Meat products in grocery stores and big chain restaurants (White Spot, Subway, Tim Hortons and A&W).

According to research by Insights West, seven percent of Canadians follow a vegetarian or vegan diet and a further 27 percent of Canadians are considering one. A recent report from the University of Guelph stated that almost 85 percent of Canadians consider themselves to be "flexitarians," eating a vegetarian meal at least once a month. The reasons given for reducing meat consumption included concerns over animal cruelty, health, religious beliefs, and environmental impact.

So how do these processed meat alternatives compare to meat? Is the Beyond Meat burger healthier than a beef burger? Let's see.

Examining the nutrition labels of the Beyond Meat patty and a beef patty on their own, Beyond Meat has fewer calories, 30 percent less total fat, half the saturated fat, and three times the iron of the beef patty (doesn't sound half-bad!).

Keep in mind that even though it's lower in fat than the beef patty, Beyond Meat is not considered low fat, with 18 grams of fat per patty, or close to a third of your daily recommended intake. This product also contains *five times more*



sodium than a beef patty, which is a concern for anyone with high blood pressure or kidney, liver, or heart issues (sounding less amazing).

Now compare the nutritional value of A&W's Beyond Meat Burger to their Mama Burger with cheese. When the patties are all dressed up to their delicious burger glory, their nutrition profiles are quite comparable in both total calories and protein. Surprisingly, the Beyond Meat has jumped to 30 grams of total fat, compared to the Mama Burger's 24 grams. Like the patty-to-patty comparison, the Beyond Burger has half the saturated fat and 50 percent more sodium.

Processed plant-based meat alternatives were never thought to be lean or low in sodium, so this information about Beyond Meat isn't shocking to me, but some people will be disappointed. We all want to reduce our environmental impact, treat animals kindly, and maintain good health, but occasionally eating a Beyond Meat burger–or any meat substitute for that matter–won't make a big difference. It's what we do every day that's going to have the biggest impact.

Bottom line, the Beyond Meat burger is no healthier than a regular beef burger and it should not be marketed as such. Beyond Meat has, however, created a lot of buzz around eating meat-free meals that taste good, which is a plus! Feel free to enjoy it occasionally, but I would encourage trying other less processed vegetarian proteins as well. If you need any meal ideas or have questions about incorporating more plant-based proteins in your diet, get in touch with your local dietitian or call HealthLink BC at 8-1-1 and ask to speak with a registered dietitian. Happy eating!

Alena Spears is the dietitian for the John Ruedy Clinic at St. Paul's Hospital and Providence Crosstown Clinic in Vancouver, BC.

INSTI now available for expanded point-of-care use in Canada

BioLytical Laboratories has announced that their INSTI HIV-1 / HIV-2 Antibody Test (INSTI) can now be used by more HIV testers and healthcare providers in Canada.

INSTI uses innovative technology to deliver instant, accurate HIV test results from a one-minute procedure. The test's Intended Use statement has been updated to make it possible for an increased range of healthcare professionals to use INSTI, including HIV counsellors and peer testers. It also allows for INSTI to be performed in more point-of-care (POC) settings including outreach testing events. This is like the CLIA Waiver in the US, which was granted to INSTI in 2012. The waiver certifies that INSTI is a "simple laboratory examination or procedure that has an insignificant risk of an erroneous result." This means the test can be performed by a variety of users in POC settings across the country.

This is a win for Canada's community-based organizations and HIV research community, who have been calling for better access to HIV POC test delivery for many years. "This is a watershed moment in Canada," said Dr. Sean B. Rourke, of St. Michael's Hospital. "With this increased delivery access of HIV POC testing, we will be able to significantly support the scaling up of community-based models to 'bring the test to the people.' It is only in this way that we will reach those who are undiagnosed with HIV and who need testing the most."

INSTI was approved by Health Canada in 2005, making it the only POC HIV test of its kind in the country. At the time of its approval, the test was designated for use only in medical POC settings such as doctors' offices, clinics, and laboratories according to the Intended Use statement. This also meant that only trained healthcare professionals such as doctors, nurses, and laboratory technicians were permitted to perform the test. INSTI is used in traditional and non-traditional testing models worldwide due to its fast, flexible procedure, accuracy and ability to detect HIV as early as 21-22 days post-infection.

Convenient, accessible HIV testing is critical amid reports that HIV is on the rise. An estimated 14 percent of PLHIV in Canada are undiagnosed, which represents 9,090 individuals who are not aware of their status. Populations who may be most at-risk include people who live in remote communities, men who have sex with men, people of African and Caribbean background, Indigenous peoples (First Nations, Metis and Inuit), people who use intravenous drugs, and at-risk youth and women.

"Health Canada's approval of this vital change to INSTI's Intended Use is ground-breaking," said Rick Galli, Chief Technical Officer for bioLytical laboratories, which developed INSTI. "INSTI will allow rapid testing to become available more widely in Canada than ever before. Studies have shown that at-risk individuals may be less likely to seek out HIV testing in traditional medical settings. Providing additional options for point-of-care testing gives us further opportunities for diagnosis and linkage to care. This can save and extend lives, giving us a new hope for ending the HIV epidemic in our country. ⊕

Source: https://insti.com/insti-in-canada/

YOUR NAME HERE

By MT O'Shaughnessy

I've stood in front of classes and talked about what it's like, for me specifically, to live with HIV in today's world. I get questions about stigma and criminalization. For me, the fact that those two things don't ever seem to get separated pretty much answers most of the questions.

Now, take the picture [as seen on the right] I shot around the West End. Over the last two months or so, that message has shown up in various spaces. Under the block is a single name. And if people are being honest, the first question, after wanting to know the name, is "what did they do?"

That is the actual sign of what stigma looks like today.

Conversations in media and on the streets heavily imply that PLHIV, or increasingly any infectious disease, are first and foremost to blame. We're not sure *what* they "did," we're not sure *why*, but we're sure there's a "good reason" for the responses.

Only–Is there? Is there ever an absolute, no question moment in which scrawling all over a neighbourhood the name of a person with the words "has HIV, Hep C" is okay? More important to me than someone's answer to that is this: we don't seem concerned with asking the question at all in the first place. Not as a community nor as a country.

We've allowed conversations to sidestep that. We're instead just reading the news as it puts up the face, name, and place of work people they *suspect* of maybe exposing someone to HIV. We don't do that for other crimes, but we just scroll to the next article on this one. And increasingly it feels like simply having HIV is in and of itself the crime.

I'm aware it's a harsh reading of things. I'm often met with silence when I bring this up. But I remember the days of "no one would do that." They did. Over and over. Stopped us at borders because our disease was a threat. And it was linked, married, and mixed in with points on moral compasses. When HIV/AIDS was about being gay and gay was about being evil.

Whoever wrote these messages, I don't know what *they* intended or why. What I do know is that on some level they, perhaps, felt that serostatus and hepatitis status are *threats* they could level at someone. And they're not wrong.

When people talk about it being different, it being better, this is Vancouver after all, I want to point to these pictures and ask, is it really though?

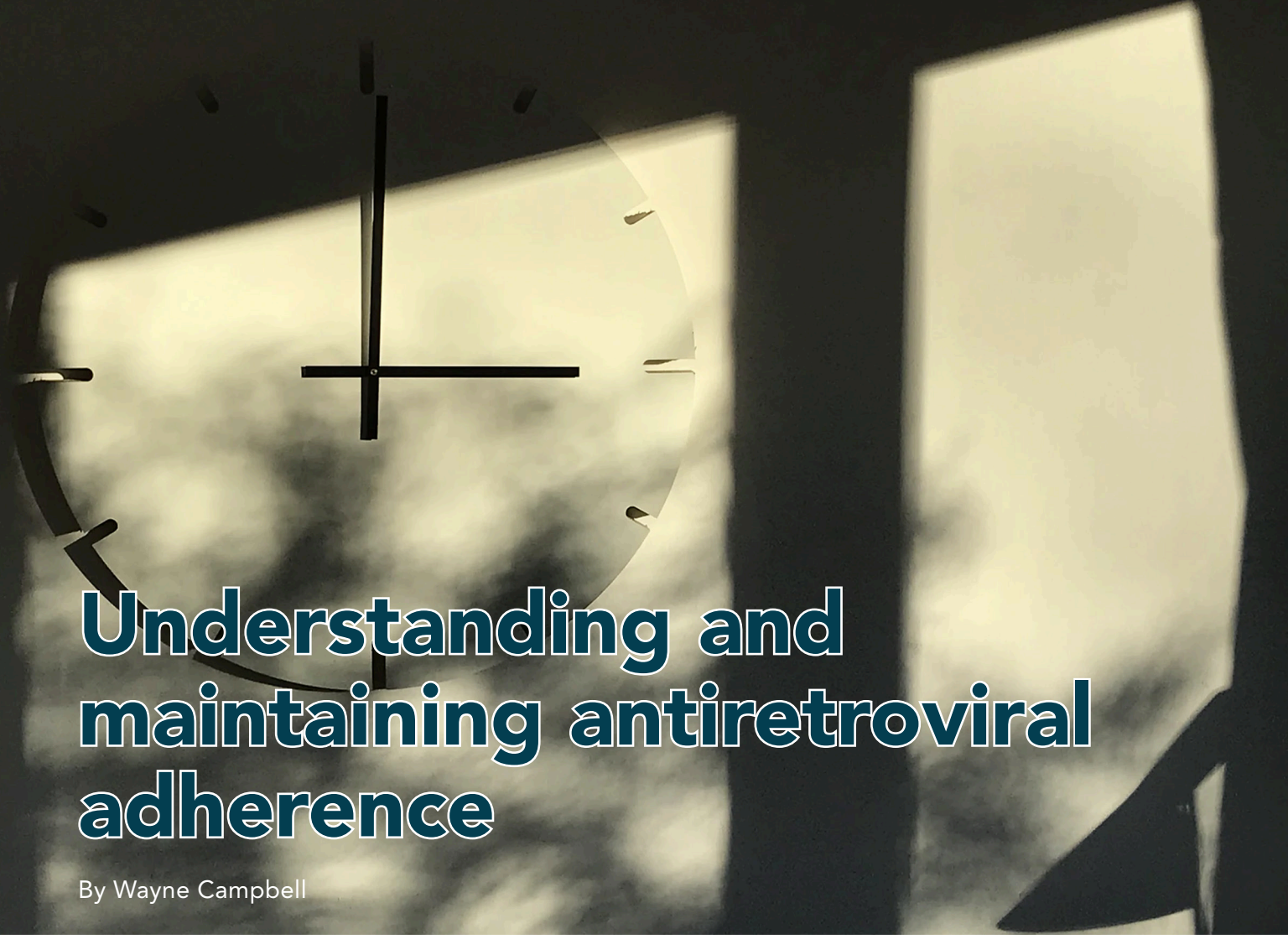
The conversation seems to centre around whether or not a person deserves this. We don't talk about *graffiti as social justice*. Or that we shouldn't even be talking about "deserves" in relation to a smear campaign simply because it's a disease people are still threatened by. And have strong prejudices against.

I know, as a human, adult male, that in this world a lot of people think I'm an asshole. So, I have to wonder, and I have ever since I first saw this on Davie Street: what's to stop someone from doing this to me? Because even if all the people I know are already aware I have HIV, the first thing they're going to ask each other is … What did he do to deserve this?

That. That's what it's like.

Imagine: Your name here. ⊕

In an upcoming textbook on critical clinical social work, MT O'Shaughnessy will coauthor a chapter around HIV and the impacts of policy and quarantine laws on care.



Understanding and maintaining antiretroviral adherence

By Wayne Campbell

Adherence means to stick to a plan or regimen. For PLHIV, treatment adherence includes, after starting HIV treatment, keeping all medical appointments and taking HIV medicines every day, exactly as prescribed. Adherence is the single most important factor under the control of PLHIV that determines the success of antiretroviral therapy (ARV).

It is best to see a health care provider as soon as possible after testing positive for HIV. In BC, it is recommended that PLHIV should start taking HIV medications right away. HIV medications help people with HIV live longer, healthier lives by reducing the risk of HIV transmission.

When selecting a new HIV medication regimen or starting meds for the first time, you should look at your lifestyle to see if there are any potential adherence obstacles. Does your daily schedule change a lot? What is your typical daily eating schedule? Do you find it difficult to swallow pills? Are you on other medications? What side effects can you tolerate? What happens if you miss a dose?

Keeping the amount of virus in your blood as low as possible is the best way to protect your health. Sticking to your treatment plan allows the medications to reduce the amount of HIV replication in your body. If you skip your medications, even occasionally, you are giving HIV the chance to multiply rapidly.

ARV reduces your viral load, ideally to an undetectable level. If your viral load goes down after starting ARVs, then the treatment is working, and you should continue to take your medicine as prescribed. Unlike antibiotics, many chronic disease medications do not make you feel different even when they are working. If you keep an undetectable viral load, you can stay healthy and have effectively *no risk of transmitting HIV* to an HIV-negative partner through sex.

If you miss doses, there is a chance the virus will change to a form that is harder to treat. This is called "resistance." ARV adherence helps prevent drug resistance. If you miss a dose, take it as soon as you remember. If it is almost time for your next dose, do not take two doses at the same time.

Sticking to a treatment plan isn't always easy. There are certain factors that can affect adherence.

Daily dosage vs twice-a-day dosage

Today, there are several once-daily fixed-dose regimens where two or more ARVs are contained in one pill. While the option of only taking one pill each day sounds appealing, these regimens may not allow for a missed dose because the doses are further apart than twice-daily doses. Missing a once-daily dosed pill can also increase odds of drug resistance.

> **If you miss doses, the virus is harder to treat. This is called resistance. Adherence helps prevent drug resistance.**

Attitude

Generally, people who feel most strongly that their medication is working well have an easier time adhering to their regimens. Over time, adherence to a daily pill regimen is difficult for some people due to pill fatigue, that is, when someone grows bored or tired of taking their pills. Talk to your healthcare provider, a peer navigator, or our Treatment Outreach Coordinator if you are feeling pill fatigue.

Someone who does not wish anyone to know they are living with HIV may avoid taking medications to avoid HIV stigma, thereby increasing the potential for non-adherence. Understanding how and why the medications work can help you maintain a positive attitude about taking HIV medication daily.

Mood

People whose lives are impacted by depression, anxiety, or other untreated mental health challenges report having a harder time adhering to HIV drug regimens than people who are not experiencing these symptoms. If you suspect that you are depressed, chat to your health care provider.

Disorder

Lowering the amount of disorder and stress in your life can generate adherence problems. Disorder can include more than just an unpredictable and overwhelming calendar of activities. People report doing "party drugs" or experiencing rapid mood swings (bi-polar disorder) makes it difficult to stay adherent. A lack of access to consistent food or permanent shelter can make ARV adherence a challenge as well. A case manager or social worker may be able to help with the disorder in your life.

Side Effects

ARVs can cause side effects that can be severe enough to make some people stop taking them. If the side effects are mild, they might go away over time. But if the side effects are interfering with your quality of life and affecting your adherence, consult your health care provider.

Primary Caregiving

The needs and concerns of the people you are caring for can be overwhelming and become your focus. Remember that your health needs are as impotent as the people for whom you care; you cannot care for others if you do not take care of yourself.

Cognitive Challenges

Studies have shown lower-education literacy contributes to missing HIV medications and creates additional barriers to accessing medical care. As PLHIV live longer, they will develop co-morbidities (other traditional illnesses associated with ageing) creating polypharmacy challenges (medications associated with the other illnesses).

Success is achieved when your ARV regimen is not complicated, is easy to access, and there is no interruption in the supply chain. Not everyone has this privilege. Some people live in remote communities where access is challenging.

> **Understanding how and why the medications work can help you maintain a positive attitude about taking HIV medication daily.**

Adherence problems aren't something to be ashamed of. It's important to discuss any fears or challenges you have with your health care provider. There are also many tips and tools you can use to help you better adhere to HIV treatment:

- Take medicine at the same time as another daily activity, e.g., eating breakfast, brushing teeth, or watching the news.

- Keep medication in an easily accessible place but be mindful if children are in the home.
- Use a pillbox and medication log. Update the log at every health care provider visit.
- Ask the pharmacy for reminder packaging, i.e., blister packs (for those with very complex regimens)
- Set a cell phone or watch beeper as a reminder.
- Meds on the go. If you find that you often need to take your meds on the go, check out portable pocket-sized pill cases. Some have built-in timers.
- Plan ahead. Make sure that you regularly refill your prescriptions, so you don't run out of your medication. And schedule time to have your bloodwork completed.
- HIV requires lifelong treatment. The best approach to managing your treatment and medication adherence is to adopt an all-inclusive health approach that includes regular visits to your health care provider, ongoing pharmacy visits, links to community support, and practicing self-care at home. For some people, it might also include lifestyle changes such as increased exercise, adopting a healthier diet, or stopping substance use to make adherence more successful.

Your needs will change over time, so a brief discussion with your health care provider, a Peer Navigator, or myself, (the Treatment Outreach Coordinator at Positive Living BC), can help improve treatment and medication adherence, while helping you succeed in achieving your health goals. ⊕

Wayne Campbell is Treatment Outreach Coordinator at Positive Living BC.

TRAVEL TIPS FOR PEOPLE ON ARVS

For PLHIV planning a vacation or a work trip requires additional preparations for the sake of medical adherence. Advance planning will help you have a more enjoyable trip. In most cases, HIV won't affect or prevent you from travelling. But domestic and international travel will require some preparation. Going to a different country will require more planning.

As a reminder, if you have an undetectable viral load, taking one dose a few hours early or late will not usually cause problems.

- **TIP ONE: After arrival, it's best to adjust to the new time zone as quickly as possible to when it's best to take your medication.**
- **TIP TWO: Travel with extra doses. If you travel a lot, always bring your meds in your carry-on luggage, and bring a few extra doses in case of flight delays and cancellations.**
- **TIP THREE: If you are travelling west to east you may need to take your medications earlier so that you can get back on schedule when you reach your destination.**
- **TIP FOUR: If you are travelling east to west you may need to take your medications later so that you can get back on schedule when you arrive home.**
- **TIP FIVE: You will need more specific advice and planning from your health care provider or a pharmacist if you encounter a complex itinerary with multiple time zone changes within a few days or a trip lasting more than 24 hours.**

FURTHER RESOURCES.

AIDSMAP offers more travel info for PLHIV, including this one on safe adherence whilst travelling

⏢ **aidsmap.com/about-hiv/travelling-hiv-medications-time-zone-changes**

General travel advice

⏢ **aidsmap.com/about-hiv/hiv-and-travel**

Travel insurance. Always a good time for a refresher!

⏢ **aidsmap.com/about-hiv/travel-insurance-people-hiv**

Positive Peers has another handy, general travel list you may find useful, including hook-up hints!

⏢ **positivepeers.org/the-plus-side/blog/travel-tips-for-people-living-with-hiv/**

The Berlin Patient

On Life, hope, and a functional HIV cure

By Jason Motz

Not even the most creative, optimistic minds of 1986 could have predicted this future scene: a conference room brimming with Vancouver medical personnel, researchers, activists and media spending their lunch hour hearing a thin, nervous man speak. On the surface, the speaker is quite average–but the man's story is far from ordinary. Timothy Ray Brown, a.k.a The Berlin Patient, is the first person to be cured of HIV/AIDS. First, to date. And those assembled have every reason to look at Brown with a special interest; he is the example of perseverance that inspires the HIV research world.

HIV/AIDS has been devastating wherever it has turned up. In 2018, HIV/AIDS was reported to affect 39.7 million people globally, with only six percent of those cases in North America and the Western and Central parts of Europe. And yet, the timeline of HIV/AIDS that once eschewed faith and flummoxed science, could culminate on one man's unique condition.

continued next page

The first half of Timothy Ray Brown's life seemed simple enough. Born and raised in Seattle to a Christian conservative mother, there was with no indication of the medical fame he would achieve in his second half. He came out early, was an avid skier (becoming well acquainted with the slopes of British Columbia), studied in Berlin and worked as a translator throughout Europe. He enjoyed a thirteen-year relationship with a German man. Everything seemed perfect. But during this relationship, the wheels came off Tim's life.

Diagnosed with HIV in 1995, Brown got onto AZT like many before him. A year later he was onto protease inhibitors. For a time, life went about rather normally. But feeling weak after a trip to New York, Brown's health was about to take a harsh turn.

As if living with HIV wasn't enough to deal with, Timothy was diagnosed with acute myeloid leukemia (AML) in 2005. Statistically speaking, this was not good. "My second death sentence," Brown says now, with a wry laugh. Brown described this harrowing part of his life in a 2015 paper called "I Am the Berlin Patient: A Personal Reflection."

> The doctors told me that I would need four rounds of chemotherapy treatments, each taking a week, with breaks of several weeks in between. I did the first round; that went well. The second round gave me fungal pneumonia, but that passed with antifungal treatment. During the third round, I got a dangerous infection. I was put into an induced coma. When I came out of that a day later, [my doctor] told me to go on vacation so I vacationed in Italy. Before the third chemo treatment, [my doctor] took a sample of my blood to send to the stem cell donor bank with the German Red Cross to look for matches for my tissue type in case I needed a stem cell transplant. This confused me because I thought this ordeal would end with the chemotherapy treatments.

Following his doctor-prescribed vacation, Brown's cancer went into remission. But that's where the science got interesting. Brown's German doctor, Dr. Gero Hütter got "the idea of looking for a donor who had a mutation called CCR5 Delta 32 on the CD4 cells making them nearly immune to HIV. CCR5 is a protein on the surface of the CD4 cell that acts as doorway for the HIV virus to enter the cell. Take away this entryway and CD4 cells will not be infected and the person will not get HIV." It was, at best, a medical Hail Mary, and were it not for Dr. Hütter's indefatigable spirit, it would have been a miss. Hütter's commitment paid off when they "found a donor with this mutation on the sixty-first attempt. The donor agreed to donate should it be necessary."

Despite the efforts of the doctors to convince Brown to have a transplant, Brown refused: "I did not need to be a guinea pig and risk my life receiving a transplant that might kill me. The survival rate for stem cell transplants is not great; normally it is about fifty-fifty." But when the cancer returned in 2006, Brown relented. Today, Brown refers to the date of his experimental transplant, February 6, 2007, as his second birth date. Following Dr. Hütter's orders, Brown immediately stopped taking his HIV medications. It was three months later when tests revealed a lack of HIV in Brown. But he wasn't clear of hurdles just yet. A second stem cell transplant in 2008 almost blinded and paralyzed him, leading to months spent at a rehab facility as Brown learned to walk again. But despite it all, he remained clear of HIV.

"I'm happy to be alive," Brown told me the day after his afternoon media appearance, "but I went through hell."

> **"I am happy to be alive, but I went through hell – Timothy Brown"**

The rub is, of course, that Brown's cure is hardly scalable. Dangerous and cost prohibitive, Brown was lucky enough to be diagnosed while in a country with a decent health care system. Luckier still to be Dr. Hütter's patient. (For his endeavours, Hütter was named a 2008 Berliner of the year by a Berlin newspaper.)

In February 2009, Dr. Hütter and his colleagues published their findings in *The New England Journal of Medicine (NEJM)*. Their paper, however, was perhaps too conservatively titled: "Long-Term Control of HIV by CCR5 Delta32/Delta32

Stem-Cell Transplantation" doesn't quite scream the medical miracle that Brown is.

As Brown tells it, his own reaction to being told he was cured was somewhat muted. "I didn't believe (I was cured) until the paper was published in the *NEJM*."

> **One of the enduring mysteries is when exactly did the virus leave his body? Did it happen gradually or all at once?**

One of the enduring mysteries of Brown's situation is when, exactly, did the virus leave his body? Did it happen gradually over time or all at once? Did the first transplant start a process then completed by the second? Somewhere in the squishy middle? "I don't think we'll ever know when (Brown) was free of HIV, "said Dr. Zabrina Brumme, Director of Laboratories at the BC Centre for Excellence in HIV/AIDS. "I don't think we'll know exactly when that was. Was it after the first transplant or after the second? "Brown had no viral load in his blood after the first transplant, but that, as Dr. Brumme points out, "doesn't mean HIV isn't somewhere" hidden away in the body.

Earlier this year, the medical media was abuzz with news of a patient in London cured much the same way as Brown: a bone marrow transplant to treat, in this case, blood cancer. As with the Berlin Patient, the London Patient's possible cure is not an easy fix for HIV the world over. It is nonetheless encouraging. In an online article for Medicalexpress.com, Andrew Freedman, of Cardiff University, said, "Whilst this type of treatment is clearly not practical for millions of people around the world living with HIV, reports such as this may help in the ultimate development of a cure."

"I'm concerned about the London Patient," Brown said. "Yes, he's been off ARV for eighteen months, but they haven't done any biopsies on him." After all, in Brown's case, it was only after colon and brain biopsies that it was determined that HIV was no longer within his body.

If anything, the prospective London Patient has the attention of the HIV world, but to some, it's too soon to say there has been another miracle cure. "People have remained suppressed with difficult to find HIV for longer (than eighteen months) and then had a rebound," said Dr. Brumme.

"We hope he's cured. It's totally possible," Dr. Brumme said, but also offered a cautionary reminder of the Mississippi Baby. In that 2010 case, a child born to an HIV-positive mother was given ARV within thirty hours of her birth. The mother and baby returned for an examination after eighteen months. No trace of HIV was found in the child. There was extensive media coverage of what the *NEJM* called a "functionally" cured child, and even talk of further research into ARV for infants born to HIV-positive mothers. However, in 2014, results of different tests showed that the child was now HIV-positive. It was a blow to HIV researchers.

As he stands before a crowd of captivated listeners, Timothy Brown is a contrast. Though he displays the weakening that ten bone marrow biopsies – ten!– will do to a body and is unbalanced from an air bubble in his brain, Brown exudes inner strength. Told by doctors he has a low but not-quite-zero chance of reacquiring HIV, Brown is now an advocate for PrEP. He is also protective of his medical celebrity status: "don't take away my cure," he says to the scientific assembly before him. It's the humour of grace, and a hard-won grace at that. He's earned his spotlight, and he infuses it with hope.

> **I am concerned about the London Patient – Timothy Brown**

He accepts that he is unique but is optimistic that someday he won't be the only Berlin Patient. "I want everyone to be cured," he says, "in the world." It's the high idealism that surviving two death sentences seems to grant. ⊕

Jason Motz is the Managing Editor of Positive Living magazine.

Learning to advocate as a caregiver

By Billy Bear

I have been HIV-positive for 25 years and an entertainer for even longer, so I know how to advocate for my own health and speak my mind. I learned how to become an advocate as a caregiver only after the day that my partner had a stroke.

It was a typical late May day, but my partner, Jeffrey, was showing signs that something was just a little off. His symptoms worsened and we went to emergency. At the hospital, I told them, "You must take him now, something is not right. Please look at him." Eventually, they checked him in and told me to return in the morning. It felt like no one wanted to tell me what was going on. I wanted answers but was getting none. I realize now that they did not have any answers in the early stages. At the time, however, I just felt ignored and lost.

When I went to emergency the following day, he was out of it and unable to communicate because the left side of his face was now paralyzed. I stood there in shock; there were no staff, and no nurses or doctors came to speak with me. All I could think about was, is he going to die? I went to the nursing station but, again, nobody gave me any answers. With no information coming my way and feeling powerless, I just cried.

A few days later, I spoke with Glen at Positive Living BC (PLBC) and Anita from AIDS Vancouver (AV) who told me how, as a caregiver, I had rights; they told me how to get my power back. They explained Providence Heath's philosophy of treating the whole family, not just the patient. However, that does not always translate into actual practice. As nurses and doctors avoid giving specific answers when they don't have the whole picture, I learned to keep asking the same questions to different doctors and nurses, and of the importance of writing down their names and their replies. Every nurse and doctor gave me their version of the same story. Soon I could put together a whole picture from the fragments of information.

Once I knew how to take my power back, the old-school HIV advocate I once was for myself returned to look out for my partner. I visited him two or three times every day for a week. Hospital staff asked what I thought about discharging him, and I said it was not a good idea. The physician released him to our home anyway. We were not given correct medication or coherent home support information. We were given a piece of paper from the physician with one line scribbled on it that I stuffed into my pocket to read later, but I could not read his writing. No time was taken to decide if we had the appropriate living space to handle his needs. We did not even know what his needs might be.

Back home, he had fourteen falls over the following days. We were unequipped to bathe him, and we feared for his safety constantly. Finally, my partner agreed to go back to the hospital. Tests confirmed that he'd had a second stroke while at home.

After he settled back into the hospital, I spoke with Glen and Anita again. They told me the discharge planning was not case managed correctly. Often, there is only one social worker for an entire floor of inpatients, so if we don't ask for the social worker, that caregiver/social worker connection can be missed. They sent me back to the hospital to request a meeting with the social worker. They explained how an Occupational Therapist (OT) should have done an assessment on our situation.

Armed with new information about a social worker, therapy, and rehabilitation facility options, I made sure the awful discharge we received before did not happen again. Anita followed up with the St. Paul's social worker to prevent anyone falling through the cracks again. The social worker I connected with was helpful. She explained to me the physician's note said to go see our general physician in a couple of days to set everything up. That was his discharge plan: dump it back on me, who knew nothing. No attempt was made to make sure I understood everything that we would need to do.

> **With no information coming my way and feeling powerless, I just cried.**

The second time around, Jeffrey stayed in the hospital for four weeks. After the disaster of the first discharge, I no longer trusted them. The social worker worked with me to rebuild the relationship with St. Paul's, and helped me understand the long journey ahead. During these four weeks, I was the vocal advocate for my partner, continually speaking with the nurses about his care. I helped with feeding Jeffrey, even changing his bed sheets as they left him in his own mess. I assisted him with his showers, and I was, at this time, his primary care giver because nurses would not do it, or they were too busy. I policed visitation requests to ensure my partner was not overwhelmed by visitors.

The weeks were intense and weighed on my well-being; I had to deal with my own chronic HIV health. I checked in with both Glen and Anita for regular emotional support. Despite this, I forgot to take care of myself during this time. Simple things like staying hydrated and well-fed just fell away. Anita had to tell me to drink water and eat food as I was becoming weak and fragile. I would tell those around me constantly that I was strong or that I couldn't slow down because I had too much on my plate. I had to keep moving because If I stopped, I would not get back up. This was not a good long-term strategy.

Questions about living alone if my partner passed away, finances, housing and other uncertainties put me in a depressed state. I had to speak with my case manager and debrief, unload, and cry in order to move away from depressing thoughts. I have always been the type to hide emotions; I only open privately to someone I trust. Jeffrey's situation has raised a lot of questions and thoughts that I never thought about before. What with my own health challenges, I assumed I would be the first to go.

St. Paul's transferred my partner to the Holy Family Rehabilitation Centre at the end of July. My well-being improved at once. I visit him three times a week, twice on the weekend. He is rehabilitating with an OT and physiotherapist, both of whom I managed to contact on day one, taking their names down right away. A case management team will deal with discharge planning and equipment request/installs when he's fit to return home.

Jeffrey is still in rehab but is getting better with the support of the OT, physiotherapist, and other staff at Holy Family Rehabilitation Centre. I'm relieved at seeing the progress he's made and am starting to feel better and more confident about a stressful situation.

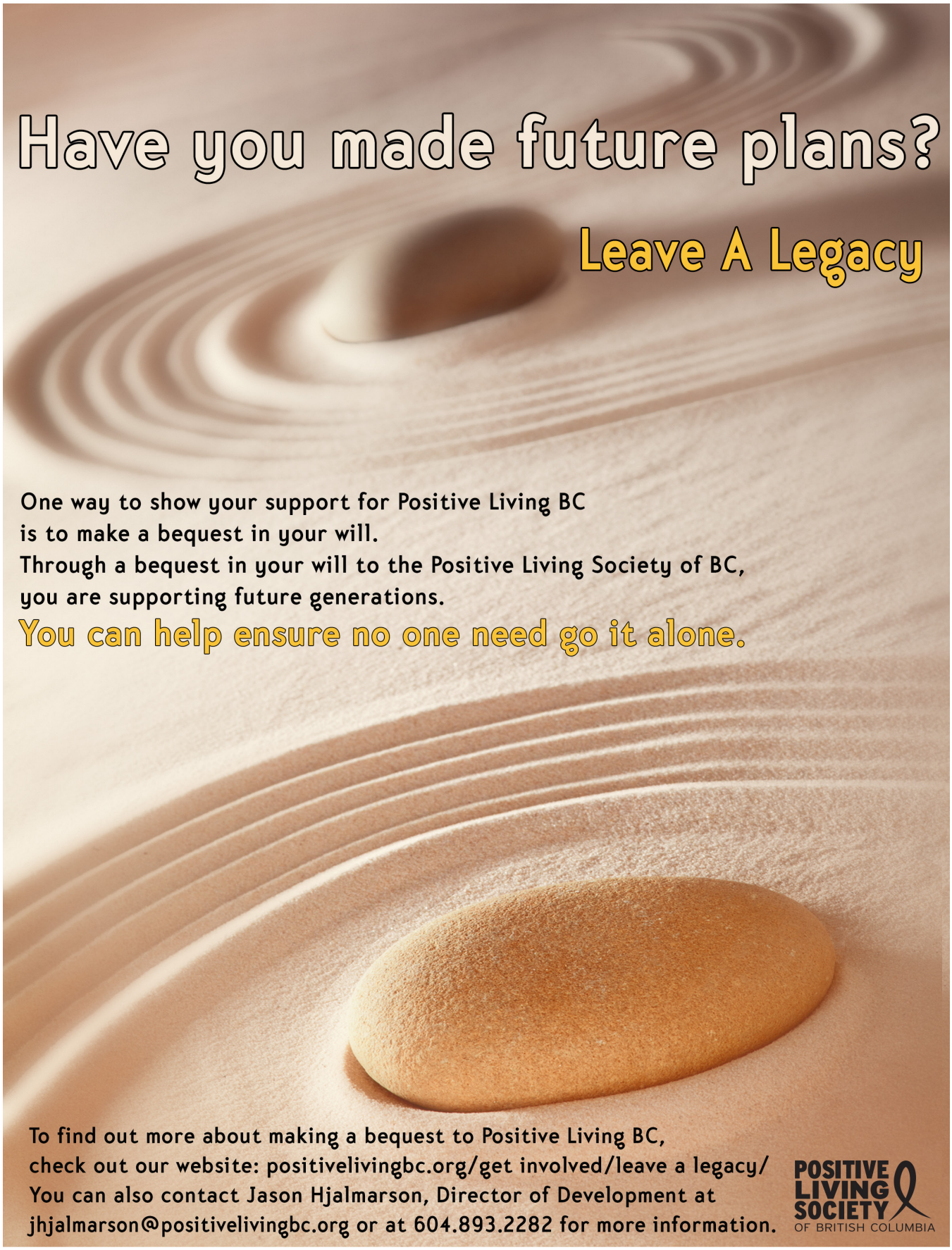
I have learned never to doubt your right and ability to deal with health care providers. We are not alone if we have groups like PLBC and AV supporting and empowering us to stand our ground and helping us own our role as a caregiver. Even though my partner is going to be discharged soon, my role as caregiver has only just begun. ⊕

Billy Bear is a long-time volunteer at Positive Living BC.

FYI

Positive Living BC has a discharge-planning brochure to help you plan for your health recovery. It includes information on what to think about before you leave the hospital, follow-up appointments, involving a caregiver and other topics.

You can get this brochure at our Peer Navigation office at the John Rudy Clinic (IDC) at St. Paul's Hospital, at our office at 1101 Seymour Street, or online at positivelivingbc.org/resources/health-resources/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Through a bequest in your will to the Positive Living Society of BC,
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To find out more about making a bequest to Positive Living BC,
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You can also contact Jason Hjalmarson, Director of Development at
jhjalmarson@positivelivingbc.org or at 604.893.2282 for more information.
POSITIVE LIVING SOCIETY
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First data on PrEP uptake in trans men

By Roger Pebody

In a US national sample of transgender men and transmasculine people, a quarter had had sex which would make them eligible for PrEP. Yet, only a third of those had had any PrEP information from their doctor, and only 11 percent had received a PrEP prescription.

The data are reported by Professor Sarit Golub in the September issue of the *Journal of Acquired Immune Deficiency Syndromes*.

Most HIV research among transgender people has focused on trans women (those assigned male sex at birth who identify as women or transfeminine). There are very few data on trans men (people assigned female sex at birth who identify as men or transmasculine). Golub says this is partly because trans men have been assumed to have sex primarily with cisgender women and therefore be at low risk for HIV.

As a result, few HIV prevention interventions have been developed that address the unique needs of trans men, and specific eligibility criteria for PrEP have not been devised. Nonetheless, a previous review of US data by the Centers for Disease Control and Prevention (CDC) showed that 15% of the 2,351 transgender people diagnosed with HIV in a five-year period were transgender men.

The survey was part of a larger project to understand the range of sexual behaviours, identities, and sexual health needs of trans men. It was developed by a transgender-led research team and promoted on social media and by trans community leaders.

Participants were adults who had been assigned female sex at birth and whose current gender identity was something other than female. People living outside the US and HIV-positive respondents were excluded.

Of the 1,808 participants, two-thirds were under the age of 30, just under a third identified as a person of colour or Latinx, and half were college-educated. Two-thirds reported a binary gender identity, whereas one third had a non-binary identity. Participants' sexual orientations were diverse–queer (38%), pansexual (16%), gay (14%), bisexual (13%), straight (10%) and asexual or demisexual (8%).

Twenty-four percent (439 people) were judged to be eligible for PrEP: 16% reported condomless receptive vaginal sex in the past six months; 7% reported condomless receptive anal sex in the past six months; 6% reported an STI in the past year; 6% reported more than five sexual partners in the past year; 3% reported sex work in the past six months.

Eligibility for PrEP did not differ by age, race, ethnicity, education or gender identity. People on lower incomes, who did not identify as straight or asexual, who were in open or polyamorous relationships, who had tested for HIV more recently, and who used stimulant drugs were more likely to be eligible for PrEP.

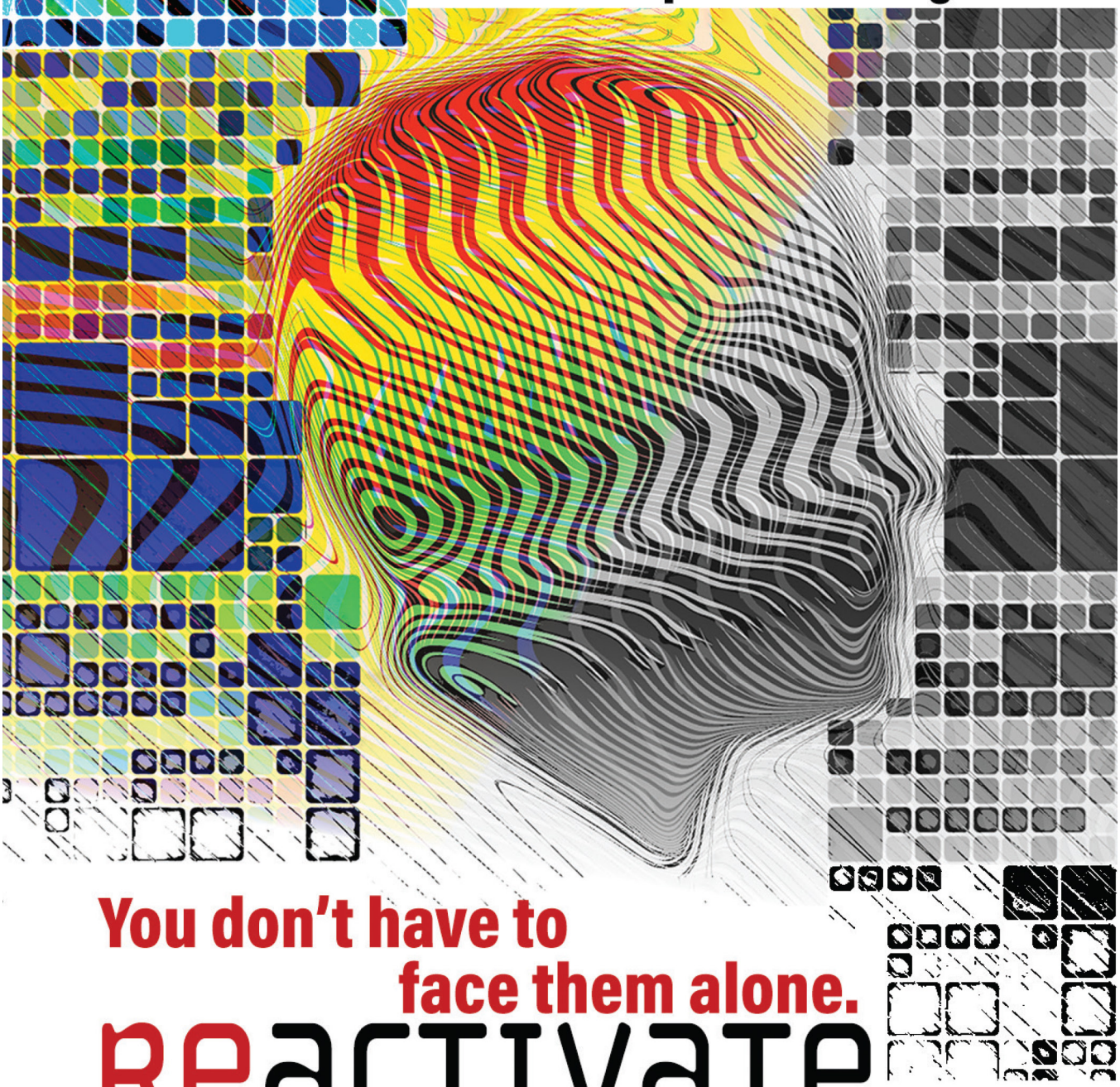
Of those who may be eligible for PrEP, 361 had seen a healthcare provider in the past year, 285 had been tested for HIV, 149 had received PrEP information from a healthcare provider, and 48 people had received PrEP. The latter figure is 11% of those eligible for PrEP.

"Enhanced efforts should be made by providers, programs, and systems to assess HIV-related risk in transmasculine patients and engage them in comprehensive sexual health care," say the authors.

Source: Aidsmap.

POSITIVE LIVING SOCIETY OF BRITISH COLUMBIA

Living a long time with HIV can have new & complex challenges.



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By UBC HIV/AIDS Awareness Club

Media coverage of HIV/AIDS seems to have dwindled or been swept under the rug as a mitigated health issue. Yet, HIV/AIDS remains a global issue, affecting 36.9 million individuals, the near-equivalent of Canada's population. As UBC students, we recognize the gap in social awareness. We want to lead the learning of the UBC student body on HIV/AIDS-related issues, and why the issues are relevant.

The UBC HIV/AIDS Awareness Club was created by Emily Yeung, a third-year biology student, in 2018. She developed an interest in HIV/AIDS by reading about HIV/AIDS treatment research. Her interest in the research soon developed into a passion for fighting the epidemic. Emily recognized the lack of a focussed HIV/AIDS group on campus and formed the UBC HIV/AIDS Awareness Club.

Founding the club allowed her to address the socially pervasive ramifications of HIV/AIDS while working with the medicine-related topics she loves. She gathered peers who were also passionate about HIV/AIDS advocacy, resulting in the formation of the current executive team: Emily Yeung, President; Jeong Min Son, Vice President; Jennie Suen, Treasurer; and Heidi Suen, Vice President of Marketing.

Heidi's interest in HIV/AIDS stemmed from watching YouTube clips of *RENT*. She took the opportunity to explore the stigmas between the movie and the local community around her and wanted to incorporate her marketing studies to wed interest with education.

Jennie saw that HIV/AIDS-related issues like social welfare, community integration, and stigma could be addressed at and with UBC. By bringing these objectives to the club, she hopes to spur on learning and offer opportunities for people to undo unfair preconceptions.

Jeong Min has long been curious about how viruses affect the human body, but she has taken a keen interest in the social and psychological aspects of HIV/AIDS and STIs and their impact on marginalized communities. As part of the UBC HIV/AIDS Awareness Club, she wants to engage students in raising awareness and promoting understanding of HIV/AIDS-related issues that affect these communities.

UBC HIV/AIDS Awareness has partnered with Positive Living Society of BC. Our club members have been attending LGBTQ+ Pride events to learn more about the issues surrounding individuals diagnosed. Our purpose was to encourage event goers to donate and attend Positive Living BC's AIDSWALK. We helped gain more than a hundred signatures by attending Pride at Grandview, SFU Surrey Pride, BC Positive Living's AIDSWALK kickoff, and Vancouver Pride.

With our partnership with Positive Living Society of BC, the club aims to promote understanding of HIV/AIDS-related issues for its members. We will hold fundraisers this fall to finance our biggest endeavour this semester: World AIDS Week at UBC. World AIDS Week culminates in a red-themed party on World AIDS Day, Sunday, December 1. We hope to see this party unfold as both an interactive awareness event and a successful fundraiser for HIV/AIDS charities. ⊕

FYI

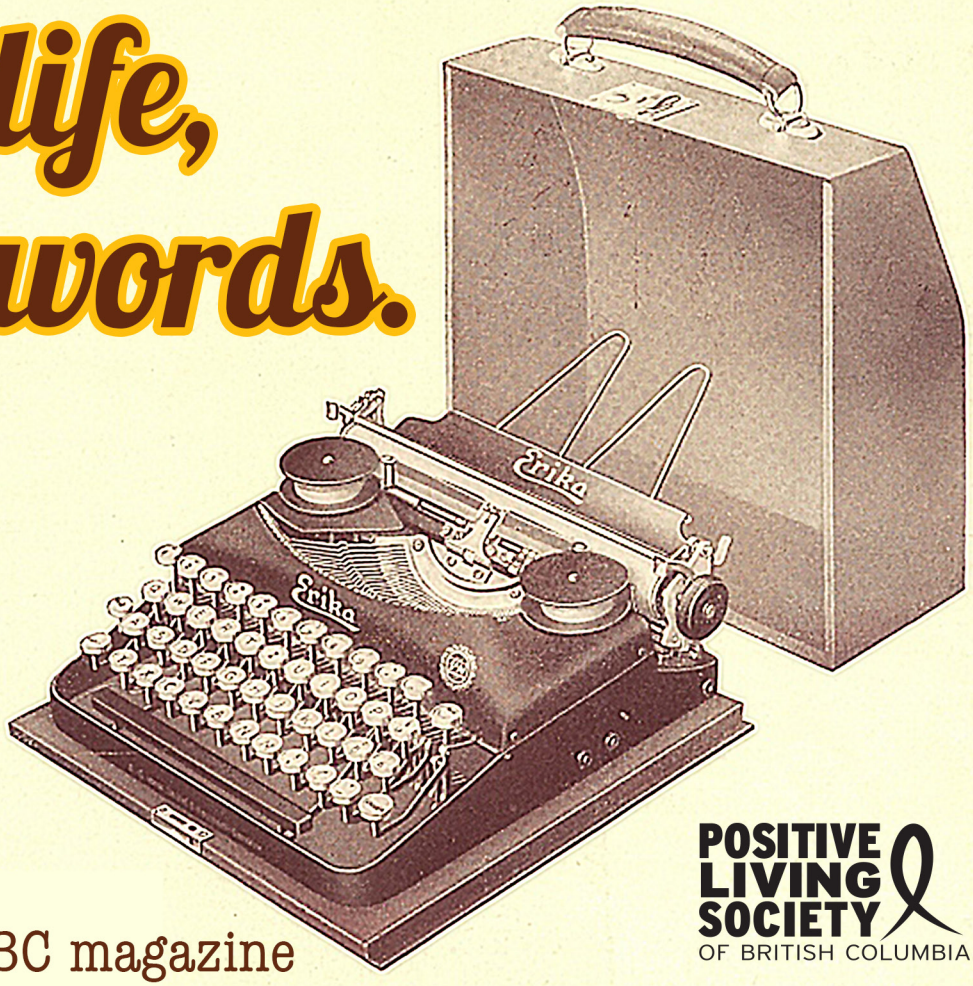
The club meets every ↴

➤Second and Fourth Friday of the month

➤From September to April ➤6PM

For more information, follow the UBC HIV Awareness Club on Facebook @UBCHIVAIDS and Instagram (#ubchivaids).

Your life, Your words.



POSITIVE LIVING SOCIETY OF BRITISH COLUMBIA

Positive Living BC magazine
is accepting article submissions
written for PLHIV by PLHIV*.
Previous writing experience preferred but not required.
Familiarity with the magazine's content is essential.

INTERESTED PARTIES, PLEASE MAIL RESUME PACKAGES TO

Jason Motz, managing editor,
Positive Living Society of BC • 1101 Seymour St • Vancouver • BC V6B 0R1
or email jasonm@positivelivingbc.org.

***Please note that these are volunteer-only positions.**

Can Cannabis Curb HIV Risk?

By Sean Sinden

The age-old portrayal of cannabis as a "gateway drug" has come under fire from the scientific community and now new research suggests cannabis legalization could affect HIV risk, treatment, and care.

The project, led by CTN Postdoctoral Fellow Dr. Hudson Reddon, analyses data from a long-term study that follows over 3,700 people who use drugs in Vancouver, including 2,600 injection drug users.

Study participants have been contacted every six months since 2005. They share information about their types of drug use, housing, employment, and HIV risk behaviour (such as needle sharing and unprotected sex) and undergo health assessments. Dr. Reddon is looking at how the trends in these data are changing with the legalization of cannabis in Canada.

As of 2015, an estimated 17.8 percent of people who inject drugs were living with HIV globally. Now there is evidence that cannabis access and use could reduce some of these risks by acting as a substitute for injectable and other hard drugs. That is, rather than being a gateway drug, cannabis may be an alternative to drugs like opioids.

"Recent research in the US has shown that cannabis legalization is associated with state-level decreases in opioid prescription and opioid-related deaths," says Dr. Reddon.

In some people, use of harder drugs, like cocaine and methamphetamine, can increase the likelihood of moving on to injection drugs. Part of Dr. Reddon's project will look at how cannabis use could reduce the frequency of injection drug use and associated HIV risks in study participants.

"We have also seen that illicit drug use can make it difficult to access to HIV treatments and adhere to them," Dr. Reddon says. "We will look at whether marijuana can potentially address some of the challenges among people who use drugs and improve the success of HIV care."

Because of the recent legalization of cannabis across the country, this research project is underway at an ideal time to provide clear insights into the effect of legalization on HIV risk.

But, it's about more than drug policy. "The opioid epidemic in Vancouver and BC has taken an unprecedented toll," Dr. Reddon says. "This project may also shed light on whether cannabis can be part of the solution to help address some of these drug-related harms." ⊕

Sean Sinden is the communications and knowledge translation officer for the CTN.

Other Studies enrolling in BC

CTNPT 030
Feasibility of crystal meth interventions among GBMSM
BC Sites: St. Paul's, University of Victoria

CTNPT 036
Novel Assay for Syphilis BC Site: BCCDC Provincial STI Clinic

CTN 283
The I-Score Study BC site: Vancouver ID clinic

CTN 291-2
Preterm Births in HIV+ Pregnancies
BC Site: BC Women's Hospital

CTN 292A
Development of a screening algorithm for predicting high-grade anal dysplasia in HIV+ MSM
BC site: St. Paul's

CTN 292B
Treatment of high-grade anal dysplasia in HIV+ MSM
BC site: St. Paul's

CTN 293
REPRIEVE Trial BC site: Vancouver ID clinic

CTN 299
Bone health in HIV+ aging women BC site: Vancouver ID clinic

CTN 300
The Engage Study BC Site: St. Paul's Hospital

Visit the CIHR Canadian HIV Trials Network database at www.hivnet.ubc.ca for more info.

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To make a contribution to Positive Living BC, contact the director of development, Jason Hjalmarson.

jhjalmarson@positivelivingbc.org
604.893.2282

Volunteering at Positive Living BC

PROFILE OF A VOLUNTEER

Jasmine Leung

Jasmine was actually one of my first volunteers when I started in the department , and she finished off a very important project that was waiting to be done over the past few years; she did a wonderful and professional job with a smile on her face and a positive attitude.
Thanks Jasmine!

Shafiyah Khan,
Communications Coordinator

What is your volunteer history?
I was an office volunteer for the Battered Women's Support Services and a skate volunteer at Chill Foundation. At Positive Living BC, as a video editor, I edit footage from interviews and seminars.

How would you rate Positive Living BC?
10/10!

What is Positive Living BC 's strongest point?
The people. They work together with a common goal and are so welcoming. Shout out to Shafiyah and Adam who are always there to help!

What is your favourite memory of your time at Positive Living BC?

Putting the History Alive series together. I enjoyed going through all of the interviews. It was interesting to hear the special stories of all the survivors, and to learn that part of history.

Why did you pick Positive Living BC?
To put my editing skills to good use by volunteering with a good cause.

What do you see in the future for Positive Living BC?
I want to see the organization grow, and to get the funding support it needs to continue the important work that it does.

Where to find HELP+

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

For more comprehensive listings of HIV/AIDS organizations and services, please visit www.positivelivingbc.org/links

A LOVING SPOONFUL
1449 Powell St,
Vancouver, BC V5L 1G8
604.682.6325
clients@alovingspoonful.org
lovingspoonful.org

AIDS SOCIETY OF KAMLOOPS
(ASK WELLNESS CENTRE)
433 Tranquille Road
Kamloops, BC V2B 3G9
250.376.7585 or 1.800.661.7541
info@askwellness.ca
askwellness.ca

AIDS VANCOUVER
1101 Seymour St
Vancouver, BC V6B 0R1
604.893.2201
contact@aidsvancouver.org
aidsvancouver.org

AIDS VANCOUVER ISLAND (Victoria)
713 Johnson Street, 3rd Floor
Victoria, BC V8W 1M8
250.384.2366 or 1.800.665.2437
info@avi.org
avi.org

AIDS VANCOUVER ISLAND (Courtenay)
250.338.7400 or 1.877.311.7400
info@avi.org
avi.org/courtenay

AIDS VANCOUVER ISLAND (Nanaimo)
250.753.2437 or 1.888.530.2437
info@avi.org avi.org/nanaimo

AIDS VANCOUVER ISLAND (Port Hardy)
250.902.2238
info@avi.org avi.org/porthardy

ANKORS (EAST)
46 - 17th Avenue South
Cranbrook, BC V1C 5A8
250.426.3383 or 1.800.421.AIDS
gary@ankors.bc.ca ankors.bc.ca

ANKORS (WEST)
101 Baker Street
Nelson, BC V1L 4H1
250.505.5506 or 1.800.421.AIDS
information@ankors.bc.ca
ankors.bc.ca

DR. PETER CENTRE
1110 Comox Street
Vancouver, BC V6E 1K5
604.608.1874
info@drpetercentre.ca
drpetercentre.ca

LIVING POSITIVE RESOURCE CENTRE OKANAGAN
168 Asher Road
Kelowna, BC V1X 3H6
778.753.5830 or 1.800.616.2437
info@lprc.ca livingpositive.ca

MCLAREN HOUSING
200-649 Helmcken Street
Vancouver, BC V6B 5R1
604.669.4090
info@mclarenhousing.com
mclarenhousing.com

OKANAGAN ABORIGINAL AIDS SOCIETY
200-3717 Old Okanagan Way
Westbank, BC V4T 2H9
778.754.5595
info@oaas.ca oaas.ca

POSITIVE LIVING FRASER VALLEY SOCIETY
Unit 1 – 2712 Clearbrook Road
Abbotsford, BC V2T 2Z1
604.854.1101
info@plfv.org plfv.org

POSITIVE LIVING NORTH
#1 - 1563 Second Avenue
Prince George, BC V2L 3B8
250.562.1172 or 1.888.438.2437
positivelivingnorth.org

POSITIVE LIVING NORTH WEST
3862F Broadway Avenue
Smithers, BC V0J 2N0
250.877.0042 or 1.866.877.0042
plnw.org

PURPOSE SOCIETY FOR YOUTH & FAMILIES
40 Begbie Street
New Westminster, BC V3M 3L9
604.526.2522
info@purposesociety.org
purposesociety.org

REL8 OKANAGAN
P.O. Box 20224, Kelowna
BC V1Y 9H2
250-575-4001
rel8.okanagan@gmail.com
www.rel8okanagan.com

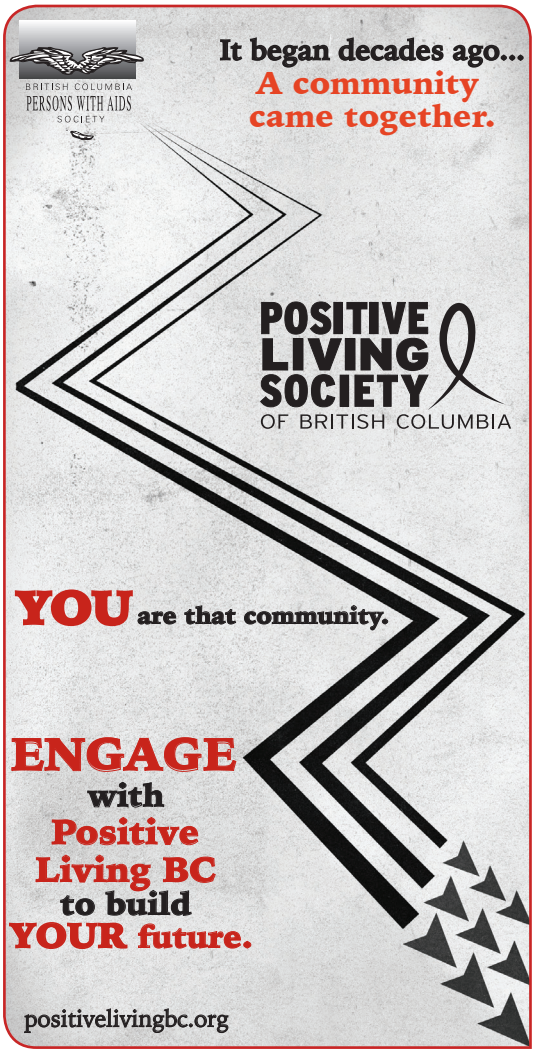
RED ROAD HIV/AIDS NETWORK
61-1959 Marine Drive
North Vancouver, BC V7P 3G1
778.340.3388
info@red-road.org red-road.org

VANCOUVER NATIVE HEALTH SOCIETY
449 East Hastings Street
Vancouver, BC V6A 1P5
604.254.9949
vnhs@shawbiz.ca
vnhs.net

VANCOUVER ISLAND PERSONS LIVING WITH HIV/AIDS SOCIETY
1139 Yates Street
Victoria, BC V8V 3N2
250.382.7927 or 1.877.382.7927
support@vpwas.com vpwas.com

WINGS HOUSING SOCIETY
12–1041 Comox Street
Vancouver, BC V6E 1K1
604.899.5405
wingshousing@shaw.ca
wingshousing.org

YOUTHCO
205–568 Seymour Street
Vancouver, BC V6B 3J5
604.688 1441 or 1.855.968.8426
info@youthco.org youthco.org



JOIN A SOCIETY COMMITTEE

If you are a member of the Positive Living Society of BC, you can join a committee and help make important decisions for the Society and its programs and services. To become a voting member on a committee, you will need attend three consecutive committee meetings. Here is a list of some committees. For more committees visit positivelivingbc.org, and click on "Get Involved" and "Volunteer".

Board & Volunteer Development_ Adam Reibin
604.893.2209 adamr@positivelivingbc.org

Education & Communications_ Adam Reibin
604.893.2209 adamr@positivelivingbc.org

History Alive!_ Adam Reibin
604.893.2209 adamr@positivelivingbc.org

Positive Action Committee_ Wayne Campbell
604.893.2252 waynec@positivelivingbc.org

Positive Living Magazine_Jason Motz
604.893.2206 jasonm@positivelivingbc.org

ViVA (women living with HIV)_Charlene Anderson
604.893.2217 charlenea@positivelivingbc.org

How to pick the perfect condom

What are some of the things you should look for when it comes to finding the perfect franger for your fella?

No matter the size of your equipment, there will be a condom that fits it; the trick however is finding the perfect fit.

Figuring out the correct size for your dick can be complex, and while there are at times only millimetres of difference, that can be the decider between a condom that is too tight and painful to wear, one that it too loose and can slip off, or one that fits like a glove. Finding a condom that is long enough, is not usually a problem (many range between 180mm and 210mm), but it is the girth or width of a condom that is usually the issue.

After a quick study of some of the condoms that are available in the Aussie market, we found three different size categories (again, we a really talking about width or the diameter here, so don't panic): Regular/Standard: 52-56mm; Slimmer/Snug: 49-52mm; Large: 56-60mm.

On each box of condoms, you will be able to find a 'nominal width,' which is the width of the condom at or near its open end. This size will give you an indication of what size category you are looking at. This distinction might be helpful for you as condom names can often be confusing, and what is 'regular' for one brand might be 'large' for another.

A good fit shouldn't feel like it's constricting the girth of your dick, neither should it feel like it might slip off with some movement. Also, you want to be taking note about how the condom feels when you are fully erect (remember, you cum when fully aroused).

If, for example, it's feeling too tight, take note of the size of the condoms and look for a size up for next time. This is easier to do if you stay with the same brand, but you can always check out the nominal width and see what is comparable in another range.

For some guys, condoms can take away a level of sensitivity, which, let's be real, can reduce pleasure and make it harder to cum. For those who want to and can, condoms with special textures or different levels of thickness can create more exciting sensations.

Many condom brands have 'ultra-thin' ranges, which allow for increased sensitivity through a thinner condom lining. This can increase your sensitivity and help if you are having trouble getting close to ejaculation while wearing condoms. It's for this reason that some guys also look into starting PrEP; a medication regime that prevents you from getting HIV. Although, it's important to note that if you are having condomless sex while on PrEP, you won't be protected from contracting other STIs, so getting tested frequently is recommended.

Another reason you might find yourself reaching for a textured condom is if you're the top and you want to give your partner a little more sensation. Ribbed and textured condoms come in a wide variety, so you and your partner can explore the range to find what feels right.

Open communication is the best way to making sure you are looking after your partner when trying new things in the bedroom and that includes condoms. ⊕

The original article can be found online at https://endinghiv.org.au/blog/how-to-pick-the-perfect-condom/, and appears here in edited form.

POSITIVE LIVING SOCIETY OF BRITISH COLUMBIA

HEALTH CLINICS

Good for your body, Good for your soul!

To BOOK your appointment email **clinic@positivelivingbc.org** or call **604.893.2203**

Health & Wellness services are FREE for Members of Positive Living BC

BIO ENERGY HEALING

MASSAGE THERAPY

NATUROPATHIC MEDICINE

REFLEXOLOGY

REIKI

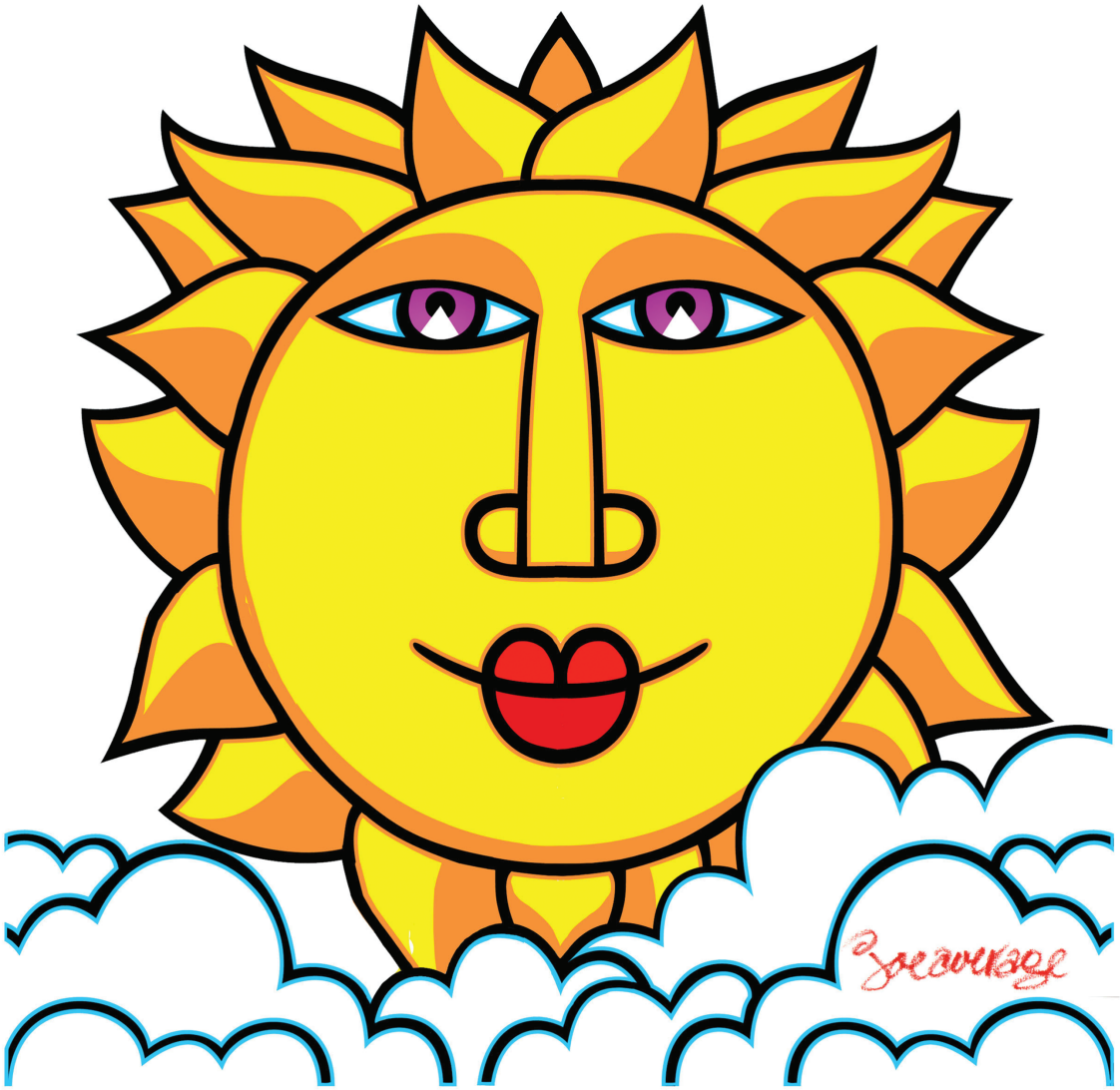
TAI CHI

THAI YOGA MASSAGE

YOGA THERAPY

34TH VANCOUVER AIDS WALK

POSITIVE LIVING SOCIETY OF BRITISH COLUMBIA



THANK YOU TO OUR CARING COMMUNITY OF SUPPORTERS.

YOU HELPED US RAISE $110,000 AND COUNTING.