

**VANCOUVER HIV/AIDS
CARE COORDINATING COMMITTEE**

ENVIRONMENTAL REPORT

1999-2002

Companion Document to the Strategic Plan

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I. INTRODUCTION

Every day 11 Canadians become infected with HIV, and there have been disturbing increases among those who are often socially and economically vulnerable. Injection drug users, women living in poverty, aboriginal peoples, young gay men and prison inmates are much more likely to become infected by HIV disease than others in the population (Canadian Strategy on HIV/AIDS, Health Canada, 1998).

The prevalence of HIV infection has been clearly linked with the social and economic determinants of health. Risk for HIV infection and the capacity to manage and maintain health while living with HIV disease are determined, in part, by factors such as income level, education, access to caring and supportive social networks, early childhood experiences, use of alcohol or drugs, and access to health care services.

Vancouver currently has the highest HIV infection rate in North America and there is an intense concentration of the epidemic in the Downtown Eastside. The epidemic is spreading to increasingly vulnerable populations, including those who are mentally ill, homeless, addicted, living in extreme poverty, involved in the sex trade and who face cultural or other barriers.

In 1994, the Vancouver HIV/AIDS Care Coordinating Committee (VH/ACCC) was formed to co-ordinate information sharing and collaboration among service organizations in tackling the HIV epidemic. The committee developed its first strategic plan in 1995 (*Vancouver Strategic Plan for HIV/AIDS Care, 1995-98*) with an emphasis on care services.

In September 1998, the Committee adopted a population health approach to the development of its second strategic plan with an added emphasis on prevention. In preparing the VH/ACCC Strategic Plan 1999-2002, Committee members first developed a draft discussion document for broad review and hosted a forum with approximately 125 participants at St. Paul's Hospital on March 18, 1999. The purpose of the forum was to seek input into the development of the plan from member agencies and other government and non-profit health and social service providers and consumer agencies involved in HIV/AIDS-related service delivery.

The population health approach provides a unifying framework with which to examine the individual, social and economic forces shaping the current HIV epidemic in Vancouver. By using this approach, the committee was able to identify population groups who are vulnerable to HIV infection, to identify partner sectors and organizations that can help address systemic challenges, and to develop a framework for collaborative strategic action.

The Environmental Report is intended as a companion document to the VH/ACCC Strategic Plan 1999-2002. It provides the research and analysis to support the strategic goals, objectives, outcomes and priority strategies in the plan. The Environmental Report examines the current HIV epidemic in terms of four broad determinants of health: Living and Working Conditions, Individual Capacities and Skills, Social Environments and Health Services. Within each category, the Environmental Report addresses a range of specific determinants of health.

In addition to the Environmental Report, the VH/ACCC Strategic Plan is accompanied by a Strategies Report. The committee acknowledges that its focus on population health and prevention is an evolving one. Therefore, the strategic plan and companion documents will need to be regularly reviewed and updated.

The strategic documents have been prepared in the context of a renewed federal AIDS strategy, *The Canadian Strategy on HIV/AIDS: Moving Forward Together* (Health Canada, 1998), a new provincial framework on HIV/AIDS, *British Columbia's Framework for Action on HIV/AIDS* (BC Ministry of Health, 1998), a new Aboriginal HIV/AIDS strategy, *The Red Road; Pathways to Wholeness: An Aboriginal Strategy for HIV and AIDS in British Columbia* (BC Aboriginal HIV/AIDS Task Force, 1999), and a proposed framework for addressing HIV/AIDS among injection drug users, *Injection Drug Use and HIV/AIDS: Legal and Ethical Issues* (Canadian HIV/AIDS Legal Network, 1999).

The Vancouver Richmond Health Board will be developing a regional HIV/AIDS plan in accordance with the provincial framework and in consultation with community service providers and consumers. The VH/ACCC Strategic Plan is not intended to become the regional HIV/AIDS plan. However, it is hoped that the Health Board will use the VHACCC Strategic Plan and companion documents to guide its own planning for HIV/AIDS.

The committee has been particularly grateful for the support of Health Canada in providing expertise on population health and in helping to produce the final documents. The committee also appreciates the research support of the Community Health Resource Project (CHRP) in providing access to original study findings. CHRP is an ongoing research project investigating the economic costs and related social issues of HIV and AIDS in Vancouver. The CHRP team is located at the Department of Health Care and Epidemiology, University of British Columbia, and receives funds from Health Canada and the British Columbia Ministry of Health.

II. POPULATION HEALTH APPROACH

There is a compelling body of evidence which indicates that people with more resources—knowledge, power, money, prestige and social connections—continue to live longer and healthier lives than those with fewer resources. This is true regardless of where the cut-off is established and despite the expansion of more equitably distributed and effective medical intervention.

Population health analysis is the study of how individual characteristics and broader social and economic factors combine to determine the health of different population groups. It links research findings about various determinants of health into a unifying analytical framework.

A population health approach has two key attributes. First, it focuses on the health of *populations*, or groups of people, rather than the health of *individuals*. Second, it is concerned with improving the health of the *general* population and the health of *subgroups* within the general population who experience much poorer health. The strategies used in a population health approach attempt to create environments that support health.

The main tenets of the population health approach (Evans, Barer and Marmor, 1994; Frank and Mustard, 1994; and Health Canada, 1996) are:

1. The determinants of health in societies at an advanced stage of development are social, economic and cultural factors at both the individual and population level, not the availability and utilization of hospital-based medical services. Despite universal access to health services in Canada, the health system has not managed to eliminate or even reduce disparities in health and well-being for certain populations. For example, it is well known that the difference in life expectancy and life quality between income levels has not been narrowed by the availability of publicly funded health care.
2. At the population level, societies with high levels and equitable distribution of wealth enjoy better health status as measured by morbidity and mortality. Those in lower socio-economic groups continue to have significantly lower life expectancy, fewer years free of disability and higher rates of illness and death for almost all causes than those in higher socio-economic groups. At the individual level, a person's immediate social and economic environment, and the way in which this environment interacts with individual psychological resources and coping skills, has more to do with health status than was previously recognized in epidemiological studies of disease.
3. It is increasingly understood that adequate nutrition and nurturing of children can prevent developmental health and social problems. What is less widely recognized is the link between early childhood development and the occurrence of major illnesses and death in adulthood. This has significant implications for interventions in the social environment, rather than the more traditional medical and public health measures that target individual risk factors and behaviours.

4. Given that so many factors affect the health of populations, it is clear that the health care system alone cannot improve health status. As most determinants of health fall outside of the traditional health sector, those working in the health sector must forge relationships with groups whose activities may have an impact on health. It is critical to have a multisectoral perspective in taking action for health, rather than focusing predominantly on the provision of health services. This perspective requires broad-based community support and participation, as well as co-operation within and between levels and departments of government.

The term “determinants of health” is a collective label given to the social, economic and environmental factors and conditions, over which individuals have limited direct control, and which are thought to have an influence on health. The determinants of health go beyond lifestyle practice to influence individual and collective behaviour.

The most important determinants of health include income, social status, social support, education, employment, working conditions, social environments, gender, culture and physical environments. The effect of these determinants can be influenced by many individual factors such as personal health practices, coping skills, biology, genetic endowment and sexual orientation. It is the complex interactions among all these factors that have the most profound impact on health.

For the purposes of this strategic plan, the determinants of health have been grouped into four broad inter-related categories, each of which includes one or more specific determinants of health. The definition of each determinant has been taken from *Towards a Common Understanding: Clarifying the Core Concepts of Population Health* (Health Canada, 1996).

1. LIVING AND WORKING CONDITIONS

Income and Social Status

Health status improves at each step up the income and social hierarchy. Adequate income ensures basic living conditions are met, such as access to clean water, adequate food and safe housing, and is essential for the maintenance of health. There is a large body of empirical evidence which links poverty to a shorter life expectancy and higher socio-economic status to a slower progression of disease.

Social status is a vital component in an individual’s personal capacity to effectively negotiate societal systems. An individual who is treated with the dignity and respect generally accorded those with high social status is more likely to benefit from the services offered by representatives of those systems.

Addressing this key determinant of health in terms of HIV/AIDS could include:

- Recognizing that poverty itself places people at risk for HIV infection
- Ensuring access for all to existing income support programs
- Improving income support measures to better meet actual living costs in Vancouver

- Improving access to costly health-related supports such as transportation, ongoing counselling and therapy, childcare, etc.
- Improving access to nutritious food

Social Support Networks

Support from families, friends and communities is associated with better health and seems to provide a buffer against health problems.

Addressing this key determinant of health in terms of HIV/AIDS could include:

- Working to remove the stigma associated with HIV disease
- Building on community initiatives that foster and develop social support networks
- Providing safe spaces for HIV-positive populations to meet
- Creating opportunities for social participation through volunteering, education and peer support
- Ensuring respite care is available

Education

Health status improves as the level of formal education rises. Education increases opportunities for income and job security, and equips people with a sense of control over their life circumstances – key factors that influence health.

Addressing this key determinant of health in terms of HIV/AIDS could include:

- Access to formal education programs for those living with or at risk for HIV disease
- Education programs which are flexible enough to accommodate the needs of different vulnerable populations
- HIV preventive education
- HIV treatment information
- Lifeskills training programs

Employment/Working Conditions

Unemployment, underemployment and stressful work are associated with poorer health. People who have more control over their work circumstances and less stress at work are healthier and often live longer than those engaged in more stressful or riskier activities.

Addressing this key determinant of health in terms of HIV/AIDS could include:

- Ensuring workplace policies on HIV/AIDS are broadly adopted and accepted by employers and employees
- Ensuring accidental exposure guidelines are broadly distributed in all relevant workplaces
- Building on the availability of retraining and return to work programs for persons living with HIV whose health has stabilized significantly
- Reducing workplace homophobia and heterosexism which alienates and demoralizes LGBT people and contributes to HIV vulnerability

Physical Environments

Physical factors in the natural environment (e.g., clean air, clean water) are key influences on health. Factors in the human-built environment such as housing, workplace safety, and community and road design are also important influences.

Addressing this key determinant of health in the context of HIV/AIDS could include:

- Access to safe, stable housing with adequate cooking facilities and proper food storage (including refrigerators)
- Access to clean, cryptosporidium-free water
- Geographically easy access to needle exchange and condoms
- Safe injecting sites with a range of services consistent with harm reduction
- Community kitchens

2. INDIVIDUAL CAPACITIES AND SKILLS

Personal Health Practices and Coping Skills

An individual's knowledge, intentions, health practices, behaviour, lifestyle choices and skills for dealing with life in healthy ways are key influences on health.

Addressing this determinant of health in terms of HIV/AIDS could include:

- Prevention education as well as personal health education for those living with HIV/AIDS
- Condoms (both male and female) and information on safer sexual practices
- Widely available clean needles and information on their safer use
- Harm reduction care and education
- Life skills training
- Psychosocial counselling

Healthy Development of Children and Youth

The effect of prenatal and early childhood experiences on subsequent health, well-being, coping skills and competence is very powerful. Children born in low-income families are more likely than those born to high-income families to have low birth weights, to eat less nutritious food, and to have more difficulty in school.

Addressing this determinant of health in terms of HIV/AIDS could include:

- Effective prenatal and postnatal care for women living with HIV/AIDS
- Effective care for children born with HIV/AIDS
- Effective care, planning and support for children with seropositive parents
- Universally accessible childcare
- Prevention and treatment of addictions, and life skills and HIV prevention services specifically designed for children, youth and young adults living with fetal alcohol syndrome/fetal alcohol effects

Biology and Genetic Factors

The basic biology and organic make-up of the human body are fundamental determinants of health. Genetic factors provide an inherited predisposition to a wide range of individual responses that affect health status. Although socio-economic and environmental factors are important determinants of overall health, in some circumstances genetic factors appear to predispose certain individuals to particular diseases or health problems.

Addressing this key determinant of health in terms of HIV/AIDS could include:

- Understanding the impact of HIV infection on pre-existing organic conditions such as severe mental illness
- Understanding what impact pre-existing organic conditions can have on risk for HIV infection
- Providing shelter and programming for the chronically mentally ill
- Providing services to hemophiliacs living with HIV/AIDS

3. SOCIAL ENVIRONMENTS

Social Environments

The values and norms of a society influence the health and well-being of its individual members and populations. Social stability, recognition of diversity, safety, good working relationships and cohesive communities contribute to a society in which health risks are reduced. Studies have shown that low availability of emotional support and low social participation have a negative impact on health and well-being.

Gender

Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. “Gendered” norms influence the health system’s practices and priorities. As many health issues are a function of gender-based social status or roles, measures to address gender inequality within and beyond the health system can improve population health.

Addressing this key determinant of health in terms of HIV/AIDS could include:

- Programming which recognizes women’s unique psychosocial and medical needs
- Education programs which improve all women’s, and especially marginalized women’s, knowledge about HIV/AIDS
- Programming which recognizes psychosocial and health needs of transgendered populations
- Education programs which improve all transgendered persons’ knowledge about HIV/AIDS

Culture

Some persons or groups may face additional health risks due to a socio-economic environment that is largely determined by dominant cultural values. These values may contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture, homophobia, heterosexism, and lack of access to culturally appropriate health care and services.

Addressing this key determinant of health in terms of HIV/AIDS could include:

- Providing access to culturally appropriate HIV/AIDS prevention, education and health care services for groups at risk
- Addressing aboriginal risk (see *The Red Road: Pathways to Wholeness. An Aboriginal Strategy for HIV/AIDS in BC*)
- Ensuring the availability of services in appropriate languages
- Recognizing and acknowledging gay culture
- Recognizing the unique psychosocial and health-related needs of gay men

4. HEALTH SERVICES

Health services, particularly those designed to maintain and promote health, to prevent disease, and to restore health and function, contribute to population health.

Addressing this key determinant of health in terms of HIV/AIDS could mean ensuring access for all to:

- Prevention services
- Pre-test and post-test counselling
- Health education, including peer-based treatment information
- Clinic services
- Counselling, including grief and loss support
- Physician expertise
- Case management
- Rehabilitation services
- Home-based care
- Day care and respite care
- Alcohol and drug treatment
- Psychiatric and mental health care
- Palliative care
- Queer-friendly, queer-supportive, non-judgmental health care

III. ENVIRONMENTAL ANALYSIS

A. CURRENT EPIDEMIOLOGY

The World Health Organization estimated that the number of adults and children living with HIV worldwide was 33.4 million at the end of 1998. In North America, 890,000 adults and children, or 2.6% of the global total, were living with HIV/AIDS as of December 31, 1998.

It was estimated that there were 6 million new infections and 2.5 million AIDS deaths in 1998 worldwide. More than 95% of the new infections were estimated to have occurred in developing countries. These countries have experienced 95% of all deaths to date from AIDS, largely among young adults who would normally be in their peak productive and reproductive years. Since the start of the epidemic nearly 20 years ago, HIV has infected more than 47 million people and caused the death of nearly 14 million adults and children.

Estimates of new AIDS diagnoses in Canada¹ and British Columbia² look like this:

	CANADA	BC
1994	1698	291
1995	1551	257
1996	1000	155
1997	498	113
1998	279	101

The British Columbia Centre for Disease Control (BCCDC) estimated that as of the end of 1998 the number of people ever infected with HIV in British Columbia, including those who have died, was between 9,500 and 10,000.

The British Columbia Centre for Excellence in HIV/AIDS reports that while the number of AIDS cases has declined dramatically due to availability of effective antiretroviral therapy, the number of people with symptomatic HIV will continue to increase and place significant demands on health care and social service systems. It is therefore appropriate to use the number and rate of people testing newly positive for HIV as a means of tracking the epidemic.

¹ HIV/AIDS and STD Epi Updates, compiled by the Bureau of HIV/AIDS, STD and TB, Laboratory Centre for Disease Control, Health Canada

² HIV/AIDS Update for Year End 1998, British Columbia Centre for Disease Control

Some of the recent trends in HIV infection reported by the BCCDC include:

MSM and IDUs

Towards the end of 1997, there was a rapid drop in the number of injection drug users (IDUs) testing newly positive for HIV. It seems likely that this number may actually fall below the number of men who have sex with men (MSM) testing newly positive over the course of 1998. This decline is felt to be consistent with epidemic saturation, rather than a triumph of preventive programs.

Aboriginal People

Aboriginal people continue to make up a significant proportion of people testing newly positive for HIV. There has been no major change within this trend, though it must be emphasized that aboriginal women carry a greater burden than aboriginal men with respect to issues of HIV/AIDS.

Women

There was a slight decline in 1998 in the number of women testing positive for the first time. This is probably simply a reflection of the decline in overall numbers of injection drug users (one-third of whom are women) who are testing newly positive.

Infants

Also noted is a substantial drop in the number of infants born to HIV-positive women who are themselves infected, as a result of antiretroviral treatment during pregnancy, labour and post-partem.

Transgendered Persons

Data on transgendered persons are best obtained through specific research projects in the transgendered communities. BCCDC information from laboratory-based HIV surveillance tends to miss transgendered persons as an identifiable group because gender is identified by physicians rather than by patients themselves.

Sex Trade Workers

A significant number of sex trade workers have continued to test positive, most of them also injection drug users. Another important phenomenon observed during 1998 is that of eight heterosexual men testing newly positive who are believed to have contracted the virus through contact with sex trade workers. It is BCCDC's hypothesis that the epidemic of infectious syphilis among sex trade workers in the Downtown Eastside may be facilitating heterosexual transmission of HIV.

Youth

No age group is seeing a clear increase in the rate of testing and this includes those between the ages of 15 to 19. However, there must always be a question as to how well voluntary testing samples individuals in this age group.

B. PROJECTIONS FOR THE FUTURE

Projections are difficult at the best of times. However, BCCDC foresees some of the following trends:

1. The rate of new infection among injection drug users will probably not be as high as it was in 1996 and early 1997. However, it will probably remain unacceptably high with an incidence settling into the 5% range as measured by the VIDUS project.
2. Although substantial declines in the number of gay men testing newly positive for HIV over the past decade have been noted, this trend is currently leveling. BCCDC suggests we are reaching a steady state whereby an incidence of approximately two percent per annum might be observed among young gay men as measured through the Vanguard cohort. Renewed efforts will be required in order to see further improvements in the situation for the gay community.
3. Improvements in offering HIV testing and antiretroviral therapy to pregnant women has reduced the rates of vertical transmission.

The BC Persons With AIDS Society points out that rates of HIV infection will almost certainly continue to increase in BC's prison population. Although accurate figures are all but impossible to obtain, there is strong circumstantial evidence that both prevalence and incidence of HIV infection among incarcerated individuals are dramatically higher than among the general population. A wide variety of cultural and institutional factors work against effective prevention strategies within the correctional system and make the provision of care, treatment and support for HIV-positive inmates difficult at best.

C. BEST PRACTICES

In the absence of a cure or effective vaccine for HIV infection, preventing the spread of HIV through public health mechanisms is the primary option for controlling the epidemic. HIV exploits human behaviour to spread from infected people to vulnerable populations. Governments can achieve the greatest impact on the spread of HIV by creating individual and group incentives to adopt safer behaviours. The effectiveness of these initiatives depends on harm reduction by those most likely to spread or to be exposed to HIV.

Harm reduction is a philosophy and a practice that minimizes harm and increases the health and quality of life of the individual. It recognizes that each individual is the expert on his or her life. Harm reduction respects the individual's decisions regarding their personal health and

endeavours to minimize any harm resulting from those decisions to the individual, their family and/or, caregivers and the larger community.

For injection drug users, harm reduction can mean use of less harmful drugs, safer drug use or practices, reduced amount of drug use or cessation of use. In Britain and Europe, where comprehensive harm reduction strategies have been implemented for some years, there is less needle sharing, less drug use, fewer deaths from drug overdose, decreased crime rates and less HIV transmission.

Harm reduction can also be applied at the broad societal level to bring about change in public policies and laws. For example, the federal *Controlled Drugs and Substances Act* (section 56) allows the Minister of Health to exempt any person or class of persons from the Act and to make regulations to that effect (section 55). These provisions can be used by the Crown to protect facilities or caregivers from criminal charges in connection with drug-related activities by their clients or patients.

In Vancouver, HIV prevalence among injection drug users is highly concentrated among those who have the least advantage in society. While injection drug use and HIV are found in most neighborhoods in Vancouver, the Downtown Eastside, which is the poorest urban neighborhood in Canada, has the highest incidence of HIV among injection drug users in North America. It is not injection drug use itself that is causing these alarming rates, but the circumstances in which these drugs are used.

The *Canada Health Act* provides for universal access to health care. Persons living with HIV, like others confronted with serious chronic illnesses are entitled to care, treatment and support. It is entirely appropriate to extend the principles of the *Act* to preventable diseases and illnesses and to invest equal attention and financial support in preventing the spread of HIV infection to vulnerable populations.

Research based evidence shows that people will respond to primary prevention programs and modify their behaviours. The stages to achieving safer behaviours begins with information and awareness about HIV and the available methods to prevent spreading HIV. Individuals and groups provided with information about prevalence and incidence of HIV are better able to assess their risks. In addition to general information about HIV, the availability of confidential HIV testing can provide information to people, communities and public health authorities that encourages and justifies preventive actions by individuals and groups.

While knowledge will induce some to adopt safer behaviour, in many cases there is an immediate burden to these changes with uncertain future benefits. Consequently, additional steps to achieve effective prevention include measures to reduce these burdens for both the infected and vulnerable populations and in some cases to create immediate incentives (or benefits) to adopt safer behaviour.

Measures to improve the availability and distribution of condoms and clean needles have been adopted to permit safer behaviours at an accessible cost. Additional measures such as making medically controlled doses of pure drugs available to addicts not in "detox" programs are being

considered. Lowering the barriers and reducing costs for practicing safer sex or injecting behaviours will also improve the effectiveness of prevention programs.

The development of community resources is complementary to changing risk behaviours and supporting individuals to promote health. HIV/AIDS service organizations complement other community agencies by providing community space for social interactions in addition to information, education, condoms, sterilized needles and other resources to meet the specific needs of populations at risk. In addition to society's recognition of the need for broad supports to arrest the spread of HIV, we need to focus on those at risk and to address the broader social and economic reasons why some people are at greater risk.

The effectiveness of prevention through behavioural change has not been directly demonstrated because of ethical and financial limitations on research. Consequently, investigators have applied mathematical models informed by research findings and calibrated by previously reported diagnosed AIDS case and HIV surveillance data to explore the options for prevention interventions.

One of the more significant findings in this work is that infections averted today have a cumulative effect in the future by disrupting the chain of viral transmission. Unlike medical treatments, the benefits of expenditures on prevention are not limited to the person directly involved in the program. The cost of averting an infection declines with time as this cumulative effect builds from the initial expenditure.

Prevention should be viewed as an investment that generates benefits in the future and spreads these benefits to those who might have been at risk. This is in marked contrast to an expenditure on treatment for an immediate health effect for a particular person.

In the light of limited government resources and the cumulative future benefits of prevention, governments need to ensure that effective prevention programs are not under-funded today. Effective programs must address the broad needs of those people who are most likely to contract or transmit the virus. Prevention programs among those most at risk can be controversial; nonetheless, primary prevention can preserve health, save lives and reduce the avoidable human and financial burden of HIV disease in the future.

D. RESEARCH

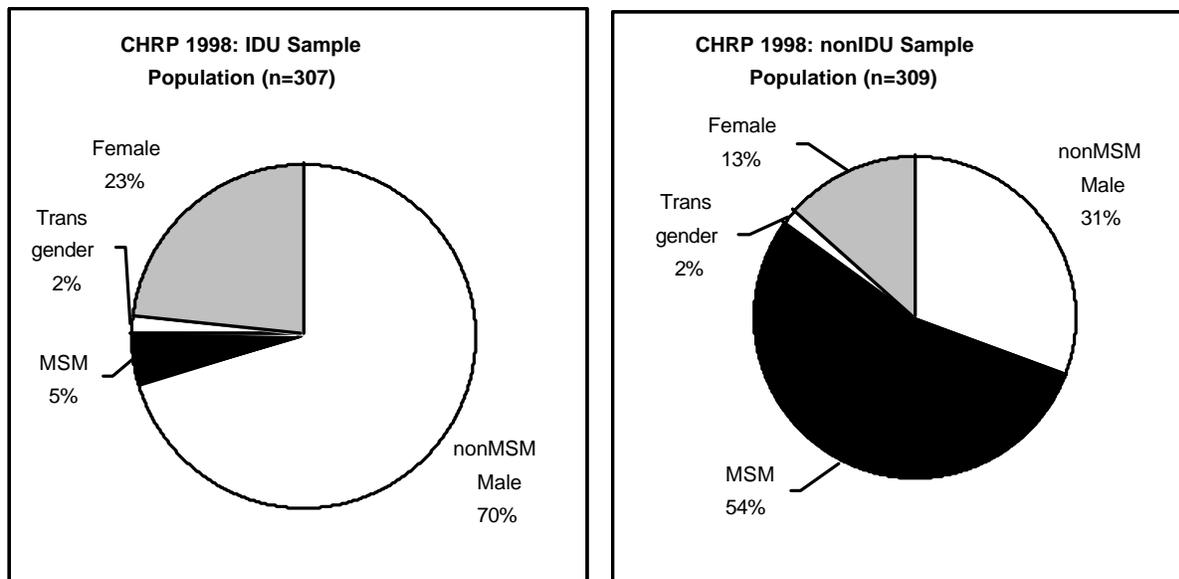
Much of the research data presented in this document has been provided by the Community Health Resource Project (CHRP). CHRP is an ongoing research project investigating the economic costs and related social issues of HIV and AIDS in Vancouver. The CHRP team is located at the Department of Health Care and Epidemiology, University of British Columbia, and receives funding from Health Canada and the British Columbia Ministry of Health.

CHRP has compiled, with the participation of 654 persons, a comprehensive database of the health care and community resources used by those persons who are living with HIV/AIDS in

Vancouver. All CHRP findings in this document are from the baseline interview of the full cohort.

The CHRP information is generally divided into two categories: participants who indicated injection drug use (IDU) as a possible route of infection and those participants who did not (non-IDU). Many tables simply compare IDUs and non-IDUs. The IDU category includes both men and women. CHRP found that most women in the sample reported injection drug use as a possible route of transmission. CHRP's findings for female IDUs are, in many aspects, the same as (or not significantly different from) those for male IDUs. Transgender IDUs form a small percentage of the CHRP population. For this reason, CHRP has kept the IDU category as an aggregate of men, women and transgendered persons. This does not mean that the analysis of women has been ignored. Rather, it simply reflects that, for the analyses presented here, there is not a statistically significant difference between male IDUs and female IDUs.

When information is presented with the categories of IDU and MSM (men who have sex with men), those categories have been kept mutually exclusive. Male participants who reported both having sex with men and injecting drugs as possible routes of infection are *not* included in either of the two groups. If someone reports a particular route of infection (e.g., injection drug use), it does not necessarily mean that the person is still engaging in this risk behaviour. It also does not mean that the person did not engage in other risk behaviours at the time they believed they became infected (e.g., MSM who shared needles might only report IDU as a possible route of infection).



The Committee would also like to acknowledge the research support of the following organizations: the Vancouver Multiple Diagnosis Committee, AIDS Vancouver, BC Persons With AIDS Society, the Vancouver/Richmond Health Board and the St. James Community Service Society.

E. DETERMINANTS OF HEALTH

1. LIVING AND WORKING CONDITIONS

Income and Social Status

Adequate income is essential for the maintenance of health for persons living with HIV/AIDS. There is well-documented local and global research which links poverty to a shorter survival time for such persons and higher socio-economic status to a slower progression of HIV/AIDS.

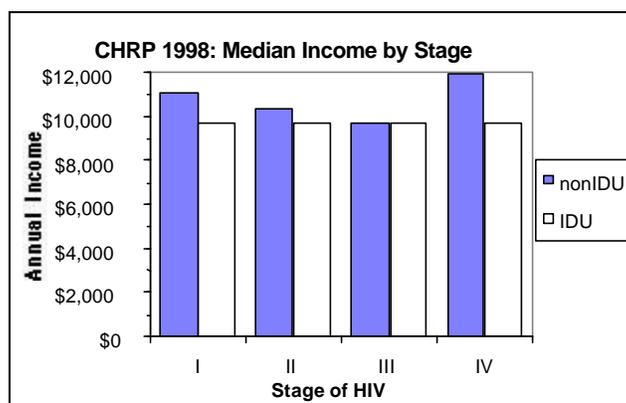
Social status is also a vital component in an individual's personal capacity to effectively negotiate societal systems. An individual who is treated with the dignity and respect generally accorded those with high social status is more likely to benefit from the services offered by representatives of those systems.

A very large percentage of persons living with HIV disease became infected when they were relatively young, before they had developed an extensive attachment to the workforce. Health Canada has determined the average age for HIV infection in Canada is now about 23 years. Others, while older, have either been unable to continue working for health reasons, or were never really attached to the workforce in the first place.

Whatever the particular situation, many persons living with HIV/AIDS in the Vancouver area today must rely on some form of income assistance such as BC Benefits/BC Disability Benefits, Employment Insurance (EI medical), Canada Pension Plan (disability) and for some people, private long term disability plans. The income from these sources is extremely limited and does not provide adequate income allowance to provide for proper housing, proper food, nutritional supplements, vitamins, over the counter medications, bottled water or transportation costs (e.g., to and from medical appointments). CHRP data indicate that 15% of participants received help with transportation from an agency, group, organization or individual at least once in the two weeks prior to being interviewed, and 17% received help with clothing and household goods.

1. CHRP Findings on Income

Most CHRP participants are receiving income assistance. The median annual income of IDUs in the CHRP study, regardless of stage of HIV, is \$9,732 (\$811 dollars per month) The annual income of non-IDU CHRP participants is slightly higher, varying by stage, from \$9,780 to \$11,964 (\$900 a month). The difference in amounts is not significant.



For the above chart the participant numbers are as follows:

Stage Group	I	II	III	IV	Total
Non-IDU	17	67	65	110	259
IDU	9	54	75	71	209

2. Ministry of Human Resources

Individuals who meet eligibility criteria receive monthly income assistance under BC Benefits legislation of \$500 (basic benefits), \$596 (disability level 1) or \$771 (disability level 2).

Statistics Canada has established a monthly low income cut-off for the lower mainland at \$1,451 for one person and \$1,813 for two persons living together. This means that a single person receiving MHR income assistance at the basic level is supported at \$951 a month *below* the low income cut-off level. A person receiving MHR level 2 disability benefits, or a combination of Canada Pension Plan and MHR disability benefits totaling \$771 a month, is supported at a level that is \$680 a month below the low income cut-off.

All applicants for BC Benefits who meet basic eligibility criteria qualify for basic benefits. In order to qualify for disability benefits at either level 1 or level 2, an application must be completed by the applicant, his/her medical practitioner and a qualified assessor. Some

individuals, such as refugee claimants, may apply for disability designation but qualify only for basic assistance.

The disability application requires comprehensive information about how an applicant's disabling or medical condition affects daily living tasks such as:

- Personal care
- Housework
- Grocery shopping and food preparation
- Finding a place to live and maintaining it
- Basic time and money management
- Transportation
- Childcare

Supplementary funds for a special diet allowance (e.g., high protein) may be available. MHR offices can provide their clients with application forms. Each form must be completed by a physician or dietitian, is usually valid for a 12-month period, and may be renewed by following the same procedure.

There are other ancillary services, such as medical supplies and equipment, that a person with HIV/AIDS may be entitled to through BC Benefits.

Consumer groups report that large numbers of those most at risk (those with mental health difficulties or addictions) are not receiving the level of benefit to which they are entitled because their health conditions are barriers in and of themselves to successful completion of the application and assessment process.

All transitions between the different types of income assistance take considerable time and present difficulties to an already ill person. Providing smoother, easier transitions between the various sources of income support would greatly benefit a person with HIV/AIDS. Inter-agency and inter-ministerial coordination could reduce the difficulties experienced by clients in these circumstances. Clients are encouraged to contact a community advocacy organization for assistance.

In consequence of protracted and concerted lobbying by the BC Persons With AIDS Society, the Ministry of Human Resources recently established a multidisciplinary advisory group, with representation from BCPWA, to review the issues and to recommend solutions for meeting the ongoing health needs of clients living with HIV/AIDS. Results are anticipated by mid-1999, at which time it is expected that funding for additional health goods and services will be made available to persons who are HIV-positive and receiving disability benefits.

3. Canada Pension Plan

Pension monies are available under the Canada Pension Plan for persons with disabilities who have paid into the plan through involvement in the workforce and who meet eligibility criteria in

terms of numbers of years worked. Each applicant must be assessed by a physician who will certify that the individual is no longer able to continue working. CPP benefits vary in amount, depending on individual contribution history. Most payments are in the \$500 to \$675 per month range. These benefits cannot supplement financial support available under the provincial BC Benefits plan. Canada Pension Plan monies are now deducted from the amount available under BC Benefits.

4. Medical Employment Insurance

Individuals who are unable to continue working may be eligible for Medical Employment Insurance. Benefits available depend on work and contribution history. Once benefits run out, an individual who is unable to return to work may apply for Canada Pension Plan and/or BC Benefits support.

5. Private Disability Plans

Relatively few individuals living with HIV disease have access to private disability plans. To illustrate, as of March 1998, more than 1,700 AIDS Vancouver clients were receiving income assistance under BC Benefits legislation while fewer than 200 clients received income from a private disability plan.

Each plan has different eligibility requirements and it can be difficult for those who have an HIV diagnosis to enrol in a plan, given that many plans have restrictions regarding “pre-existing conditions.”

6. Community Services

The disparity between level of income support available and actual cost of living with HIV disease in Vancouver has resulted in the development of a number of community services whose goal is to address some of the gaps which have developed. A good example is the network of food providers now in operation. Many persons living with HIV disease must scrimp on their food budget to make up the difference between MHR’s shelter allowance and the actual cost of housing in Vancouver.

The Vancouver Food Bank provides an ongoing free food service for those in need. The AIDS Vancouver Grocery, which is supported by the Vancouver Food Bank, the Tzu Chi Compassionate Relief Foundation and the MAC Foundation, provides a more specialized grocery service to persons living with HIV on a limited income. In an average week, the Grocery serves about 500 individuals. This service is designed for persons able to prepare their own meals. If someone is ill and unable to attend the Grocery, delivery may be arranged. Vancouver Native Health Society also operates a weekly food bank, in conjunction with their outreach

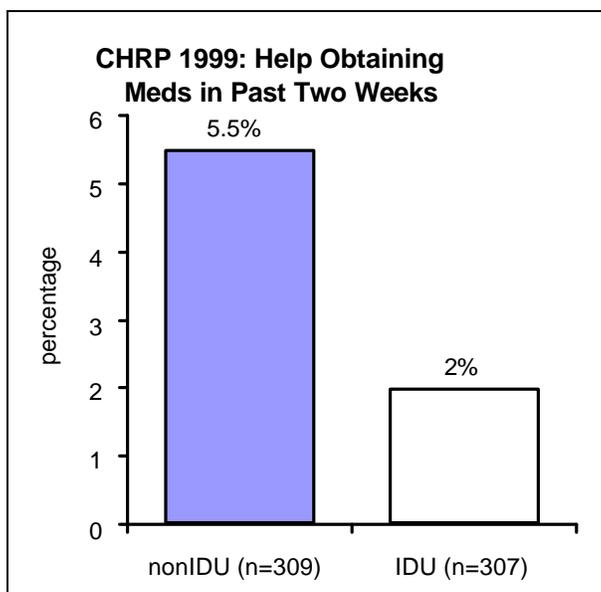
program, for persons living with HIV. There is also a wide range of food providers who distribute meals and sandwiches.

Building Nutritional Health: HIV, Injection Drug Use, Poverty and Nutrition in Vancouver's Downtown Community, a report prepared by the HIV, IDU and Nutrition Working Committee, looks closely at the experience of getting food while living in poverty.

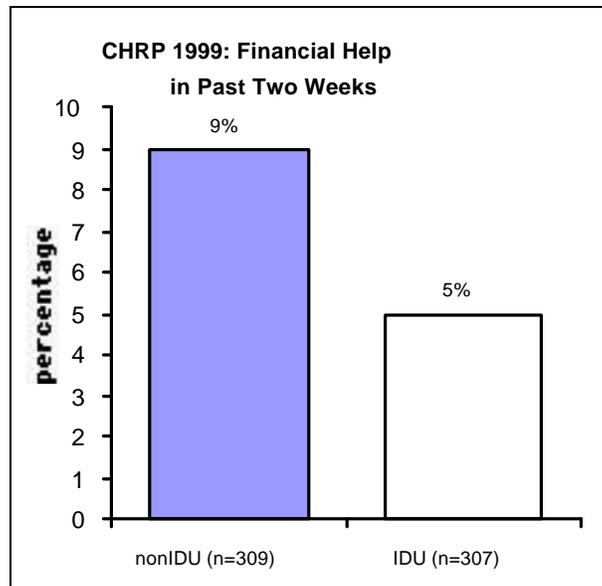
BCPWA's Complementary Health Fund reimburses qualifying members up to \$35 per month for receipted purchases of vitamins, nutritional supplements, bottled water and other health care products and services not covered by Medicare or Pharmacare.

BCPWA's Polli and Esther's Closet offers free clothing and small appliances to those in need. Located in the Pacific AIDS Resource Centre, Polli and Esther's is open Wednesdays and Thursdays from 11:00 a.m. to 2:00 p.m. and is supported entirely by donations. BCPWA members may shop there once a week. Some items, such as jackets, jeans and running shoes, are restricted to one/one pair per member per month.

Community organizations are also called upon to assist financially with the purchase of essential medications for persons living with HIV disease. CHRP asked its participants if they had received any financial help from a community agency to obtain therapeutic drugs, such as anti-fungals. The chart below shows that 5.5% of non-IDUs and 2% of IDUs received help with obtaining therapeutic drugs at least once in the two weeks prior to the interview.



More generally, as the following chart shows, CHRP found that 9% of non-IDUs and 5% of IDUs received some form of financial help from a community agency at least once in the two weeks prior to the interview.



7. Advocacy

Community advocates, social workers, clinic staff and community case managers are able to help individuals living with HIV/AIDS gain access to programs and services and deal with problems and issues that arise.

In increasing numbers, HIV-positive persons receiving BC Benefits, especially those with a Disability Benefits II designation, are applying for so-called Schedule C benefits. Under this rather obscure regulation, a successful applicant could receive additional BC Benefits payments of between \$400 and \$600 per month. The application and appeal processes for Schedule C benefits are extremely confusing and complicated and can take up to six months. As a result, advocacy services, such as those provided by BCPWA, are essential in all but a handful of cases.

Social Support Networks

Traditionally, individuals have depended on family and friends for social support. There are a number of initiatives that acknowledge the importance of family and friends in the context of HIV/AIDS. These include counselling programs that help HIV-positive individuals and their families grapple with a diagnosis, support groups for caregivers and partners, and respite programs that give caregivers an opportunity for a break in providing care.

However, for many living with HIV/AIDS, family and friends are not consistently available. Some have been estranged from family through long histories of individual and systemic abuse, while others have experienced rejection because of HIV status, sexual orientation, substance use, or a combination of factors. Others have lost partners and friends to HIV and find themselves leading relatively isolated lives.

In response to this situation, Vancouver has developed a range of programs and services designed to build social support networks among those affected by HIV/AIDS. These efforts have often been developed by specific groups identified as being at increased risk, or by agencies that have recognized an emerging need. However, more needs to be done; in particular, there is an urgent need for social spaces for gay men outside of the bar scene.

Seropositive individuals living outside Vancouver's West End and Downtown Eastside areas often find themselves having to leave their own neighbourhoods as they seek to develop social networks. Many individuals living in outlying municipalities depend on Vancouver initiatives when they engage in the process of building a supportive social network.

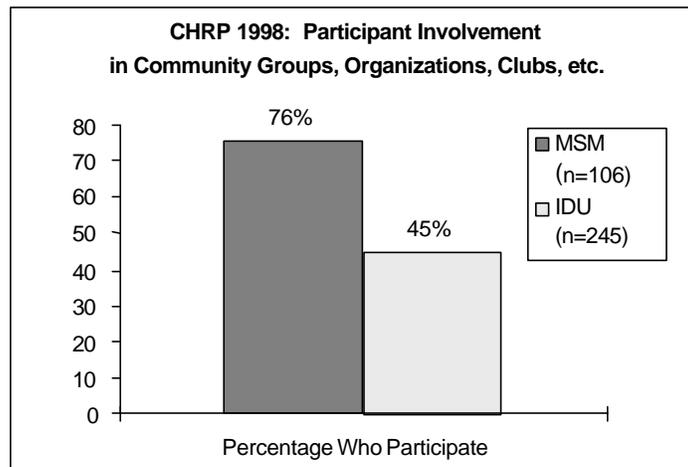
During 1997 and 1998, the Vancouver Drug Users Organization (VANDU) began building a larger pool of participants and developing different ways of establishing connections in this community. Participants speak with confidence about the impact VANDU has had on their learning.

In early 1998, the Vancouver/Richmond Health Board aided in the establishment of a new agency, intended to assist in the implementation and monitoring of its Downtown Eastside HIV/AIDS Action Plan. The group, called the Consumers' Board, was intended to be widely representative of the various communities resident in the DTES and included a number of recovering injection drug users.

Both VANDU and the Consumers' Board have supported the concept of developing a resource centre in the Downtown Eastside as a way of building on these initiatives. The Vancouver/Richmond Health Board and Health Canada have been leading a process to examine how and where such a resource centre might be developed.

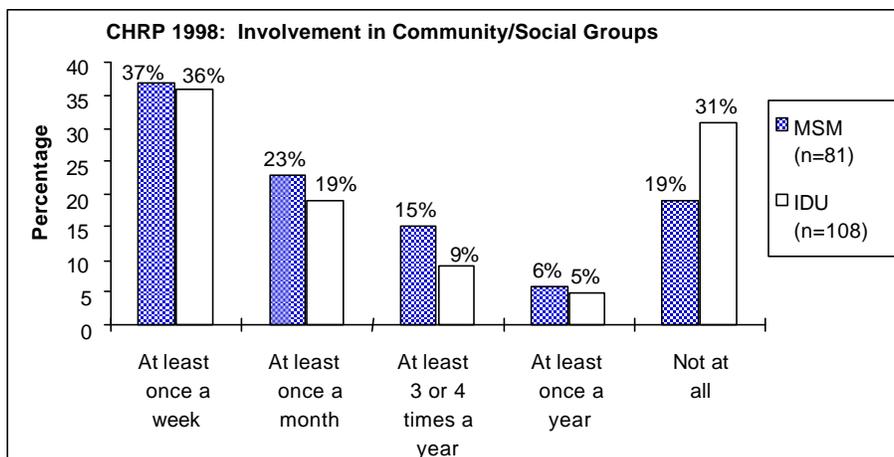
1. CHRP Findings on Social Support Networks and Community Involvement

CHRP has accumulated data on social support networks and community involvement. The following graphs illustrate some of these findings.

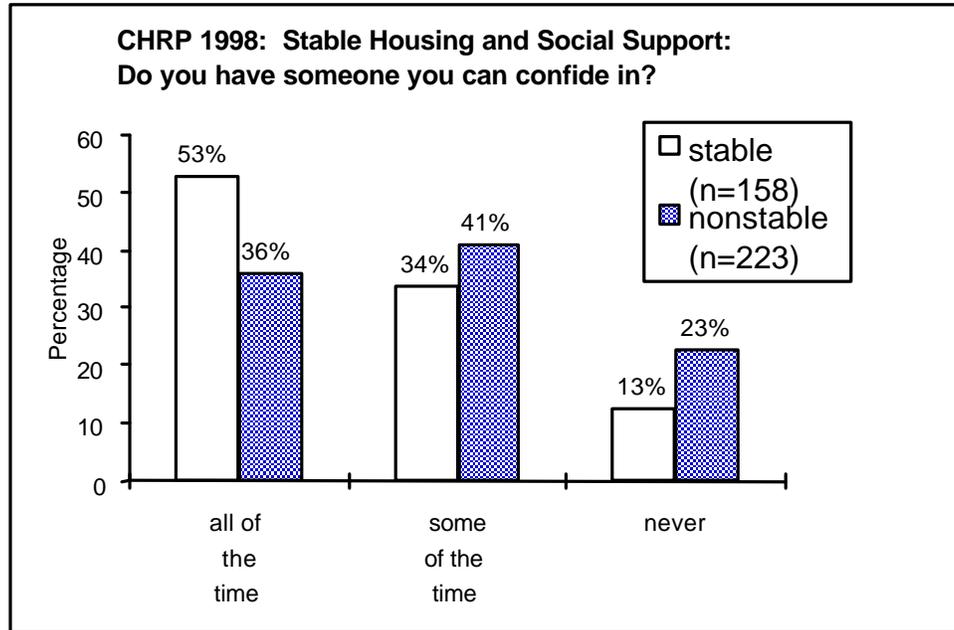


Seventy-six percent of MSM participate in organizations such as community groups, cultural associations, school groups, church social groups, or social, fraternal or civic clubs. Forty-five percent of IDUs participate in similar organizations.

The following graph shows that of those who do belong to organizations, IDUs were more likely to report “not at all” for their level of participation.



CHRP also examined social support and stable/non-stable housing. Participants in stable housing have more reported support than those in non-stable housing. For example, participants were asked several questions, including “Do you have someone to confide in?”



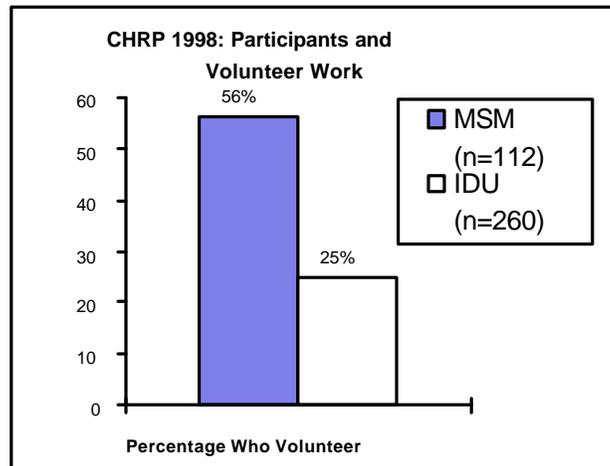
Fifty-three percent of participants in stable housing have someone to confide in most of the time, compared to 36% in non-stable housing.

CHRP also asked participants if they had someone who could help out in a crisis: 56.5% in stable housing said “all of the time,” compared to 37% of those in non-stable housing. Twenty-eight percent of those in non-stable housing said they “never” have someone to count on in a crisis, compared to 14% of people with stable housing.

Finally, CHRP asked if participants had someone to advise them on personal decisions: 49.5% of those in stable housing said “all the time,” compared to 31% in non-stable housing. Twenty-six percent of those in non-stable housing responded “never,” compared to 11.5% in stable housing.

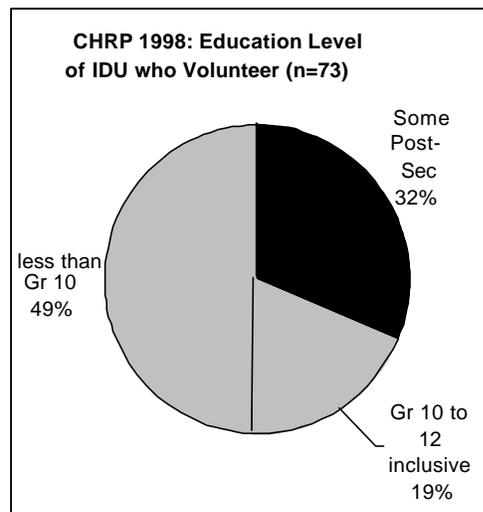
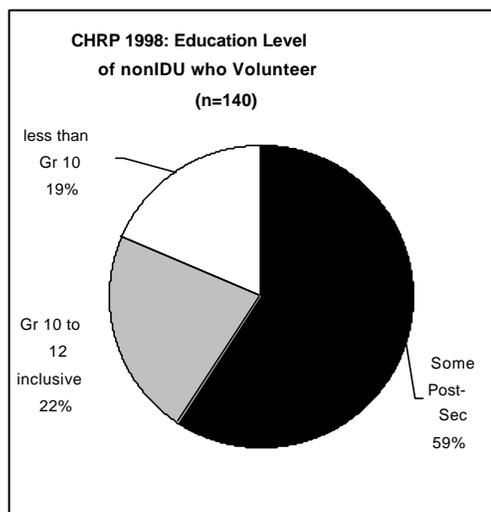
From the CHRP data a distinct pattern is starting to emerge: people in stable housing have more social support and a greater social network than those in non-stable housing.

CHRP also looked at volunteer activities as reported by participants. Volunteering is an important way in which persons living with HIV disease can both contribute to creating social support networks for others and participate meaningfully in a social support network for themselves. The graph below shows the response to the question, “Do you do volunteer work?”



CHRP found that 56% of MSM do volunteer work, compared to 25% of IDUs. This fact should be of interest to policy and program planners, as well as to AIDS service organizations.

There is a correlation between volunteering and level of education, as indicated by the charts below.

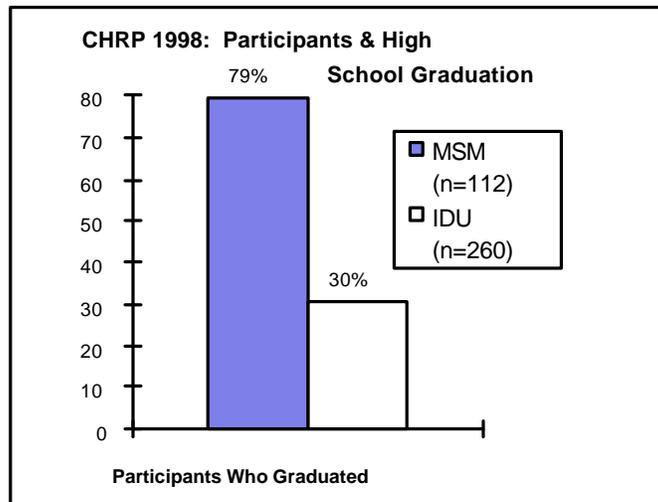


Education

Level of formal education has a powerful impact on the HIV/AIDS epidemic in Vancouver. As an example, the BC Centre for Excellence in HIV/AIDS, through the Vanguard Project, has found that young gay men with less than high school education are twice as likely to be risk takers in the context of HIV/AIDS. Once infected, education levels appear to have a direct impact on how individuals manage their own health. For example, a 1997 BC Centre for Excellence study found a positive relationship between higher levels of education and the use of complementary therapies.

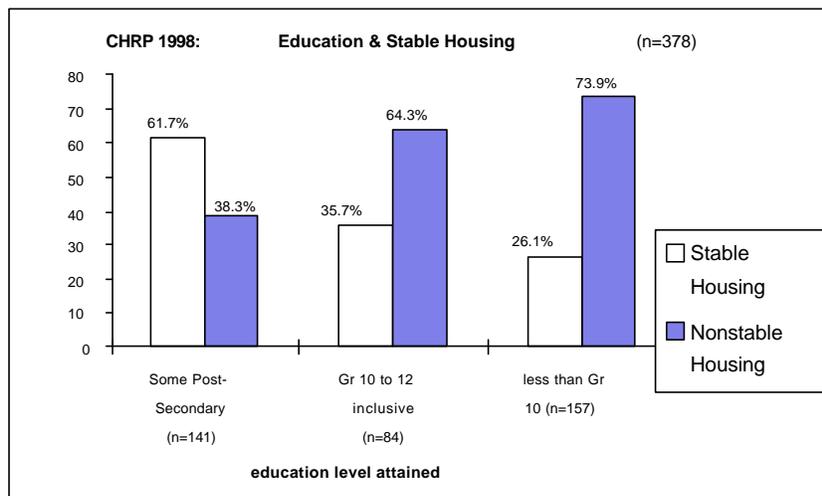
1. CHRP Findings on Education

Again, the CHRP study is able to give us an overall picture of the formal education levels attained by study participants.



CHRP found that 79% of MSM have graduated from high school, compared to 30% of IDUs.

CHRP has also compared education levels with housing and found that of its participants, 38.3% of those with some post-secondary education live in non-stable housing. In comparison, 73.9% of those with less than a grade 10 education live in non-stable housing. Stable housing is defined as living in a house or an apartment with two or fewer moves in the previous year. Non-stable housing is defined as living in housing other than a house or apartment, such as a single room occupancy hotel, boarding house, rooming house, etc., or living in a house or an apartment with more than two moves in the previous year.



2. Available Resources

Education initiatives relevant to persons living with HIV/AIDS, or those at risk, are available. The Ministry of Education, Skills and Training (Skills BC) offers a range of skills and training programs, although information about access appears to be confusing and complex for many. The Vancouver School Board offers Grade 12 equivalency or GED programs through a number of adult learning centres and continuing education programs.

Prevention initiatives are provided within the education system. YouthCO AIDS Society delivers peer-based education programs at schools.

Resources for professional education and development are currently provided by several organizations:

- Funded by the Ministry of Health, the Department of Professional Education and Care Evaluation of the BC Centre for Excellence in HIV/AIDS is mandated to provide educational programs for practising health care professionals and students in the health care professions throughout British Columbia.
- Funded by Health Canada, AIDS Vancouver's Training Institute provides training and education on HIV/AIDS in workplaces to employees who work with or provide service to persons living with HIV/AIDS, including recovery house staff, transition house staff, MHR financial aid workers and emergency shelter staff, among others.
- The Justice Institute has been recently contracted by the Vancouver/Richmond Health Board to deliver a training series to newly hired outreach workers in the Downtown Eastside.

Employment/Working Conditions

A number of important issues relating to employment and working conditions fall within the scope of this plan. These include:

- Workplace policies with respect to seropositive employees
- Collective agreements that protect the rights of seropositive employees from workplace discrimination
- Prevention and management of occupational exposure to HIV
- Employee benefit plans that include disability support for workers
- Disability plans and government benefit programs that can reasonably allow those whose health stabilizes or improves to re-enter the workforce without jeopardizing access to benefits in the future

1. Workplace Policies and Collective Agreements

The now defunct Business and Labour Coalition on AIDS in the Workplace worked during the mid-nineties to raise awareness about the need for effective and supportive workplace policies and enlightened collective agreements on HIV/AIDS. The AIDS Vancouver Training Institute has provided follow-up support in this area for workplaces wishing to craft or redesign policies, particularly in the context of training needs.

2. Prevention and Management of Occupational Exposure to HIV

Occupational exposure to HIV/AIDS and minimizing the risk of infection are two key issues for health care providers. The province has established written guidelines on the prevention and management of occupational exposure to HIV. The BC Centre for Excellence in HIV/AIDS, in collaboration with the Workers Compensation Board, has produced a video, *The Prevention and Management of Occupational Exposure to HIV/AIDS*, that describes safe work practices and the management of occupational exposure while working with all clients.

3. Benefit and Disability Plans

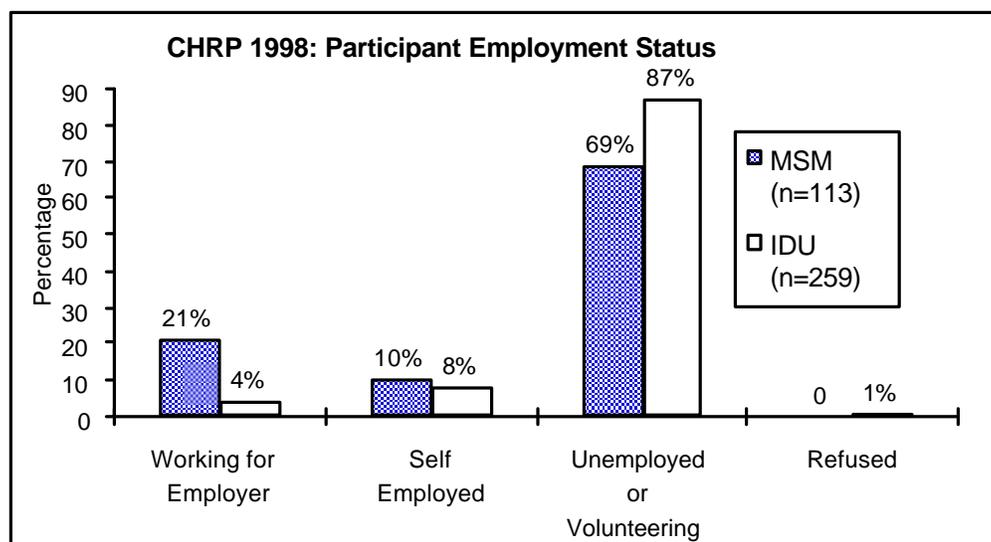
The recent advent of antiretroviral therapies has improved many infected individuals' health status enough that they are returning to paid and unpaid work. There are only limited services available to train and retrain, counsel or assist those willing to re-enter the workplace. Little research has been done to determine the impact on disability claims if these attempts are short-lived. Few employers have addressed non-traditional work practices that would allow persons living with HIV/AIDS the necessary flexibility to succeed.

The BC Coalition of People with Disabilities led an initiative to overhaul the MHR disability benefits program, with the result that disabled persons no longer have to be labeled permanently disabled but may now receive a designation for the purpose of benefits that recognizes that individual conditions may stabilize and improve at times. The Canada Pension Plan still requires a physician's certification that an individual is permanently unable to work. Individual disability plans vary in their coverage and flexibility.

In partnership with ASIA, YouthCO and Healing Our Spirit, the BC Persons With AIDS Society undertook an extensive examination of workforce re-entry issues. Having concluded and reported on this endeavour, BCPWA is now embarked on a project in partnership with the International Association of Machinists' "IAM Cares" program to provide counselling and referral services for persons living with HIV who wish to return to or begin work. Operating Mondays and Fridays out of BCPWA's PARC offices, and Tuesdays, Wednesdays and Thursdays out of the offices of IAM Cares in Burnaby, the program is operational as of July 1999.

4. CHRP Findings on Employment

The Community Health Resources Project has also looked closely at employment. The graph below shows that there are very high levels of unemployment for both MSM and IDUs living with HIV. The graph is not adjusted for stage of HIV progression. For those in the earlier stages of HIV disease, unemployment rates are somewhat lower: 60% for MSM and 78% for IDUs. Most CHRP participants are in later stages of the disease.



Physical Environments

Safe, adequate and affordable housing is a major health determinant for people living with HIV/AIDS and a critical issue for many living at heightened risk for HIV disease. Because of the scarcity of such accommodation, particularly in the lower mainland of British Columbia, there is a critical and urgent need for additional housing options. In terms of preventing HIV transmission, research from the BC Centre for Excellence in HIV/AIDS suggests that injection drug users with unstable housing were twice as likely to become infected with HIV. Another study conducted by the Centre for Excellence and Wings Housing Society shows that seropositive persons with unstable housing are more likely to be admitted to hospital for acute care than those in stable housing.

For those currently homeless or at risk, the affordable housing supply is not adequate to meet the demand. There are a number of new initiatives being developed with the cooperation of BC Housing, the City of Vancouver, the Vancouver/Richmond Health Board and non-profit organizations.

It became clear by the late 1980s that in British Columbia, and particularly in central Vancouver, housing subsidies could promote better health and quality of life, in a cost-effective manner, for people living with HIV/AIDS. Most seropositive individuals are relatively young, do not own

their own dwellings, and have not been in the workforce long enough to accrue the kinds of income support benefits needed to maintain even a simple dwelling in Vancouver. Changes to social housing policy, particularly the federal government's withdrawal of additional social housing support, have meant fewer available subsidized housing options in Vancouver's downtown peninsula and neighbourhoods have been unable to hold onto their affordable housing. Particularly in Vancouver, this can mean having to live in extremely marginal circumstances, often in single room occupancy (SRO) hotels with shared bathroom facilities. Food preparation facilities, if available, are shared with other hotel residents. Conditions are not conducive to the adequate nutrition and rest, freedom from stress, and medication regimes necessary to effectively fight HIV/AIDS.

There are three methods through which people living with HIV/AIDS can obtain housing assistance:

- Rent supplements
- Non-profit housing
- BC Housing regular applicant stream

1. Rent Supplements

There are 147 portable rent supplements, jointly funded by the federal and provincial governments, that are administered through Wings Housing Society, McLaren Housing Society, Vancouver Native Health and Healing Our Spirit BC First Nations AIDS Society. This number has not increased since 1994 when the federal government ceased providing additional money for housing.

McLaren and Wings Housing Societies have pursued additional subsidies through private and corporate fundraising. McLaren currently has 17 privately funded subsidies and Wings had one funded through a major drug company. McLaren devotes a considerable amount of time just to maintain funding. Corporate funding for Wings' one additional subsidy was not renewed in 1998/1999.

2. Non-Profit Housing

McLaren operates Helmcken House, a 32-unit complex for people living with HIV/AIDS. Wings operates The Bonaventure, a 30-unit, multi-bedroom complex across from St. Paul's Hospital that houses approximately 57 people. Both of these projects are funded through BC Housing.

The Portland Hotel, operated by the Portland Hotel Society, provides 70 single rooms for some of the most difficult to house, including those living with multiple problems. More than half the residents are HIV-positive. The new Portland Hotel, which is currently under construction, will provide housing in a far more appropriate setting. The Portland Hotel Society receives funding from a variety of sources, including Greater Vancouver Mental Health Services and the Vancouver/Richmond Health Board's HIV residential care program.

In conjunction with BC Housing and the Vancouver/Richmond Health Board, the Portland Hotel Society is also working on the renovation and operation of the Sunrise and the Washington, two single room occupancy hotels also located in the Downtown Eastside.

Other non-profit housing options, including co-ops, require that the person apply to each site individually. Some have declared dedicated suites for persons living with HIV disease. However, application to non-profit housing can be a time-consuming, complicated task that most people living with HIV/AIDS are unable to effectively undertake, and often those most needy do not live long enough to benefit from the wait.

Bridge Housing Society offers some dedicated housing suites for HIV-positive women and their families.

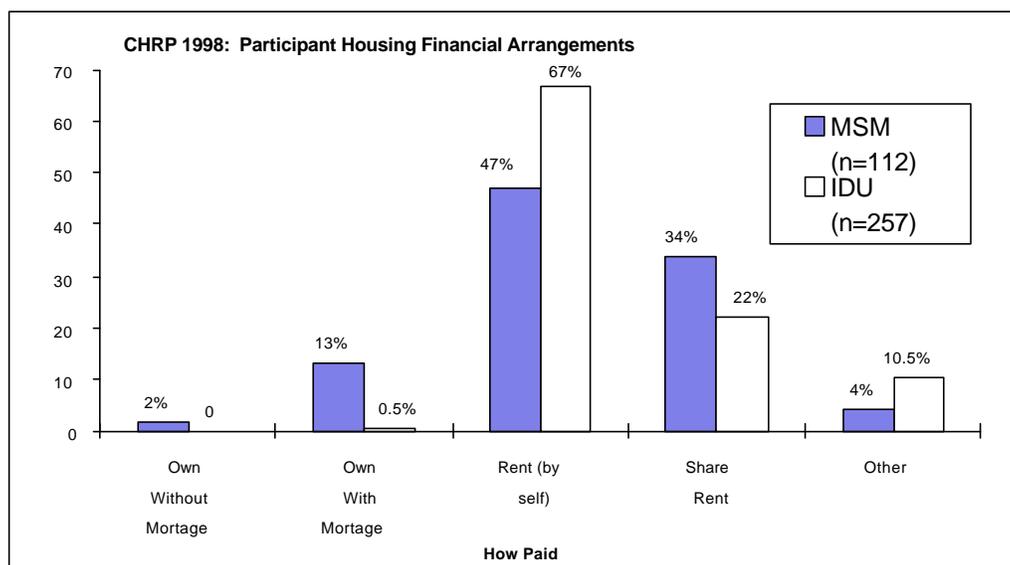
A small number of housing cooperatives (members of the Cooperative Housing Federation of BC) offer one suite in their building that is dedicated to a person living with HIV disease.

3. BC Housing Regular Applicant Stream

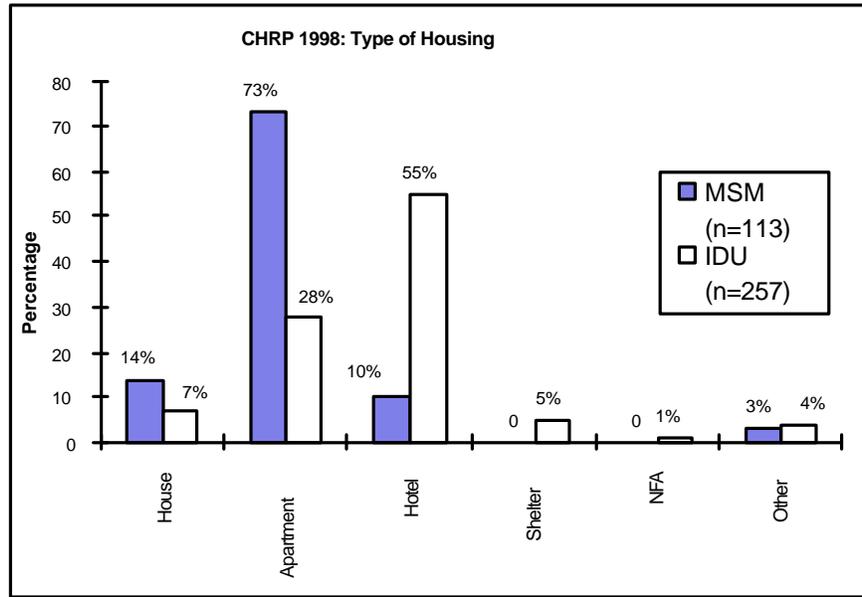
BC Housing provides self-contained units in permanent housing developments for individuals and families.

4. CHRP Findings on Housing

Current housing situations for persons living with HIV/AIDS are by and large very problematic. The Community Health Resources Project found that in a study including 412 participants, more than 60% of male and female injection drug users lived in one room or less.



Whereas 15% of MSM own a house (most with a mortgage), less than 1% of IDUs own a house with a mortgage. Further, while 47% of MSM rent and pay the entire rent themselves, 67% of IDUs pay the entire rent themselves. It is worthwhile to note that this would largely be attributable to IDUs living in SRO hotels while most MSM are living in apartments (see next table). Thirty-four percent of MSM share the rent with others, compared to 22% of IDUs.



The above graph shows the type of dwelling in which CHRP participants live. The CHRP found that 73% of MSM live in an apartment and 10% of MSM live in a hotel while 28% of IDUs live in an apartment and 55% of IDUs live in a hotel.

Six percent of CHRP participants received help from an agency, group, organization or individual with finding or keeping a place to live in the two weeks prior to their interview.

All agencies are noting a critical shortage of housing for persons living with multiple diagnoses. In 1997, the Vancouver Multiple Diagnoses Committee completed a report titled *Looking for Housing Solutions: A Direct Consultation with Vancouver Women Living with Multiple Diagnoses*. The women who participated in the study were very clear about what they needed in order to feel safely housed. The majority of women who participated in the study thought staff support attached to their housing would be a good idea.

In spite of new initiatives in the housing area, longer survival times are only increasing the seriousness of the safe housing shortage. The table below shows numbers of subsidies available in the context of waiting lists at various agencies.

Housing Wait List Numbers			
Agency	Current Subsidies	Numbers Waiting	1997 Turnover
Healing Our Spirit	10	130	2
McLaren	59	150	9
Vancouver Native Health	25	?	?
Wings	102	625	15

Housing workers predict wait lists will continue to grow as the number of people living with symptomatic HIV increases in the wake of more effective antiretroviral therapies.

In terms of HIV-related residential care options, the Vancouver/Richmond Health Board currently funds a 10-bed unit at the Dr. Peter Centre, two beds at May's Place Hospice, and some programming at the Portland Hotel. At times, waiting lists for these facilities can be long. It is important that further work be done to increase residential care options for those living with HIV within residential care resources in the broader community.

The number of persons requiring some form of supported housing continues to grow. There is a growing group of individuals, often living with HIV and a combination of addictions and/or mental health issues, who are not well accommodated in the current range of housing options. This trend affects the entire service spectrum, from acute care facilities that must delay discharge for lack of options, through to independent housing facilities that try to accommodate individuals who ultimately fail for lack of available support.

In the housing vacuum outlined above, emergency shelters such as Lookout and Triage are playing an increasing role in providing shelter to those without adequate housing and for whom few options are available. In some cases, patients are being discharged directly from acute care facilities to emergency shelters due to the lack of options.

Lookout, for example, currently dedicates five beds for mentally ill people living with HIV disease. There are challenges, though, with medication management, and the shelter has had to rely on the volunteer services of a physician to cope.

2. INDIVIDUAL CAPACITIES AND SKILLS

Personal Health Practices and Coping Skills

Various prevention programs in Vancouver have focused on personal health practices and coping skills as ways of preventing the spread of HIV disease. Programs such as AIDS Vancouver's Man to Man, needle exchange programs, and prison education and outreach programs all focus in part on providing the information and materials individuals need to make informed decisions around their own personal health practices.

To date, the idea of health and wellness has generally been overlooked in HIV/AIDS care. The benefits of maintaining and improving general good health are numerous and well worth involving the community on a more active basis. The obvious cost benefit to the health care system alone makes it worth the time and funds required for promotion of this concept. For the purposes of this plan, the term "health and wellness" is defined as any treatment that maintains or improves physical wellness (by, for example, preventing opportunistic infection); emotional or spiritual treatment that improves overall outlook on life; and psychological treatments that encompass information seminars about treatment options. Complementary therapies include bodywork, vitamin supplements and antioxidants that combat harsh drug treatments and their effects on the body.

The benefits of health-promoting practices are many:

- Regular moderate exercise can help reduce the impact of infectious disease
- Exercise will slow the loss of muscle tissue
- Increasing muscle mass can maintain health and promote independence
- Regular physical activity can help prevent depression
- Proper nutrition information and practices can prevent opportunistic infection
- Vulnerable populations benefit from being given more options that promote health
- More wellness options ensure substance users have a greater degree of reducing harmful behaviour

Health and wellness promotion reduces hospital visits. It means less strain on already overextended organizations that provided health care and support. Improved personal health practices and coping skills involve active participation in an individual's own treatment plans. Social support networks are strengthened by increased community capacity to care for persons at home.

Several agencies are involved in promoting health and wellness in the context of HIV/AIDS:

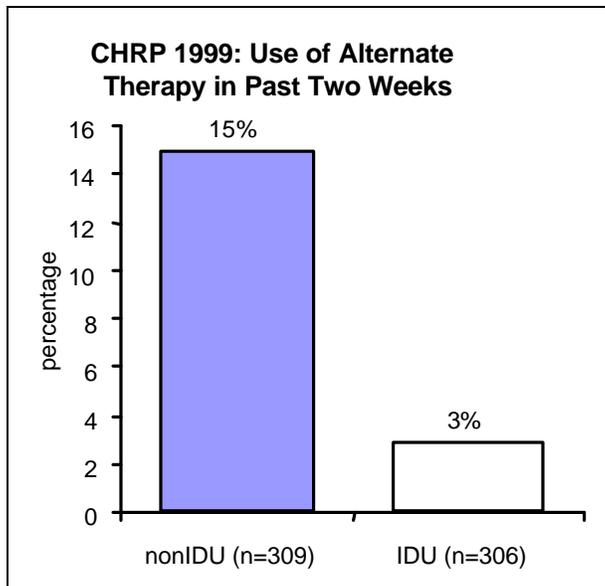
- Friends for Life Society provides holistic support services that focus on the mind, body and spirit connection. Members are provided with the tools they desire to promote their health and wellness through information seminars, counselling and bodywork

- BCPWA's Complementary Health Fund reimburses HIV-positive members for complementary or alternative therapies not covered by the health care system, to a maximum of \$35 per member per month
- BCPWA's Treatment Information Program (TIP) provides a full range of information about conventional, alternative and complementary therapies to HIV-positive persons through personal consultations, community forums, a series of information leaflets, and the bi-monthly publication *TIP News*; the TIP office, located in the Pacific AIDS Resource Centre at 1107 Seymour Street, is open Monday through Friday from 10:00 a.m. to 5:00 p.m.
- BCPWA's Support Services Department offers peer-based counselling, support counselling and healing retreats
- Residents of the Portland Hotel have in-house access to a small range of complementary therapies and aesthetic services
- Positive Women's Network provides monthly one-day retreats and annual weekend retreats that include massage, reiki, shiatsu, reflexology, and iridology
- Chrysalis Society teaches meditation and provides aromatherapy and art therapy to persons living with HIV disease and AIDS
- VANDU, through its peer initiatives, has given participants opportunities to learn new coping skills and adapt behaviour
- SOS provides outreach to the Spanish-speaking community, particularly refugees, and offers assistance in addressing health concerns and risk behaviour
- AIDS Vancouver's Man to Man program has been working within the gay community to build a better understanding of the underlying factors which influence gay men's personal health practices with respect to HIV/AIDS
- Carnegie Centre has held large public events designed to provide information to individual participants while building the public profile of HIV-related issues

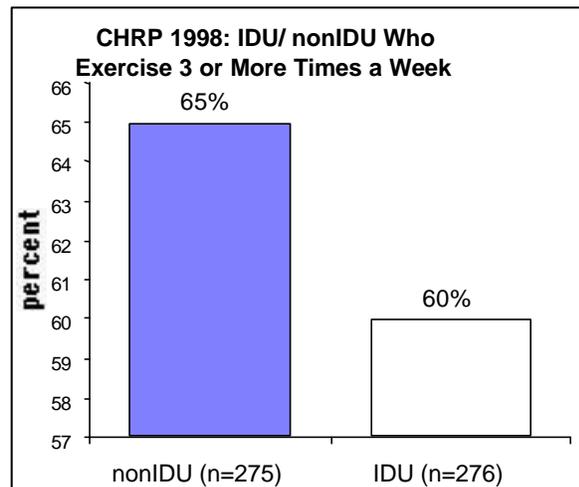
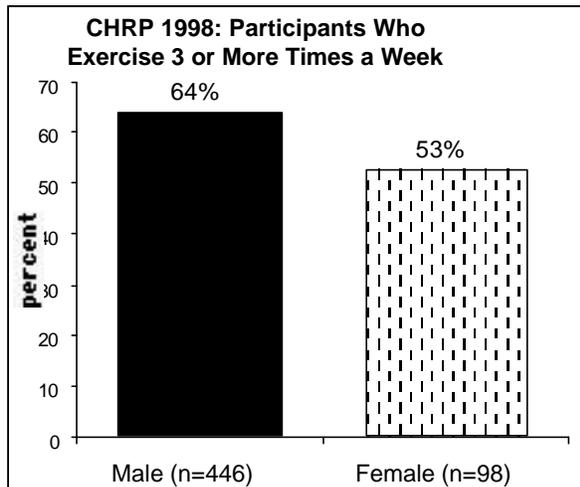
1. CHRP Findings on Personal Health Practices and Coping Skills

The Community Health Resources Project asked the participants in its study a number of questions relating to such personal health practices and coping mechanisms as alternative therapy, exercise, and the use of cigarettes and alcohol.

CHRP asked participants if they had received any alternative therapy and found a statistically significant difference ($p < 0.001$) between IDUs and non-IDUs. The chart below shows that 15% of non-IDU participants used some form of alternative therapy (traditional Chinese medicine, massage, meditation, etc.) at least once in the two weeks prior to the interview, compared to only 3% of IDUs.



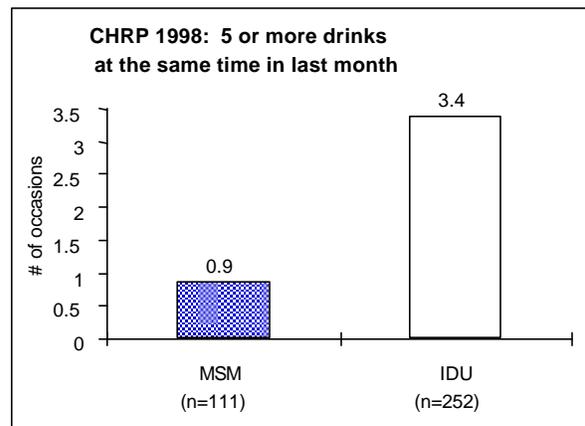
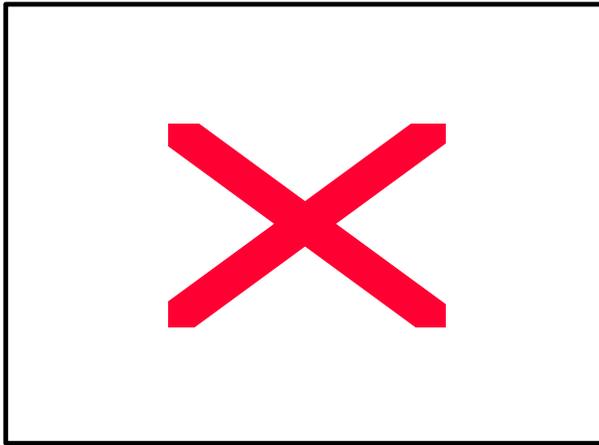
CHRP also found a statistically significant difference ($p=0.005$) between males and females in the amount of time spent exercising. CHRP found that 64% of males and 53% of females in the study exercise for at least thirty minutes at least three times a week. There was no statistically significant difference between the IDU and non-IDU groups.



The majority of CHRP participants smoke cigarettes on a daily basis: 55% of MSM smoke on a daily basis while 84% of IDUs smoke on a daily basis.

The average MSM who smokes daily began at age 16. The average IDU who smokes daily began at age 13. Though it is not reasonable to suggest that all 13-year-old smokers will go on to become IDUs, the above findings do suggest that some will. An area of important investigation is to determine what psychosocial preconditions make smoking more likely for some in early adolescence, and whether these same preconditions make future injection drug use more predictable.

On average in the four weeks prior to the interview, IDUs had 5 or more drinks on at least 3.4 occasions. For MSM the average is 0.9 times.



Healthy Development of Children and Youth

The key to the healthy development of children born to HIV-positive mothers is effective care, planning and support. For pregnant women, it is important that they have access to effective HIV testing and prenatal care.

The following are important aspects of the care required for infants born to seropositive mothers from birth until the infant's HIV status is determined:

- Appropriate delivery and a neonatal resuscitation facility with universal infection control precautions
- The option of administering hepatitis B vaccine with or without immunoglobulin
- The option of oral antiretroviral therapy in the first day of life
- Adequate nutrition to replace breastfeeding
- Appropriate monitoring and therapy of neonatal drug withdrawal
- Appropriate support of the parent or guardian to ensure a safe and secure environment for the infant
- Routine immunization
- Referral to the infant development program as required
- Access to appropriate testing for the presence of HIV and HCV
- Monitoring of prophylactic antiretroviral therapy for the first six weeks of life
- Appropriate psychosocial support for the parent or caregivers

The following are important aspects of effective planning, care and support for children infected with HIV and their families:

- Access to lifelong appropriate medical care, involving a family physician and/or pediatrician and an HIV specialist for therapy, monitoring and follow-up
- Access to appropriate antiretroviral and prophylactic therapies and adherence to medication schedules
- Immunization
- A safe and secure home environment that is able to provide consistent care, adequate nutrition and a sociable, active life in a loving environment
- Access to community facilities, schools and training programs without discrimination
- Access to recreational activities
- Access to development or counselling programs as required
- Access to child-appropriate palliative care, home care programs, and bereavement counselling
- Access to special learning programs as required
- Access to disability facilities as required
- Access to support services
- Support and training for the extended family members, foster parents or adoptive parents who assume care or guardianship of children infected or affected by HIV/AIDS, including support with grief and bereavement
- Ongoing care if the primary caregiver is unable to provide care
- Access to appropriate clinical trials

The following are important aspects of the care required for children of HIV-positive parents:

- Access to appropriate medical care
- Appropriate immunizations
- Access to development or counselling programs
- Access to community day care centres, schools and training programs
- An appropriate home environment with adequate care, nutrition and social activities in a loving environment
- Access to special learning programs as required
- Access to subsidized child care for all programs in which HIV- positive parents participate
- Support for seropositive parents in making long term plans for the care and guardianship of their children
- Ongoing care when the primary caregiver is unable to provide care
- Bereavement counselling

Other important aspects of the care and support required for healthy child development in the context of HIV/AIDS include:

- Support for children living in poverty
- Financial support for nutrition, transportation and child care

- Support for families struggling with complex medical therapies
- Support for families struggling with drug and alcohol issues
- Access to appropriately developed sex education programs for children and youth
- Respite care for caregivers
- Support for mothers and pregnant women whose fear of child apprehension prevents them from accessing medical and support services

Some of the services currently available include the following:

- Clinical HIV management, nutritional management and psychosocial support for infants born to seropositive mothers and infants and children infected with HIV (Oak Tree Clinic, Women and Family HIV Centre at Children and Women's Health Centre of BC)
- Respite and palliative care and bereavement counselling (Canuck Place; undergoing restructuring; increased service for all socioeconomic groups is required)
- Family support services (Hummingbird Kids Society; Western Canadian Pediatric AIDS Society's Camp Moomba)
- Access to and enrolment in appropriate clinical trials for children infected with and affected by HIV (Canadian Pediatric Research Group through Oak Tree Clinic)
- Support, information and education to aboriginal and multicultural communities (Bridge Clinic, Oak Tree Clinic, Healing Our Spirit; more services are required in the lower mainland and the rest of BC)
- Delivery and HIV management of the newborn (Children's and Women's Health Centre of BC, St. Paul's Hospital, Victoria General Hospital; better coordination is required at other delivery units in Vancouver, the lower mainland and the rest of BC)
- In-services for day care centres, child care agencies and foster parent groups about universal precautions adapted to childcare settings (nurse clinician from Oak Tree Clinic)

Biology and Genetic Factors

This strategic plan does not directly address HIV vulnerability, care and support in relation to biology and genetic endowment. Future work is needed to develop better understanding in this area.

Hemophiliacs, for example, comprised a very significant proportion of persons infected with HIV disease early in the epidemic due to their use of tainted blood products. The Canadian Hemophilia Association has taken a lead role nationally in advocating for the interests of its members.

Also, persons with organic brain disorders, including the chronically mentally ill, comprise a large group of persons vulnerable to or living with HIV. Some HIV-related supports and services have been dedicated to this group; for example, the Strathcona Mental Health team at Greater Vancouver Mental Health Services dedicated two full-time outreach nurses with an intentional focus on mentally ill persons at risk for or living with HIV disease.

The Mental Patients Association dedicates outreach time to individuals living with mental illness and often HIV disease, who are referred by the criminal justice system.

Recently, the critical situation faced by persons living with both mental illness and addictions, particularly in the wake of the HIV outbreak among injection drug users in Vancouver, has received extensive and much needed media and public focus. However, it must be remembered that those living with serious mental illness who are not injection drug users continue to face serious risk of HIV infection. Ongoing prevention work through centres such as The Living Room and The Kettle is vital.

3. SOCIAL ENVIRONMENTS

Key social environments in which the HIV epidemic occurs are the home, school, workplace and community, as well as the larger social service, health care, legal and correctional systems. These environments are shaped, in turn, by gender and culture. Each social environment poses unique challenges for the design, delivery and acceptance of effective HIV prevention and treatment strategies.

Gender

1. Women

HIV-positive women face a variety of unique medical and psychosocial issues. The same social determinants that tend to make women particularly vulnerable to HIV infection also result in many HIV-positive women not receiving optimal care. Almost one quarter of all newly diagnosed infections in BC occur in women. The proportion of HIV-positive women who use injection drugs has increased, and a disproportionate number of HIV-positive women are aboriginal.

Women who are HIV-positive are often isolated and may lack supportive social networks. The stigma associated with HIV infection is very real for women, especially in ethnocultural communities and rural communities. Many women live in poverty, lack safe and secure housing, have difficulty maintaining adequate nutritional intake, lack transportation, and face major child care difficulties. They may also face violence within their relationships and their communities. Further, women continue to be the major caregivers in our society, and child care, partner care, and parent care issues can preclude women from adequately addressing their own health care needs.

Optimal women-centred HIV care must not only address the psychosocial and other barriers to care, but must take into account the unique medical issues associated with HIV in women. These include gynecologic complications such as cervical cytologic abnormalities, inflammatory and infectious diseases of the female genital tract, as well as menstrual cycle changes and issues associated with menopause. There may also be intrinsic differences in viral load in women and differences in side effects and toxicities to antiretroviral drugs.

Reproductive issues must be addressed in a non-judgemental fashion, and women's reproductive choices respected and supported. Management of pregnancy requires specialized care, with the woman involved all facets of decision making, including the use of antiretroviral therapy during pregnancy. Optimal pregnancy care, including antiretrovirals, has resulted in dramatically decreased rates of perinatal transmission (now less than 5% in women receiving care). Optimal care requires close collaboration between the woman, an HIV-aware obstetrician, an HIV specialist, a pharmacist, a nutritionist, a social worker and a pediatric HIV specialist.

The provincial initiative recommending that all pregnant women in the province be offered HIV testing as part of routine pregnancy care has resulted in more than 6,000 women being tested in each of the last three years. There continues to be a need for improvement in this area, however. It is clear that many women are still not being offered testing in pregnancy, while some are being tested without their knowledge and consent. HIV diagnosis of women in pregnancy not only decreases the rate of perinatal transmission, but also means that more women will potentially be able to access new antiretroviral therapies.

Diagnosis of HIV infection in women remains problematic. Unless women identify themselves as being injection drug users or partners of injection drug users, they continue to be viewed by many health care professionals as being at low risk, and many women are still not being offered testing. Lesbians, especially, are considered at low risk for HIV by physicians. As a result, women are still being diagnosed late in the course of HIV disease. It is likely that many women in the province remain unaware of their HIV status.

There are resources available to HIV-positive women in BC. The *Directory of Services for HIV-Positive Women and Children* was published in October 1997. Further help, support and care can be obtained through the Positive Women's Network and the Oak Tree Clinic.

2. Transgendered Persons

Transgendered persons living with HIV/AIDS also face an enormous range of issues and challenges. Individuals may find themselves leading isolated lives. The stigma associated with HIV disease may be compounded by the stigma faced by the transgendered community in general. Access to non-judgemental care and support is essential.

The former High Risk Project worked to create a supportive social environment for transgendered persons and to provide a range of practical supports to community members. A successor organization is currently in the developmental stage.

The LGBT Health Care Access Project conducted community consultations with the FTM community in Vancouver. Reports from FTM community members revealed both negative and positive experiences when seeking health care.

On the positive side, it was noted that providers are becoming more informed on FTM health issues and, as a result, respect is being demonstrated and care is improving.

Many of the negative experiences reported seemed to result from a lack of information about FTM issues in general, a lack of experience on the part of providers when working with FTMs, and negative attitudes held by care providers. Participants suggested that research, information and education must be circulated in the health care systems and society at large if these situations are going to be prevented in future.

The LGBT Health Care Access Project also held community consultations with the MTF community in Vancouver. Again, both positive and negative experiences with the health care system were reported.

Some MTFs reported positive experiences, particularly at Downtown Eastside facilities, which were perceived as more respectful than centres in outlying areas.

On the negative side, MTFs said it was difficult to find knowledgeable, non-judgemental and non-prejudiced providers, informed people at government offices, and supportive people within gay and lesbian organizations.

In the words of one participant: “Mental health services have been the worst. If I need help, I present as a male. Even if the issue is not directly gender-related – for example, depression – one is dismissed and told to go to the Gender Identity Clinic, but the Clinic can’t deal with depression, and the medical system won’t because you’re transgendered.”

Culture

The HIV/AIDS epidemic has disproportionately affected persons from particular cultural groups:

1. First Nations and Aboriginal Populations

It is difficult to estimate the number of First Nations people who are infected with HIV in Canada. Several HIV testing studies have been done within specific First Nations and aboriginal populations; however, any attempt to paint a national picture of HIV prevalence and incidence has been patchwork at best. There is no national database on the number of First Nations persons and aboriginals who are HIV-positive, as only AIDS cases are reported. The BC Centre for Disease Control does keep track of HIV test results and has data on ethnic status. Even with these data, we do not know how many people are HIV-positive but have not yet been tested.

The exact nature or strength of barriers to testing for HIV for First Nations persons is unknown. If persons infected with HIV do not get tested, the official prevalence and incidence numbers that policy and program makers use will be low. There are many plausible scenarios that might lead one to believe new and existing HIV infection rates among First Nations persons are higher than those currently reported by centres for disease control.

Relative to the general population, First Nations persons have higher morbidity and mortality rates. If poor health is normalized in a community, it is possible that initial symptoms of HIV – prolonged fever or diarrhoea for instance – might not motivate one to visit the doctor. This

scenario is more compelling if health care providers are, for a variety of reasons, difficult to access. Further, even if a First Nations person does go to the doctor, they may not feel comfortable consenting to an HIV test.

Though anonymous testing is generally available in urban centres, it may not, in reality or perception, be available in rural settings. In many First Nations communities there still exists a strong social stigma against HIV and AIDS. If the social consequences of a positive test are high, one may choose not to be tested. This is especially true if the person has any reason to believe that confidentiality of the test results will not be kept. Shame and fear of social isolation might also leave people with little alternative but to conceal they have tested HIV-positive. For instance, a First Nations person who became infected and tested HIV positive while living in an urban centre might return home and choose not to behave in any way, including telling family or friends, that would reveal they had HIV. For these reasons, HIV status might be hidden either directly (by not disclosing status to others) or indirectly (by not being tested). In the latter case there will be no record that the person is HIV positive.

If HIV status is directly or indirectly hidden, there are important implications for receiving proper care and succeeding with effective prevention programs. With the implementation of more effective treatments, the consequences of not accessing appropriate treatment and care could be especially severe. Hidden status, especially when indirect, is also very important for prevention. Someone who does not know they are HIV-positive might still engage in behaviour that unknowingly puts uninfected persons at risk. If the above scenarios are plausible, the actual prevalence and incidence rates of HIV for First Nations persons might be far higher than currently reported.

For these reasons, it is very important that the environment within First Nations communities allow people to seek HIV testing. First Nations persons have to know that their HIV test results will remain confidential and that if the test is positive, their community will support them as best it can in all phases of the disease.

The First Nations Community Health Resources Project (FN-CHRP) represents a research partnership between the University of British Columbia and the Assembly of First Nations. FN-CHRP is a pilot research study on the resource impacts and economic costs of HIV and AIDS among First Nations persons living in Vancouver. This study represents an important first step in identifying the profound economic costs that HIV and AIDS will have for affected First Nations individuals, families and communities across Canada.

Initially, the First Nations Community Health Resources Project expected to recruit between 100 and 150 First Nations participants who were HIV-positive. At the beginning of the project it was thought that a target of even 100 participants might be difficult to achieve. This was for two reasons. First, the Laboratory Centre for Disease Control had estimated 240 aboriginal AIDS cases in all of Canada, ever, by the end of 1995. This was a reported underestimate since 41% of reported AIDS cases did not contain ethnic identifiers. Still, this low figure suggested a target of even 100 participants might be difficult given the study was located in one urban centre, Vancouver. Secondly, it was felt that First Nations persons might be reluctant to participate given the broad feeling of being “researched to death” Among other reasons, this sentiment

exists because academic information has rarely been returned in a meaningful way to First Nations persons. Recruitment for FN-CHRP started in Vancouver in March 1997. More than 200 HIV-positive First Nations persons agreed to participate in FN-CHRP in the following months.

The FN-CHRP survey asked the question, “When you are back home, how comfortable do you feel telling people you are HIV-positive?” Of those who responded, 63% (40 of the 63 respondents) stated that they were either “somewhat uncomfortable” or “very uncomfortable”. Thirty of these 40 negative responses were “very uncomfortable.”

When asked why they where uncomfortable back home, 8 of 63 (12.7%) responded “personal safety” or “gay bashing,” etc., 18 of 63 (28.6%) responded “banishment” or “not wanted around”, and 22 of 63 (34.9%) responded “stigma.” Comments from more detailed responses included:

- “People don’t understand”
- “Lack of acceptance and understanding”
- “Gossip that goes around”
- “They feel they can catch it”

Of those respondents who considered Vancouver home, 40% (42 of 106) felt uncomfortable disclosing their HIV status to others. Interestingly, no one stated that their discomfort was based on concerns that access to health care would be threatened.

The results from the FN-CHRP survey are consistent with the scenarios presented above where barriers to testing and seeking proper care might exist in home communities.

FN-CHRP data used below are from 151 persons enrolled in Vancouver before July 1, 1997. From the tables below it is clear that both First Nations women and men are becoming infected with HIV. Though much of the infection is reportedly taking place due to injection drug use, women are becoming infected through unprotected sex with men and similarly men are becoming infected through sexual contact with women.

Gender of Participants		
Gender	Number	Percent
Male	102	67.5
Female	45	29.8
Transgender	4	2.7
Total	151	100.0

Reported Infection Route		
Risk Category	Number	Percent
Male, Injection Drug Use (IDU)	55	36.42
Male, Sex with Male (SM)	22	14.57
Male, SM and IDU	4	2.65
Female, IDU	29	19.21
Female, not via IDU	16	10.60
Transgender (SM or IDU)	4	2.65
Male, Sex with Female	9	5.96
Male, Other	12	7.95
Total	151	100.00

Median Time from Infection		
Reported Transmission Route	Number	Median* Time from Seroconversion (Years)
Male, Sex with Male	19	7
Male, Injection Drug Use (IDU)	48	4
Female IDU	29	2
Female, no IDU	13	2
Male, Sex with Female	9	2

* The term "median" means that half the sample was equal to or less than the median figure and half the sample was equal to or greater than the median figure

The epidemic of HIV disease is still in its early stages for First Nations persons. Persons living with HIV can be asymptomatic for many years before their immune system breaks down and they succumb to AIDS. Table 3 shows that many First Nations persons have become infected with HIV only in the last few years. This means that the highest need for care and treatment and support is still in the future.

First Nations communities will have to plan adequately to care for persons in their community who are living with HIV and AIDS. If stigma and shame remain for First Nations persons living with HIV, they may choose not to return home for care, treatment and support.

First Nations persons living with HIV in Vancouver are accessing combination drug therapies at a rate significantly lower than non-First Nations men who have sex with men. The reasons for this are not clear but will be investigated in future research.

FN-CHRP will continue analysis and attempt to identify costs unique to First Nations persons living with HIV. Future analysis will include the costs of caregiving and support from friends and family.

It will be difficult for First Nations communities to plan properly for future HIV/AIDS care, treatment and support needs if First Nations persons are hesitant to get tested. Uncertainty about the number of First Nations persons living with HIV also makes the effective prevention programs difficult to design and implement.

The BC Aboriginal HIV/AIDS Task Force released a comprehensive report in 1999 title, *The Red Road, The Path to Wholeness: An Aboriginal Strategy for HIV and AIDS in BC*. The recommendations are referenced in detail in the Vancouver HIV/AIDS Care Co-ordinating Committee (VH/ACCC) 1999 - 2002 Care Strategies document.

2. Other Ethnocultural and Linguistic Communities

Language barriers, different ethnocultural norms and persistent myths about HIV/AIDS have contributed to a limited awareness of risk behaviours and prevention strategies in newcomer populations. Many service providers are often unaware of the risk for HIV in different ethnic communities. It is important to recognize what may have put newcomers at risk before immigrating to BC. For example, unsafe injections during mass immunization campaigns have been cited as the main reason for transmission of HIV cases in developing countries.

Language is the largest barrier to care faced by HIV-infected persons who don't speak English. Over 50% of children in Vancouver schools come from homes where the mother tongue is not English, and over 100,000 people in the GVRD speak neither English nor French. V/RHB Community Health Services clinics, Bridge Health Clinic (serving refugees and marginalized immigrants), and most hospitals now offer care in most languages either through interpreters or the AT&T language line. Increasingly, physicians in the community who speak languages in addition to English are accepting HIV clients.

The BC Centre for Disease Control, STD Division collaborates with different ethnic communities in getting information out in their first language and, in conjunction with the Vancouver/Richmond Health Board, has published updated educational materials on HIV and other STDs in Vietnamese, Chinese, Spanish, Punjabi, Hindi, and Amharic (Ethiopian). The BCMHSS Women's Project has also translated these materials into Burmese and Khmer (Cambodian).

The street nurse program has outreach workers for STDs/HIV/AIDS who speak Spanish and Burmese. Storefront Orientation Services (SOS) located in the Downtown Eastside also provides outreach to the Spanish speaking refugees and new immigrants for HIV/AIDS services. The Asian Society for the Intervention of AIDS (ASIA) focuses on the East and Southeast Asian communities by providing education, support and advocacy to help address factors that marginalize members of these cultural groups, including HIV phobia, homophobia, racism and sexism.

Some newcomer groups believe that AIDS is a “gay disease.” As a result, many women do not realize that they are at risk when they are in a monogamous heterosexual relationship. They either do not recognize that their male partners may also have sex with men, or they do not realize injection drug use is prevalent in certain sub-cultures within their communities.

Other groups are concerned about intergenerational and intercultural conflict when behavioural norms for Canadian youth are perceived as wrongful by newcomer parents. This can result in overly restrictive and/or abusive parenting that may increase the likelihood of youth leaving home and ending up on the street. There is also concern for gender and power relationships in newcomer communities and the increased risk for transmission of HIV to vulnerable partners in abusive relationships.

Since 1997, peer education/support groups have been held in the first language of women from nine different language groups through the BC Multicultural Health Services Society, Refugee and Immigrant Women’s Health Project for the Prevention of STDs/HIV/AIDS. The curriculum is developed and regularly updated by representatives from each of the nine language groups. By building trust with a small group of women who meet together for eight to ten sessions, there is an opportunity for women to learn about their risks, to find personal solutions within their community, and to learn how to look outside of their cultural group for help when necessary. This program is now in the process of securing funds to develop an STD/HIV/AIDS peer education for the men in these language groups.

An additional barrier to some newcomer populations, specifically refugee claimants and those who have not yet qualified for residence status, is the lack of coverage under the Medical Services Plan. Through collaboration among the BC Centre for Excellence in HIV/AIDS, Oak Tree Clinic, BC Centre for Disease Control, V/RHB clinics, community clinics, AIDS service organizations and other non governmental organizations, there is an attempt to stretch the safety net to its maximum in order to catch those who would otherwise fall between the cracks.

In 1995, the Ministry of Health published a discussion paper on a proposed multicultural health policy framework. The paper identified key obstacles to equitable health status and access to health services in a multicultural society, including:

- Health care providers who may lack knowledge or sensitivity to cultural norms, beliefs, and family and social relationships relevant to the health status of individuals from other cultures
- Under-representation of ethnocultural minorities in professional caregiving roles and in decision-making roles at most levels in the health system
- Language and communication barriers in health care encounters
- Needs of diverse populations that are not being considered in health service planning
- Barriers in the health care system that may block individuals and communities from obtaining adequate health care (initiatives to make services culturally responsive may be minimal and vulnerable to budget constraints; inflexible institutional rules and regulations may unreasonably fail to accommodate cultural differences that affect effectiveness or client-perceived quality of care)

3. Gay Men

The BC Centre for Disease Control's Report shows that young gay and bisexual men continue to seroconvert at alarming rates [see Appendix C].

Homophobia, racism, and other forms of stereotyping and discrimination are factors contributing to gay men's vulnerability to a range of health concerns, including HIV. The impact of growing up gay in a homophobic world may hurt the development of self-acceptance and self-esteem. It may also stand in the way of development of interpersonal skills needed to respond effectively to health concerns.

The Vancouver Lymphadenopathy AIDS Study (VLAS), begun in 1982, represents the largest and longest-running study of 1,000 gay men in Canada. The Vanguard Project began in 1995 as an extension of the VLAS. These studies have examined the relationship between the social determinants of health and HIV risk and disease progress among gay men. Findings of these studies include:

- HIV-positive gay men with incomes less than the poverty level were twice as likely to die within a 10-year period relative to gay men with higher incomes
- Young gay men with less than a high-school education were nearly twice as likely to be risk takers
- Young gay men with a history of sexual abuse were twice as likely to be risk takers

The Vanguard Project, a study of HIV incidence and associated risk factors, looks at the rates at which young gay and bisexual men are becoming infected with HIV. The project examines the factors that might put young gay and bisexual men at risk for HIV, and looks at which sub-populations of the gay community are in need of particular attention. The project has found a strong correlation between early experiences of non-consensual sex and ongoing risk behaviour in adults. The study suggests that traumatic experiences early in life may discourage or prevent gay men from establishing coping skills around sex, work, where they live, and the kinds of social networks they establish. This can be particularly important when it results in difficulty negotiating relationships with partners and friends. A lack of self-acceptance, low self-esteem, and limited social support in the community can increase vulnerability to health concerns such as HIV, STDs, drug and alcohol use, anal health problems and violence in relationships.

Male sex trade workers are especially vulnerable. The Vanguard Project has found that male sex trade workers are vulnerable to HIV infection because of unfavourable living conditions, substance use and sexual risk behaviour. Unstable housing appears to place male sex trade workers at particular risk for HIV infection.

The LGBT Health Association, through the LGBT Health Care Access Project, conducted a community consultation through focus groups with community members. Most participants found local health services to be good. In particular the effectiveness of LGBT clinics at The Centre and at the Downtown Community Health Centre was noted.

However, many gay men reported that they used the health care system with caution. It was perceived that homophobia exists across the system (emergency rooms, specialists and male doctors were mentioned specifically), and this creates difficulties in accessing health care and disclosing sexual orientation, sexual practices and health concerns.

Gay or gay-friendly doctors were found to be important but difficult to find. Youth in particular reported difficulty in finding gay-friendly clinics. Access was also noted as a difficulty by gay First Nations and Latino men and gay men of colour. Gay men who are immigrants or refugees also reported a fear of disclosing sexual orientation.

Gay First Nations men and gay men of colour reported that they separated out their health concerns, bringing general concerns to their family doctor and gay-related health concerns to LGBT-specific clinics.

The groups recommended improving the health system by educating care providers about homophobia, biphobia, HIV/AIDS and racism. They also suggested expanding culturally sensitive, multilingual, LGBT-friendly service in hospitals and health care organizations.

Gay men and men who have sex with men are faced with many important issues with respect to HIV/AIDS. These issues include:

- Coming out
- Self-esteem
- Body image
- Prevalence of drugs and alcohol in the gay community, particularly in social spaces
- Social isolation and lack of support networks
- Internalized homophobia and societal homophobia and heterosexism
- HIV prevention fatigue
- Cumulative grief and loss in the gay community
- Lack of gay role models
- Childhood abuse
- Domestic violence and abuse

Social Environments

1. Legal System

There are many important legal issues that affect people who live with HIV/AIDS. These include:

- Medical and financial decisions in the event of personal incompetency
- Choices in health care interventions
- Confidentiality and disclosure
- Discrimination on the basis of sexual orientation and/or HIV status
- Informed consent (for example, in relation to testing, treatments and participation in clinical trials)

People with HIV/AIDS are encouraged to have certain legal documents in place, including a will, a living will, a power of attorney, a health care directive and, in some cases, a deed of committee.

The availability of accessible and affordable legal services is limited. While legal aid is available to people with low incomes, the eligibility requirements are restrictive. Only those individuals with very low incomes are able to obtain legal aid; for example, for one person the monthly income cut-off is less than \$1000. Furthermore, access to legal aid is becoming even more difficult since the BC government cut \$6 million from the budget of the Legal Services Society in February 1997. For people living with HIV in need of legal advice who do not qualify for legal aid, the options are limited: a private lawyer or a community advocacy organization with limited capacity to deal with legal issues. Private lawyers are expensive, although there are some law firms who tailor their fees to meet the income level of the client.

The 1998 Supreme Court of Canada decision in *R. v. Cuerrier* held that individuals aware of their HIV-positive status may be found guilty of a criminal offence if they do not disclose their HIV status to a partner before having unprotected sex. This decision has created an urgent need for education, both for people living with HIV and also for a myriad of service providers such as health care workers, counsellors and therapists for whom the decision will have repercussions in areas such as confidentiality and duty to warn.

New legislation pertaining to guardianship has been promised for some time and will have an impact on individuals living with HIV/AIDS.

Although not able to offer members legal advice, BCPWA's Individual Advocacy Services Department can offer assistance, including representation, with a wide range of quasi-legal issues, including residential tenancy, BC Benefits, Canada Pension and Canada Disability Pension, Employment Insurance, wills and estates, guardianship and representation, and many others.

Eight percent of CHRP participants received legal assistance from an agency, group, organization or individual at least once in the two weeks prior to being interviewed.

Education regarding legal issues is important and is the responsibility of all agencies serving people with HIV/AIDS. In conjunction with legal issues, many agencies are also in need of expertise and resources to develop policy and ethical guidelines related to many aspects of HIV/AIDS.

2. Correctional System

Although the mandates of the federal and provincial corrections and forensic psychiatric services extend throughout the province, service provision is concentrated in the lower mainland. Corrections and forensic psychiatric services are not physically located in Vancouver (with the exception of the Vancouver Pretrial Services Centre and the Forensic Psychiatric Outpatient Clinic). However, offenders use the HIV/AIDS programs and services provided by Vancouver hospitals (primarily St. Paul's) and community-based agencies such as AIDS Vancouver and BCPWA. Many offenders, especially those who serve short sentences in BC correctional institutions, live in Vancouver prior to and after incarceration and use other services provided by the community, such as income assistance, housing and mental health care. Most of the halfway houses to which inmates from federal institutions in the Fraser Valley are released are in the greater Vancouver area. It is for these reasons that corrections services are included in this strategic plan.

Planning must include provision for the medical and the psychosocial support needs of people in correctional institutions and on supervised community release. Serious efforts to implement effective harm reduction and prevention programs must be increased in an attempt to stem the HIV epidemic. Without an effective and aggressive general plan to standardize and improve all current facets of HIV/AIDS care in all institutions, there will be staggering increases in the number of seropositive inmates living in and being released from prisons.

a. Federal Corrections

The federal system is responsible for offenders serving sentences of two years plus a day. All male offenders reside in federal institutions located in the Fraser Valley, with the exception of one institution near Victoria. Federal female offenders are provided with care and custody through a ministerial agreement with BC Corrections and reside at the British Columbia Correctional Facility for Women in Burnaby.

Voluntary nominal (i.e., not anonymous) testing for HIV is offered to every offender upon intake, at the commencement of the sentence, and again upon transfer to other institutions during incarceration. As well, an inmate can present him or herself at any time during their sentence for testing.

Currently, all offenders are offered care and treatment on a voluntary basis which is in accordance with the BC Centre for Excellence in HIV/AIDS "Therapeutic Guidelines for Care and Treatment". All offenders who are HIV positive are provided with periodic consultant appointments as follow-up for care and treatment, in collaboration with the team of specialists at

St. Paul's Hospital. Psychological support is available in all federal correctional settings on request or by referral from health services staff.

In the Correctional Services of Canada (CSC), the requirements for vitamin and nutritional supplements are reviewed on a case by case basis with the health care team and consultants from St. Paul's Hospital.

Offenders can access treatment and medications through two distribution programs: directly observed therapy or self directed administration. This is negotiated and provided at the choice of the offender.

Each offender is assessed and presented individually to the National Parole Board for possible compassionate release once they have reached the end-stage of HIV/AIDS disease.

CSC reports that harm reduction activities such as bleach and condom distribution, as well as peer counseling and methadone maintenance programs, are fully supported in BC federal correctional facilities. Quarterly routine audits are completed to ensure that adequate supplies of quality products are discreetly available to all offenders at all sites.

b. BC Corrections

All offenders in this system are serving sentences that are two years less a day. Long-term care of seriously ill female prisoners will have to be addressed; otherwise, chronic care needs will be minimal in BC corrections facilities. Those offenders who are incarcerated during the terminal stage of AIDS may be eligible to receive a compassionate discharge and make use of medical facilities in the community. Those offenders who are not discharged and require acute medical care are transported to a local hospital. The HIV/AIDS program at St. Paul's Hospital has treated several provincial inmates in the acute or terminal stages of AIDS.

None of the provincial facilities in BC has an accredited medical facility and it is not part of any plan to create "hospitals" within the BC corrections system. Inmates requiring hospital-type medical care will continue to be referred out to local hospitals. Given the expectation of a dramatic increase in HIV among the inmate population in the coming years, regional health boards in areas where BC corrections facilities exist must be aware that the presence of these facilities in their areas will have an effect on regional hospital resources.

c. Community Corrections

Community assessments are completed on every conditionally released federal and provincial offender. Probation and parole officers assess the available personal and community support and police and community resources. Issues addressed range from housing and substance use to medical needs. If the offender discloses that he/she is HIV-positive, resources such as AIDS Vancouver, BCPWA, and St. Paul's Hospital may be mobilized. However, there is currently no funding for the services provided by community agencies to released offenders in transition between institution and community, and this has been identified as one of the most serious gaps

in service. As well, probation and parole officers and halfway house staff need training and education regarding the resources available to persons with HIV/AIDS.

d. Forensic Psychiatric Services

Inmates requiring psychiatric assessment or mental health services may be placed with Forensic Psychiatric Services. Patients at FPS who become ill with HIV/AIDS-related conditions must be transferred in order to receive acute care.

e. HIV Testing

All correctional facilities routinely offer HIV counselling and testing on a voluntary basis to all offenders upon entry to the system. In federal centres, a confidential nominal testing procedure is offered by health services staff with extensive pre- and post-test counselling. Anonymous testing by outside agencies allows maximum access to testing and is currently being offered on a trial basis in some provincial corrections facilities. In the BC forensic and correctional system, some pre- and post-test counselling is provided by nurses and physicians; however, anecdotal evidence suggests that most patients do not receive adequate pre- and post-test counselling.

f. Nutritional Counselling and Psychological Support

The responsibility for running alcohol and drug counselling programs within provincial correctional facilities lies with BC corrections. Mental health care is supplied to inmates of BC correctional facilities by Forensic Psychiatric Services and locally contracted psychiatrists and psychologists. FPS provides counselling through treatment nurses, physicians and psychologists on staff.

Provincial corrections and the Forensic Psychiatric Institute provide inmates with HIV/AIDS nutritional services and counselling, as well as vitamin and nutritional supplements and extra meal portions when needed. In federal corrections, the requirements for vitamin and nutritional supplements are reviewed on a case by case basis with the health care team.

Psychological support is available in all federal corrections settings on request or by referral from health care services.

g. Community Interfaces

Federal and provincial corrections plan to continue to provide access to community groups in the HIV/AIDS field to visit and provide services to offenders. In provincial institutions, these include BCPWA, clergy, native elders and public health nurses who provide resource information and psychological and emotional support. Educational events sometimes allow offenders to obtain information anonymously. In some institutions, support groups have been established. In federal institutions, public health nurses do not provide services as yet, but if anonymous testing were to be implemented, this would change. AIDS Vancouver and BCPWA's Prison Outreach Project do establish and support peer counselling programs, education fairs,

educational programs and individual support as requested in federal institutions. However, neither federal nor provincial corrections provide funding to these external agencies to cover transportation and other related costs of providing these programs.

h. Community Input

There are already many processes in place in the forensic and correctional system for consumer input; for example, the Patient Concerns Committee at FPS, the Office of the Ombudsman, the BC Council on Human Rights, the BC Civil Liberties Association, the Division of Investigation, Inspection and Standards, citizens' advisory groups in both federal and provincial institutions, the federal investigator, and various inmate committees. There is also communication with families and personal physicians by staff in forensic services and corrections.

i. Education

A health promotion teaching program was developed as a cooperative effort between federal and provincial corrections and Forensic Psychiatric Services. It was intended that all agencies would be using this program. The basics of health and hygiene, including STDs and HIV, were to have been covered in an 18-module format which was designed to reach the particular population in an effective manner. The program was run a couple of times in a few institutions and then never used again. A similarly developed program originated out of the accepted recommendations of the ECAP Report. Through the combined efforts of federal inmates and community AIDS workers and advocates, this program passed the pilot project and was printed and distributed. However, in British Columbia it was deemed by the Directors of Health Care to be insufficient for inmate training. The manual was then cut down and rearranged, and has only been taught in two institutions to two inmate groups.

After diagnosis of HIV infection, education and counselling are offered to each individual patient/offender as part of the treatment program, though there are reports that such service is inconsistent across the system.

4. HEALTH SERVICES

Access to multidisciplinary community and acute health care services has been a cornerstone of Canada's health care system. In the current context of regionalization, many service models are being re-examined to ensure that service is being delivered as effectively and economically as possible. What follows is a general summary of such services for the Vancouver area, moving from community to acute to palliative care.

Community Health Centres, Clinics and Outreach

Since the reorganization of health services in January 1996, a model of community health centres has been introduced by the Vancouver/Richmond Health Board. A community health centre is a user-friendly facility that provides local residents with a range of health services and an overall

approach reflecting the perspective of the public. Programs are integrated whenever possible to simplify their access and use by the community and are delivered by multidisciplinary teams. The rationale behind the implementation of community health centres is to improve access, to integrate service and administration, to reform primary care, to use a population health approach and to involve the consumer and the public.

- **Downtown Community Health Centre**

412 East Cordova

255-3151

Monday to Friday, 8:30 AM to 4:30 PM; no appointments

Primary care, methadone, HIV care, dental care, pharmacy, food store, TB clinic, dietitian, money management and assistance with access to social programs; restricted to individuals residing in the Downtown Eastside or who are homeless; case management and advocacy service is also available one day per week with an AIDS Vancouver staff person

- **Downtown South Community Health Centre**

1065 Seymour Street

659-1144

Tuesday to Friday, noon to 7:30 PM; Saturday, 10:00 AM to 6:00 PM; appointment times available

Primary care, addiction medicine, HIV care, alcohol and addiction counselling, assistance with access to social programs, dietitian, psychiatric services, needle exchange and the Vanguard Project; serves clients residing in the Downtown South, West End, or who are gay, lesbian, bisexual or transgendered, homeless or street kids

- **West Side Community Health Centre**

2110 West 43rd Avenue

261-6366

Primary care; this is a new centre and is currently working on establishing its programs

In addition, there are several clinics in the city that provide services to groups at risk.

- **IDC (The John Ruedy Immunodeficiency Clinic)**

5th Floor, St. Paul's Hospital

Monday to Friday, 8:00 AM to 4:00 PM

Pharmacy counselling, nutritional counselling, social work support, nursing assessment and education, physiotherapy, pentamidine administration and laboratory; team members include medical experts in infectious disease, antiretroviral therapy, family practice medicine, dermatology, oral disease and gastroenterology; connections to off-site ophthalmology, psychiatry, respiratory and neurology services are maintained; IDC plays a leading role in the drug research program, working closely with the BC Centre for Excellence in HIV/AIDS and the Canadian HIV Trials Network; annual visits number more than 17,000

- **Bridge Health Clinic**
3rd Floor, Mount St. Joseph Hospital
3080 Prince Edward Street
877-8550
Monday to Friday, 1:00 PM to 4:00 PM; Wednesday, 1:00 PM to 5:30 PM
Primary care, family planning, HIV care, methadone, well baby services, immunizations and health counselling; free clinic for refugees and new immigrants

- **Vancouver Native Health**
449 East Hastings Street
255-9976
Monday and Tuesday, 10:00 AM to 8:00 PM; Tuesday and Wednesday, 9:30 AM to 8:30 PM;
Friday to Sunday, 9:30 AM to 5:00 PM; no appointments
Primary care, HIV care, methadone, blood testing, etc.

- **Monday Health Project**
1065 Seymour Street
Monday, 1:00 PM to 5:00 PM
Multidisciplinary clinic for LGBT people

1. The AIDS Prevention Street Nurse Program

The goal of the AIDS Prevention Street Nurse Program is to reduce the transmission of STDs and HIV among marginalized persons. The outreach program focuses on HIV/STD education, testing, diagnosis and management. Street nurses also provide support and advocacy, crisis counselling, first aid, harm reduction education, counselling and support, and medical and social service referrals.

The program currently has two storefront clinics. The Main Street Clinic serves a target group made up mostly of street-involved persons, at risk through injection drug use and sex trade work. The Bute Street Clinic serves gay, lesbian, bisexual and transgendered populations. Sessional physicians provide part-time services at the two storefront clinics.

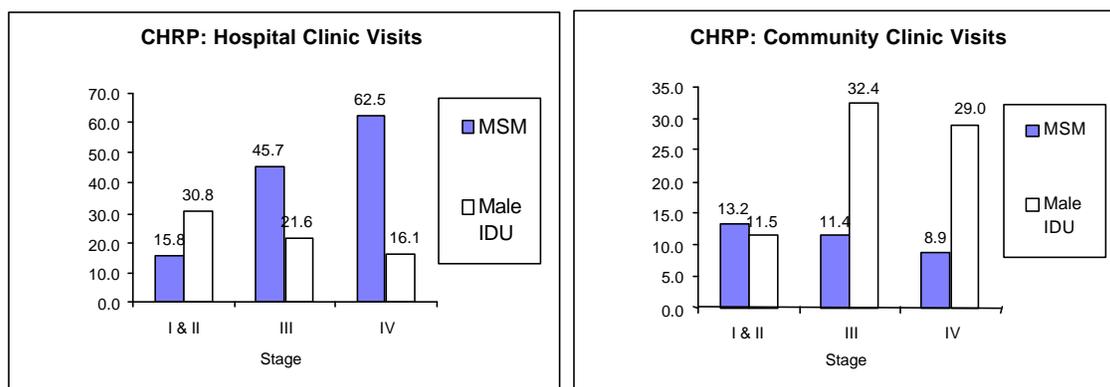
Street nurses, in partnership with several agencies, provide education and clinic services to street-involved youth and adults at a variety of outreach sites, including jails, detox centres, hotels, residences, drop-ins, community agencies and on the street.

The total number of client contacts in 1998 was 48,484.

- **Main Street Clinic**
219 Main Street
660-9695
Monday to Friday, 10:00 AM to 6:00 PM
 - **Jails and Detox Centres**
660-9569
Monday to Thursday, 7:00 AM to 6:00 PM
 - **Seymour Youth Outreach**
660-6776
Monday to Thursday, noon to 10:00 PM
- **Bute Street Clinic**
1170 Bute Street
660-7949
Monday to Friday, noon to 7:00 PM
 - **Mobile Outreach**
660-9695
Monday to Friday, 5:00 PM to 10:00 PM
 - **Downtown Eastside Street Outreach**
Monday to Saturday, 10:00 AM to 5:00 PM

2. CHRP Findings on Clinic Use

The following charts show CHRP’s findings on the use of hospital and community-based health clinics. The two categories compared are MSM and male IDUs. Similar data for female IDUs will be reported in the near future for the entire CHRP sample.



For both tables above the numbers of participants are as follows:

Stage \ Group	I & II	III	IV
MSM	n=38	n=35	n=56
Male IDU	n=26	n=37	n=31

As HIV progresses, the percentage of MSM who report a visit to a hospital clinic increases while visits to community clinics decrease. The opposite happens for male IDUs; there is an increase in community clinic visits in Stages III and IV, with a corresponding decrease in hospital clinic visits.

Community Case Management

Community-based organizations recognize there is a pressing need to develop better systems for case management in partnership with clients, the professional community and government. Integrated case management focuses on the management of clients' needs across provider and agency lines to link clients to the appropriate level of resources. Case management is a partnership between the manager and the client; it entails the continual assessment and follow up of the client's needs. Case management is particularly important for clients who have multiple problems, such as HIV/AIDS and substance abuse or psychiatric illness, because they need to have access to many organizations and resources.

Case management service is currently available through AIDS Vancouver's support service department, the Vancouver/Richmond Health Board (particularly for those requiring home care and allied support, with some clinic staff), the Vancouver Native Health Society, DAMS, and Greater Vancouver Mental Health Services, including Strathcona Mental Health's HIV Team and the Assertive Care Team.

Physician Services

Access to physician services is essential for the management and prevention of HIV infection. Through early identification of HIV infection and treatment with appropriate medications, viral loads can be reduced to undetectable levels with subsequent enhanced health for the individual and decreased risk of transmission to others. For individuals with AIDS-defining illnesses, access to physician care is often complex, especially when AIDS affects more than one system and various specialists are required. Access to palliative care is equally important for AIDS patients with end-stage disease. In addition to treatment of HIV/AIDS, access to physician services for addictions, including methadone treatment, forms part of the spectrum of harm reduction services aimed at decreasing the spread of HIV and the harm of addiction to the individual.

In Vancouver, the most common barriers to accessing physician care include but are not limited to poverty (including lack of transportation and telephones), social isolation, language and cultural barriers. Homophobia and heterosexism within the health care system present additional barriers, on both an individual care provider level and on a more systemic level. Limited availability of physicians providing HIV/AIDS-specific services and methadone treatment further compromises access; for someone requiring specialist care for the medical complications of HIV, several different physicians may be involved in the person's care. It is difficult for even the most sophisticated consumers of health care to negotiate their way through the maze of private fee-for-service offices, public clinics and hospitals. This complex arrangement of physician services is particularly challenging for anyone unfamiliar with the health care system; access to care is even more compromised when any of the other barriers mentioned above co-exist with confusion about how to move through the system.

Community clinics are attempting to overcome the barriers to accessing physician care through promoting the one-stop-shop model of care, where harm reduction modalities and other prevention services are made available at one site along with physician care. In the community clinic setting, payment of physicians through salary or sessions eliminates the barrier of fee-for-service; clients have the additional benefit of a multidisciplinary team approach to their care. Counsellors with cultural competence can be of great assistance to physicians in helping the clients to understand and accept the treatment regimens and life-style choices that will optimize their health and reduce the risk of transmission of HIV to others. It is also easier to provide interpretation in a variety of languages in a clinic setting than in a private office, thus addressing the barrier of language. By being situated in their own neighborhood, populations served by a community clinic can much more readily access the physician services they need for prevention and treatment of HIV. Neighbourhoods with the highest concentration of disadvantaged populations living in poverty and social or cultural isolation are natural settings to build upon the community clinic model and so benefit those people with HIV who face the most barriers to physician care.

1. Access to Primary Care Physicians

Private practitioners

- The College of Physicians and Surgeons of BC provides three references by geographic area, gender and language
- The BCCDC lists physicians by language who accept HIV/AIDS patients

Hospital-based clinics

- Oak Tree Clinic
- St. Paul's Hospital IDC

Community-based clinics (see above)

2. Services Provided by Primary Care Physicians

General medical care

- Regular check-ups
- Blood work
- Medications
- Completing forms for disability benefits, EI medical benefits, MHR, etc.
- Referral for outpatient specialist care (8% of CHRP participants visited a specialist at least once in the two weeks prior to being interviewed)
- Admission to hospital for inpatient care

Inpatient care (primary care physician or admitting physician)

Emergency care

3. Cost of Care

Permanent residents of BC with PHN and valid Medical Services Plan

- Qualify for medical services plan after three months in BC
- Qualify for hospital care without charge
- Basic medical services plan covers:
 - Full cost of care by medical doctors
 - Physiotherapist, registered massage therapist, chiropractor, naturopath (12 visits per year; there is a user fee of \$10 per visit; if the practitioner is not working under the medical plan, then the client must pay the full cost of the visit and will only be reimbursed a portion by MSP)
 - Optometrist (once every two years)

Visitors, tourists, non-residents

- Will be charged for physician and hospital services
- Health insurance for travellers may have restrictions such as no coverage for pre-existing conditions
- Hospitals vary in their daily charge for non-residents

Refugee claimants

- May qualify for some physician and hospital services, including laboratory testing and medications, through Interim Federal Health (IFH)
- Immigration officer at port of entry or at interview when claim is made will determine eligibility for IFH
- Restrictions apply to those eligible for IFH, and prior approval must be sought for medications not on the BC Pharmacare formulary and for tests and care not considered emergency or essential as per IFH guidelines

Community Clinics

- Costs associated with primary care at most community clinics are absorbed by block funding and salaried or sessional physicians
- Hospital care and many of the tests and medications required for HIV/AIDS care are commonly not provided by community clinics

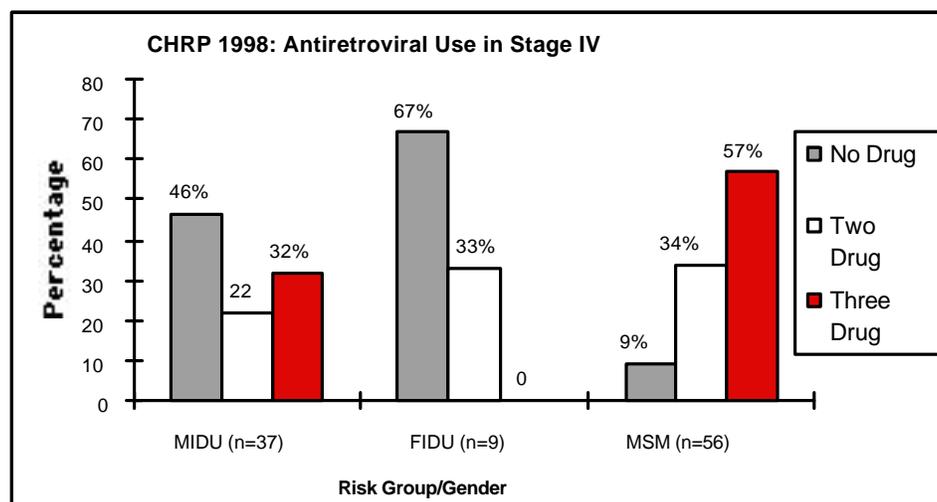
Medications, Including Antiretroviral Therapies

1. CHRP Findings on Antiretroviral Use

The graph below shows some of CHRP's preliminary findings on antiretroviral use, broken down into gender and transmission groups. It shows what percentage of each group (in stage IV) are using antiretrovirals. Approximately 9% of MSM are not taking any antiretrovirals,

compared to 46% of male IDUs and 67% of female IDUs. Sixty-seven percent of MSM are taking a three drug combination, while 32% of male IDUs are taking three drugs. No female IDUs in stage IV are taking three drug therapy, though the number in the sample (nine) is very small.

The numbers of each group are small because, at this time, CHRP has not been able to stage everyone in the study. Staging of participants is done by using CD4 count and some clinical diagnoses. Some participants don't know or can't remember their CD4 count while others may decline to provide this information. The group of people who do not know their CD4 count is potentially very interesting. Are these people being tested and choosing not to find out the results? Are they possibly forgetting the results, or are they people who have decided not to get regular testing or who are having difficulties accessing testing?



It is critical that caregiving systems are examined closely to develop a better understanding of why male and female injection drug users are not accessing antiretroviral medications. It is vital that new treatment systems that are developed which improve realistic access to antiretrovirals for this group.

Methadone Program

Methadone is used in Canada for the treatment of opiate users. It is a long-acting, synthetic opiate agonist with good oral efficacy. Oral methadone has proven to be effective in suppressing opiate withdrawal following cessation of drug consumption. Methadone is also prescribed daily, over months or years, to some people, with the expectation of reducing opiate use and associated harm. This is termed "methadone maintenance treatment" within the medical community.

By 1994, more than half of all methadone patients in Canada were located in British Columbia, the majority in the Vancouver area.

While methadone is not the solution to the growing epidemics among mixed injection drug users in Vancouver (those using heroin in conjunction with other substances), there is strong evidence that methadone programs can assist many heroin users in reducing their injection use.

In British Columbia, methadone can only be prescribed by physicians who are specifically licensed to do so through the BC College of Physicians and Surgeons, and the number of patients for whom a licensed physician may prescribe methadone is restricted.

Until recently, access to methadone has been extremely limited, particularly in the Downtown Eastside, where until mid-1996 there was only one methadone-licensed local physician. By 1997, some clinic physicians had obtained methadone licenses and the number of methadone spaces in the Downtown Eastside had increased to about 150. While the Ministry of Health, in conjunction with the BC College of Physicians and Surgeons, has increased the number of physicians authorized to prescribe methadone, more action is still needed in this area.

For offenders in provincial and federal correctional facilities in British Columbia, there is access to a methadone maintenance intervention and treatment program. This program encourages the offenders to participate in substance abuse counseling and provides extensive support. Once the offenders are released into the community, the correctional staff liaise with the community support network established by the BC College of Physicians and Surgeons.

The relative absence of local community services to support addicted people has contributed to some reluctance among agencies and residents to support expanded methadone availability, particularly in the Downtown Eastside. Residents and users have also expressed concerns about diversion of methadone to the streets and the pharmacological effects of methadone itself. Many have pointed out that methadone is not tolerated or suited for all, which is one reason why it can't be the only solution.

Canada's National Action Plan on HIV, AIDS and Injection Drug Use calls for improving access to methadone treatment by:

- Changing legislation and regulations to allow physicians to prescribe methadone like any other drug, making methadone more accessible
- Making appropriate training available to physicians to encourage their involvement in providing methadone treatment to injection drug users
- Reducing and eliminating other barriers to being on methadone, and basing decisions regarding methadone-carrying privileges on reliable and responsible behaviour of the individual
- Creating a central coordinating agency to link users and doctors at the local level, so that users know how to access methadone services
- Communicating the results of research on the effects of methadone on pregnancy and breastfeeding to practitioners and the general public, especially women
- Investigating other alternative drug therapies beyond methadone, such as buprenorphine, naltrexone and levo-alphaacetylmethadol (LAAM)

In Vancouver, there is a need to:

- Provide coordinated, quality-controlled methadone programming with evaluation and accountability in the Downtown Eastside and throughout the Vancouver area
- Expand the capacity of the Vancouver downtown methadone system to serve opiate-addicted people
- Provide methadone programming within settings that also offer an array of basic, lifeskills, recreational and medial supports

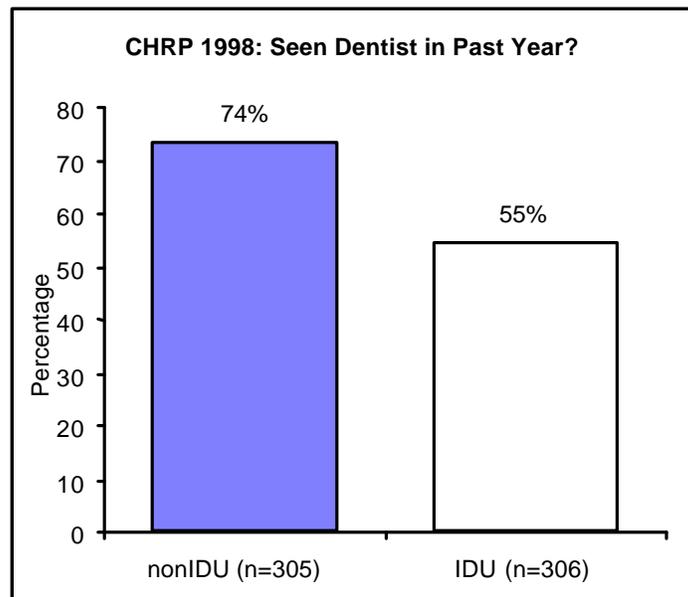
Dental Care

Good preventative dental care is an important part of a complete health program for people living with HIV/AIDS. However, given the fact that dental care is not well integrated into our overall health care system, cost barriers can be large and at times insurmountable for persons living on low incomes. Dental care in the Vancouver area is largely available through dentists in private practice. People living with HIV/AIDS, who are either employed or living on a private disability plan, may have the costs of such services covered through a dental plan. Those without access to such a plan must pay the full cost of dental care. Persons receiving income assistance are eligible for emergency dental service.

1. Services Available

- Individuals receiving benefits from the Ministry of Human Resources are eligible for some dental coverage, generally emergency only
- There is a dental clinic available through the Downtown Community Health Centre for Downtown Eastside area residents only
- IDC, an outpatient clinic at St. Paul's Hospital, provides preventive and ongoing dental care
- Some clients without the ability to pay the cost of dental care are able to access dental services through the University of British Columbia School of Dentistry clinic, which functions as part of the teaching program
- There is a high risk dental clinic at Vancouver General Hospital

2. CHRP Findings on Dental Care



The above graph shows a statistically significant difference ($p < 0.001$) between IDUs and non-IDUs who accessed dental care in the past year. CHRP data show that 45% of IDUs have not accessed dental care in at least one year.

Acute Care Services

1. St. Paul's Hospital

St. Paul's Hospital has played a major role in the provision of care to individuals with HIV/AIDS since the early 1980s. In February 1997, an 18-bed HIV/AIDS ward was opened and staffed by a designated multidisciplinary team of physicians (an internal medicine specialist and two clinical associates), nurses, pharmacists, a clinical nurse specialist, a dietitian and social workers. There are four social workers: one assigned to the HIV/AIDS ward, another who sees off-service patients and two aboriginal social workers who work half-time in the hospital and half-time in the community following aboriginal clients. The average daily inpatient census is 30. Patients who are not admitted to the HIV/AIDS unit are cared for on other units in the hospital (e.g., palliative care, medical units).

Increasing numbers of injection drug users are being admitted to the hospital. In 1994 there were an average of 43 IDU discharges per month and in the fiscal year 1997-98 an average of 92 IDU discharges per month. Data from the last fiscal year indicate 46% of these IDU patients are HIV-positive and approximately half of all IDUs are admitted for problems directly related to the use of injection drugs (e.g., abscesses, sepsis, endocarditis, etc.). The IDU Consult Team, consisting of an addiction physician and the clinical nurse specialist for HIV/AIDS, receives medical

referrals regarding hospital management of care (i.e., drug withdrawal, pain control, HIV prevention, education and support) and discharge planning.

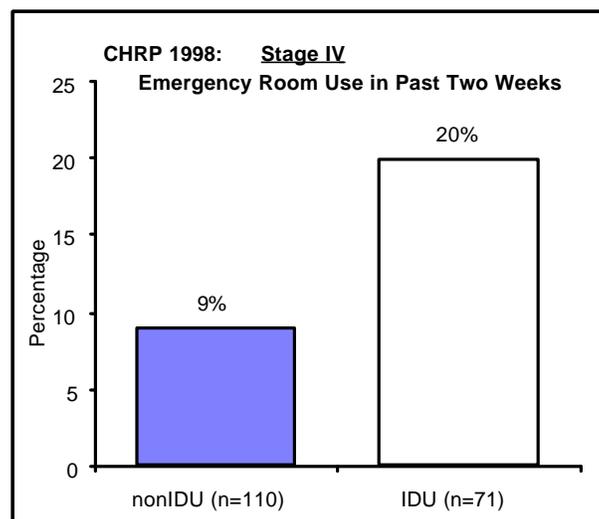
The AIDS Care Team is a multidisciplinary team with representatives from the hospital and the community. The team reviews current inpatients, discharges and deaths on a weekly basis with the goal of improving the continuity and coordination of care. In addition to patient care, research on new therapies is conducted through St. Paul's in conjunction with the Canadian HIV Trials Network and the BC Centre for Excellence in HIV/AIDS.

2. Vancouver General Hospital

Vancouver General Hospital has an HIV/AIDS clinical care team that is composed of one social worker and four doctors working rotating shifts to ensure that Monday to Friday there is always an on-call HIV/AIDS specialist. The team is involved in consultations, assessments, interventions and treatment with each patient who is referred to them. Referrals come from social workers, physicians and other health care workers, both inside the hospital and from the community. This previously informal information exchange between hospital and community has been formalized in weekly community meetings that facilitate the timely exchange of information between hospital-based and community-based service providers.

Given the large number of injection drug users who are seen by the HIV/AIDS clinical care team at the Vancouver General Hospital (currently estimated at 85% to 90% of all referrals), the clinical care team works closely with the Chemical Dependency Resource Team (CDRT). Working in close collaboration with CDRT enables the HIV/AIDS team to provide appropriate in-hospital care and community referrals for both patients' HIV/AIDS status and their substance abuse. In addition to the direct medical care provided by the hospital, patients and their families have access to counseling, education and social work services to ensure awareness of appropriate community resources and discharge planning options.

3. CHRP Findings on Emergency Room Use



The above graph shows a statistically significant difference ($p=0.040$) between IDUs in Stage IV and non-IDUs in Stage IV who access emergency room services. CHRP asked, “In the past two weeks, did you go to a hospital emergency room for medical care?” Nine percent of non-IDUs answered yes, compared to 20% of IDUs.

Thirteen percent of CHRP participants visited an emergency room at least once in the two weeks prior to being interviewed. Seven percent of CHRP participants were patients in a hospital for at least one night in the two weeks prior to the interview.

Home-Based Care

All the services of home-based care uphold the individuals’ dignity and the right to remain at home as long as possible with full participation in their own care. Waiting lists continue to grow and organizations struggle to serve as many people as possible with limited resources. The epidemic curve currently allows agencies to serve only those most in need, often because of poverty and other social issues, with the result that those living with HIV/AIDS who are less ill cannot access any but the most rudimentary services and support. The implication for the next wave of very ill people, both after lengthy infection periods and failure of antiretroviral therapy, is that these services are going to be flooded with eligible applicants who cannot be served.

1. Continuing Care

The Vancouver/Richmond Health Board is responsible for a range of home-based care and support. Case managers determine the level of home support required for those who are ill at home and unable to care for themselves adequately. Reassessments are conducted when the level of need changes. Home supports services can include basic care, housecleaning, laundry and other assistance with daily living tasks. Increased pressure has been placed on the home care system as patients are discharged earlier from acute care, but funding has not kept pace with needs.

Home care nursing support is available from local health units. Earlier in the epidemic, the Burrard Unit developed great expertise in providing home care nursing support for those living with HIV/AIDS. More recently, North Unit nurses have been carrying an increasing proportion of the HIV/AIDS case load. Current issues include people living with HIV in single room occupancy hotels and other sub-standard or unstable housing situations which make it difficult to provide effective home care nursing.

Home care nurses are able to assist with medication management, wound care and dressings, etc.

2. Other Care at Home

Care and visit teams, such as those provided by AIDS Vancouver, Healing Our Spirit and Friends for Life, are composed of volunteers and may supplement services already going into the home. They offer quality, reliable support that includes companionship, practical assistance and personal care but does not replace the role of professional homemakers. They also make referrals and act as liaison with various other support programs.

Thirteen percent of CHRP participants received help at home from an agency, group, organization or individual at least once in the two weeks prior to being interviewed. This help could be for medical problems, personal care, housework or other needed services.

3. Day Programs

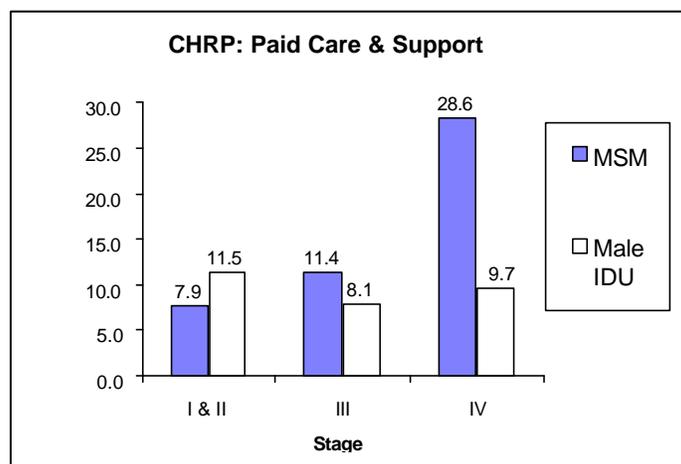
The Dr. Peter Centre Day Program provides a unique health care service to individuals living with HIV/AIDS who face life threatening health deterioration. The focus is on fostering the participants' abilities to manage their own care to the greatest extent possible. Programs and services include hot meals, nursing support and health education, individual and group therapy, nutrition consultation and education, recreation and exercise, socialization, complementary therapies, primary worker support and individual care plans, transportation assistance and respite and support for partners, family members and friends.

The Vancouver Native Health Society operates a storefront drop-in program which offers a range of support services, including food programs, nursing support and physician care, medication management, outreach to single room occupancy hotels and other residences in the Downtown Eastside neighborhood, and a range of support groups and other services. The focus includes reaching out to marginalized, often multiply diagnosed Downtown Eastside residents who otherwise may face difficulties in accessing the level of care and support they require.

Friends for Life, established in 1983, provides more than 50 health and wellness programs without charge to its members. The goal of all programs is to help members cope with the anxiety and stress of living with a life threatening illness while improving their overall quality of life. Among the programs available are support groups, one-on-one counseling, a resource library, workshops on a wide variety of topics, massage therapies, social support and meals.

4. CHRP Findings on Home Care Use

The following graph shows the percentage of respondents who said they had received paid care and support at home in the previous two weeks. Specific types of care include nursing, cleaning and laundry and homemaker services.



For the above table, numbers of participants are as follows:

Group \ Stage	I & II	III	IV
MSM	n=38	n=35	n=56
Male IDU	n=26	n=37	n=31

The number of persons receiving paid care and support at home in stage IV is much higher for MSM than for male IDUs. This might be directly tied to housing issues. It may be much more difficult to access home care and support if you live in a non-stable housing environment. More IDUs than MSM live in what might be considered non-stable housing.

5. Residential Care

Residential care and hospice service for persons living with HIV/AIDS in Vancouver is currently offered through May's Place, St. James Community Services Society, and by the Dr. Peter Centre Residence. In addition, referrals are sometimes made to long-term care facilities for individuals living with HIV who require 24-hour care and support. Education programs for staff in these facilities have been designed by the Department of Education and Health Care Evaluation, BC Centre for Excellence in HIV/AIDS, in order to assist facility staff with skills needed to provide effective and safe care.

However, a significant number of people living with HIV/AIDS have been kept in acute care facilities considerably longer than strictly required while awaiting placement in appropriate long-term care facilities.

Three percent of CHRP participants were patients in a residential care facility, nursing home or hospice for at least one night in the two weeks prior to being interviewed.

Medical Equipment

Medical equipment such as wheelchairs, bath benches and electric scooters are available to persons on BC Benefits who are able to establish medical need for such equipment. Additional assistance in this area is available from occupational therapists who work out of local health units. Those on private disability plans may be able to recover part of the costs associated with such equipment.

For those who are ineligible under the above programs, there are a number of community agencies who provide loans of medical equipment. The Red Cross has a large medical equipment bank, as does AIDS Vancouver's medical equipment loan program.

Five percent of CHRP participants had to buy, rent or replace special medical equipment, such as eyeglasses, canes or nebulizers, in the two weeks prior to being interviewed.

Food and Nutrition Programs

Dr. Michael O'Shaughnessy, Centre Director for the BC Centre of Excellence in HIV/AIDS, has predicted that malnutrition and wasting will become the leading causes of death in the current AIDS population in British Columbia (April, 1999).

Opportunistic infections associated with HIV/AIDS often render a person unable to shop for, prepare or eat wholesome meals. The requirements of highly active antiretroviral therapy, poverty, limited facilities and the personal skill level of many HIV-positive individuals further complicate people's abilities to meet their nutritional needs. The consequence is weight loss and increased risk of compromise to the immune system.

Maintaining healthy nutrition levels, therefore, is vital to the health and well-being of people living with HIV/AIDS. Many agencies and departments of health are now providing more than basic food services. People living with HIV/AIDS can obtain nutritional counseling through their physicians and various clinics or agencies on an outreach basis.

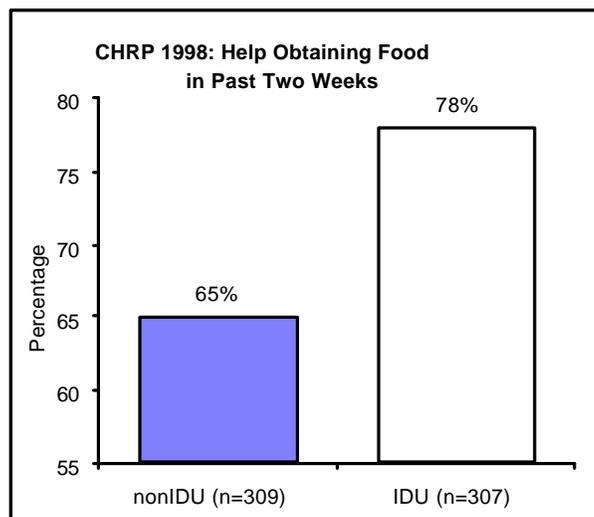
Several agencies provide free or low-cost meals to people living in poverty, although few have the capacity to provide more than very basic meals. Most of the agencies are just beginning to look at the unique requirements of the HIV/AIDS population. For example, the special diets required by people living with HIV/AIDS because of the disease and/or medication are beyond the scope of most agencies given their limited resources. Similarly, line ups and the lack of home delivery can preclude some people in the end stages of the disease from accessing service.

One agency, A Loving Spoonful, delivers a week's supply of free, nutritious, frozen meals, fresh fruit and bread to people living with HIV/AIDS who have been referred by their physician. Eligibility for service is based on a medical assessment. Loans of microwave ovens and small refrigerators can also be arranged. The current program does not provide the full, recommended daily allowance of nutrients, although recipes are tailored for HIV disease and HAART issues.

Another organization, Food for Thought, provides nutritious meals and an opportunity for social support to persons living with HIV/AIDS in the Downtown Eastside neighbourhood.

Grocery programs, which supplement the food and personal hygiene items that individuals on limited incomes are able to purchase, are a necessity for many people living with HIV/AIDS. For example, in 1998 more than 700 people living with HIV/AIDS used either the AIDS Grocery or Vancouver Native Health Food Bank each week.

1. CHRP Findings on Food Program Use



The above chart refers to participants who said they had received help obtaining food in the previous two weeks. These food services may include meals served away from home, prepared meals delivered to the home, or groceries (for example, from a food bank). As the chart shows, there is a statistically significant difference ($p < 0.001$) between IDUs and non-IDUs who use food services. On average, over 71% of CHRP participants receive help in obtaining food.

Palliative Care

Palliative care, as a philosophy of care, is the combination of active and compassionate therapies intended to comfort and support individuals and families who are living with a life-threatening illness. Palliative care strives to meet physical, psychological, social and spiritual expectations and needs, while remaining sensitive to personal, cultural and religious values, beliefs and practices.

Palliative care is planned and delivered through the collaborative efforts of an interdisciplinary team including the individual, their family of choice, caregivers, and service providers. Palliative care is provided in the home, in free-standing hospices, in hospitals with or without a designated palliative care unit, and in long-term care facilities.

Respite care offers short-term elective admissions to facilities with designated respite beds. The benefits are two fold: the family and caregivers are given a rest from caregiving and the client's symptom management and care needs can be reviewed by the palliative care team. Planned respite admissions allow clients to remain at home with greater support.

Palliative care services are available in the community through home nursing care and consultation with the Vancouver Home Hospice Program. Palliative care physicians are on-call 24 hours a day. St. Paul's Hospital and Vancouver Hospital have designated palliative care units. These units serve as the tertiary care areas for palliative care. In other words, there are those situations that cannot be adequately managed in a home or home-like environment and admission to a special unit is required. St. James Community Services provides palliative services through May's Place on Powell Street. May's provides a place of comfort, physical and spiritual, for many residents of the Downtown Eastside. Cottage Hospice is scheduled to open early in 1999. The Dr. Peter Foundation opened its Day Centre in 1997 followed by the Residence in 1998. Both programs are in St. Paul's Hospital Comox building until a permanent site is constructed. Although not called a hospice, the residents of the Dr. Peter Residence do receive palliative care services as needed. Additional professional nursing care is provided through the Health Board's community program and the Vancouver Home Hospice physicians make home visits.

Additional knowledge and skills are needed by caregivers in HIV palliative care to understand and meet the needs of the growing numbers of injection drug users who are dying in the city. Health Canada is sponsoring a pilot project to address these issues. Local organizations need to support these endeavours by collaborating in the project.

Although palliative care has been located in long-term care facilities, this concept is not universal for the elderly. Persons living and dying with AIDS who have needed placement prior to their imminent death have not been accepted into traditional continuing care intermediate or long-term facilities. The reasons for this are vague, oblique and biased. This is one area that the community needs to re-examine, particularly because HIV disease is a more chronic condition now than it was fifteen years ago.

Caregivers are not well prepared to deliver palliative care in the prison systems. Again, the reasons for this are unclear and need to be openly addressed.

Problems still faced by clients who wish to remain at home are:

- Having to pay for drugs that are received free in hospital
- Having to pay for dressings and other supplies that are supplied free in hospital
- Having to go into hospital because of insufficient nursing and ancillary supports after hours and on weekends
- Lack of compensation for family or friends who provide core care at home who have to leave employment
- Lack of coordination between hospitals, family physicians and care providers
- Substandard care for people living in SROs

The Vancouver/Richmond Palliative Care Coordinating Group is meeting with the Vancouver/Richmond Health Board to develop a regional plan for palliative care. The BC Hospice Palliative Care Association is a partner in an HIV/IDU palliative care project.

Mental Health Services

Psychiatric complications may develop as a result of HIV/AIDS or mental illness may be present prior to the person contracting HIV. There are also a number of people who have multiple diagnoses including psychiatric illness. The psychiatric complications of HIV disease include depression, adjustment disorders, anxiety or panic disorders, delirium, mania, psychosis and organic brain disease or dementia. These conditions are common, particularly with HIV disease progression, but are treatable. The causes of these psychiatric symptoms include medication side effects, HIV-related central nervous system disease, the cumulative effect of multiple stressors and losses, characterological or genetic predisposition of the person and substance abuse.

There is increasing evidence that people with serious mental illness living in large urban centres represent a group vulnerable to contracting HIV. The reasons for this are multifaceted and relate to the nature of mental illness. They include cognitive deficits and psychopathology, ambivalence, discomfort in traditional health care settings, vulnerability to sexual victimization and self-medication with drugs and alcohol. Clients with chronic mental illness need special education, such as harm reduction and follow-up (often outreach) services. Historically, clinic-based mental health services have been under-utilized by this population

At present, there are insufficient psychiatric services for people with HIV/AIDS and serious mental illness in Vancouver, although there are some specialized services in the Downtown Eastside. Mental health services are offered through Greater Vancouver Mental Health Community Teams and various specialized programs. Assessment services are available through Psychiatric Assessment Unit at Vancouver General Hospital and emergency departments at acute care facilities.

Currently, the HIV/AIDS Psychiatry Outpatient Program at St. Paul's Hospital attempts to meet needs for assessment (including neuropsychiatric), short-term intervention and ongoing treatment for individuals with mental health complications arising from HIV. However, because of limited staffing and resources, it is not capable of providing a higher volume of patient services, as requested by the community.

There are limited resources for people with less severe mental health difficulties or those requiring individualized support from a private psychiatrist. There are insufficient psychiatric services for people with HIV/AIDS and serious mental illness or less severe mental health difficulties. Services between provider agencies are poorly coordinated and waiting lists are often long. The lack of appropriate and coordinated service delivery between agencies and organizations has the biggest impact on those clients with multiple diagnoses.

1. Multiple Diagnoses

Clients with multiple diagnoses include those who have a psychiatric disability, chemical dependency, HIV/AIDS and/or other conditions. These clients may not adhere to treatment regimens or use traditional medical or psychiatric services that exists for people with HIV/AIDS.

The Strathcona Mental Health Team now has two psychiatric HIV/AIDS-specialized outreach workers and there has been approval for some psychiatric sessionals to work with this program. As well, the Assertive Community Team program at GVMHS is able to provide some services to people with multiple diagnoses including HIV/AIDS.

The inter-agency Vancouver Multiple Diagnosis Committee has identified the following gaps in services that also need to be addressed:

- Supported housing options throughout the Vancouver area
- Better access to detoxification programs and facilities
- Recovery houses and treatment centres that welcome women and their children
- Grief and loss counselling
- Women's health centres with on-site child care
- Alternative treatments and therapies
- Education of mental health professional about HIV/AIDS and its relationship to psychiatric illness, multiple diagnoses and treatment
- Support for GVMHS efforts to develop educational strategies for case managers and physicians

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V. APPENDICES

A. STRATEGIC PLAN AT A GLANCE

VISION

To reduce population vulnerability to HIV infection and improve the health of people infected and affected by HIV and AIDS

MISSION

To maximize information sharing, collaboration, planning and action by organizations that have the potential to reduce the vulnerability of the general population and of particular population groups in Vancouver to HIV infection, and to improve the health status of those populations infected and affected by HIV and AIDS.

In order to accomplish its mission, the committee will:

- Foster an inter-agency environment that supports the exchange of diverse opinion
- Identify current and emerging issues in HIV/AIDS epidemiology, research, education, prevention and care, treatment and support
- Develop collaborative, multi-sectoral approaches to addressing these issues
- Strengthen the capacity of the overall community and responsible authorities to respond to the changing nature of the HIV epidemic
- Create a strategic plan every four years with the involvement of the larger community of HIV/AIDS service organizations to co-ordinate the efforts of committee members
- Strengthen the capacity of member agencies to implement the strategic plan and to use the plan as a framework to guide their own strategic and annual service planning
- Implement the strategic plan and monitor its progress on an ongoing basis
- Recommend action to be taken by the committee, member agencies, HIV/AIDS service organizations, key decision makers and the overall community

VALUES

- Inclusion
- Contribution
- Co-operation

DETERMINANTS OF HEALTH

- Living and Working Conditions
- Individual Capacities and Skills
- Social Environments
- Health Services

STRATEGIC GOALS, OBJECTIVES, OUTCOMES and PRIORITY STRATEGIES

STRATEGIC GOALS	STRATEGIC OBJECTIVES	POPULATION HEALTH OUTCOMES	PRIORITY STRATEGIES
<p>1.To promote living and working conditions that maximize the health and well-being of people infected and affected by and vulnerable to HIV/AIDS</p>	<p>1.1 To support actions that provide an adequate income for people infected and affected by and vulnerable to HIV/AIDS</p> <p>1.2 To support actions that improve the social support networks of people infected and affected by and vulnerable to HIV/AIDS</p> <p>1.3 To support actions that provide educational opportunities for people infected and affected by and vulnerable to HIV/AIDS</p> <p>1.4 To support actions that address the unemployment, underemployment and working conditions of people infected and affected by and vulnerable to HIV/AIDS</p> <p>1.5 To support actions that address negative factors in the natural and human-built environment of people infected and affected by and vulnerable to HIV/AIDS</p>	<ul style="list-style-type: none"> • Increased levels of income assistance for people infected and affected by and vulnerable to HIV/AIDS • Increased participation in healthy social support networks by people infected and affected by and vulnerable to HIV/AIDS • Increased access to educational opportunities for people infected and affected by and vulnerable to HIV/AIDS • Increased access to training/re-training for people infected and affected by and vulnerable to HIV/AIDS • Increased rate of entry/re-entry to workplace for people infected and affected by and vulnerable to HIV/AIDS • Increased safety, security and fairness in the workplace for people infected and affected by and vulnerable to HIV/AIDS • Increased availability of affordable and appropriate housing for people infected and affected by and vulnerable to HIV/AIDS • Increased housing security for people infected and affected by and vulnerable to HIV/AIDS 	<ul style="list-style-type: none"> • Take actions to ensure income support measures better meet actual living costs in Vancouver • Work with government partners to ensure Schedule C responds to the changing needs of people infected and affected by HIV/AIDS and target populations • Take actions to create opportunities and safe spaces for healthy social participation for people infected and affected by HIV/AIDS and target populations • Take actions to ensure the education system safely accommodates gay, lesbian, bisexual, transgendered and Two-spirit youth • Take actions to improve income security during transition to and from work for people infected and affected by HIV/AIDS • Take actions to increase the availability and accessibility of safe, affordable and appropriate housing for people infected and affected by HIV/AIDS and target populations • Take actions to improve housing options for Aboriginal peoples infected and affected by and vulnerable to HIV/AIDS • Take actions to increase the availability, accessibility and appropriateness of long term care facilities for people infected and affected by HIV/AIDS

STRATEGIC GOALS	STRATEGIC OBJECTIVES	POPULATION HEALTH OUTCOMES	PRIORITY STRATEGIES
<p>2. To enhance individual capacities and skills that maximize the health and well-being of people infected and affected by and vulnerable to HIV/AIDS</p>	<p>2.1 To support actions that enhance the emotional, mental, spiritual and physical capacity of people infected and affected by and vulnerable to HIV/AIDS</p> <p>2.2 To support actions that strengthen healthy coping skills and health practices for people infected and affected by and vulnerable to HIV/AIDS</p> <p>2.3 To support actions that enable the healthy development of children and youth infected and affected by and vulnerable to HIV/AIDS</p> <p>2.4 To support actions that take into account the underlying biology or genetic pre-dispositions of people infected and affected by and vulnerable to HIV/AIDS</p>	<ul style="list-style-type: none"> • Increased knowledge of how to maximize health status while HIV positive • Increased life expectancy and quality of life of people living with HIV/AIDS • Increased knowledge of the health risks and impacts of HIV/AIDS among the general population and target populations • Decreased rate of HIV infection among the general population and target populations • Increased sensitivity of HIV/AIDS service system to the needs of people whose inherent biology or genetic composition makes them vulnerable to HIV infection • Increased access to services by people infected and affected by and vulnerable to HIV/AIDS because of inherent biology or genetic composition 	<ul style="list-style-type: none"> • Take actions to promote personal health and wellness concepts to health care providers, people infected and affected by HIV/AIDS and target populations • Take action to increase research on complementary and alternative therapies for the treatment of HIV/AIDS, and to increase coverage of such therapies under public and private health plans • Take actions to increase harm reduction education and practice by target populations, service providers, and people infected and affected by HIV/AIDS • Work with government partners and school boards to ensure system-wide HIV education for school trustees, employee groups, teaching staff and students • Take action to improve awareness, education and access to HIV testing, counselling and support for all young people, and to increase services for young people infected and affected by and vulnerable to HIV/AIDS • Take actions to ensure prevention, care and support for individuals infected and affected by and vulnerable to HIV/AIDS due to underlying biology or genetic predisposition

STRATEGIC GOALS	STRATEGIC OBJECTIVES	POPULATION HEALTH OUTCOMES	PRIORITY STRATEGIES
<p>3. To foster social environments that maximize the health and well-being of people infected and affected by and vulnerable to HIV/AIDS</p>	<p>3.1 To support actions that ensure basic human rights and procedural protections are accorded to people infected and affected by and vulnerable to HIV/AIDS</p> <p>3.2 To support actions that promote social acceptance of people infected and affected by and vulnerable to HIV/AIDS</p> <p>3.3 To support actions that address gender inequality and bias experienced by people infected and affected by and vulnerable to HIV/AIDS</p> <p>3.4 To support actions that address cultural inequality and bias experienced by people infected and affected by and vulnerable to HIV/AIDS</p> <p>3.5 To support actions that address lifelong social and economic deprivation experienced by people infected and affected by and vulnerable to HIV/AIDS</p>	<ul style="list-style-type: none"> • Increased consumer satisfaction with fairness and respect in community and public service delivery • Increased public acceptance of people who engage in risk behaviours • Increased implementation of harm reduction practices by publicly funded institutions • Increased availability of gender and transgender-specific HIV/AIDS education, care, treatment and support services • Increased availability of culturally appropriate HIV/AIDS education, care, treatment and support services • Increased access to HIV/AIDS services by target cultural populations • Increased sensitivity of HIV/AIDS education, care, treatment and support services to the needs of extremely socially and economically deprived people 	<ul style="list-style-type: none"> • Take actions to ensure greater understanding by service systems of the Charter of Rights and Freedoms and its implications for service delivery • Take actions to eliminate conditions or requirements which limit access to HIV/AIDS-related treatment, care and support • Take actions to have harm reduction principles and practices incorporated into health, social and justice systems, and to promote harm reduction education for service providers in those systems • Take actions to have BC Ministry of Health review methadone regulations, policies and procure to ensure they conform with the care, treatment and support needs of injection drug users • Take actions to improve access to culturally and linguistically appropriate HIV/AIDS prevention, education, treatment, care and support for people infected and affected by HIV/AIDS and target populations • Take actions to promote the implementation of <i>The Red Road: An Aboriginal Strategy for HIV/AIDS in BC</i> • Take actions to ensure newcomer communities are aware of HIV transmission risks, prevention strategies and ways of accessing care • Take actions to address the unique psychosocial and health needs of people who have experienced chronic or historic social and economic deprivation

STRATEGIC GOALS	STRATEGIC OBJECTIVES	POPULATION HEALTH OUTCOMES	PRIORITY STRATEGIES
<p>4. To advocate for available, effectively co-ordinated, accessible and responsive health services for people infected and affected by and vulnerable to HIV/AIDS</p>	<p>4.1 To advocate for health services that are designed to prevent the spread of HIV infection</p> <p>4.2 To advocate for health services that maintain, improve and restore the health and functioning of people infected and affected by and vulnerable to HIV/AIDS</p> <p>4.3 To advocate for health services that address gaps and avoid unnecessary duplication in prevention, care, treatment and support for people infected and affected by and vulnerable to HIV/AIDS</p> <p>4.4 To advocate for health services that are client-centred, culturally sensitive and accessible to all people infected and affected by and vulnerable to HIV/AIDS</p> <p>4.5 To advocate for health services that anticipate and respond to the changing needs of people infected and affected by and vulnerable to HIV/AIDS</p>	<ul style="list-style-type: none"> • Increased availability of health services along the continuum of care from prevention to palliative care • Increased access to health services by people living with HIV/AIDS and target populations • Increased use of recognized best practices in health service design and delivery • Increased involvement by people living with HIV/AIDS and target populations in the design and evaluation of health services • Increased use of universal precautions by health care workers and facilities 	<ul style="list-style-type: none"> • Take actions to increase availability of comprehensive acute and community based addictions care and follow-up for people infected and affected by HIV/AIDS and target populations • Take actions to increase the availability and accessibility of detox beds and shelter environments for people infected and affected by HIV/AIDS and target populations • Take actions to improve access to comprehensive addiction maintenance programs for injection drug users • Take actions to improve access to medication management education and support for people infected and affected by HIV/AIDS • Take actions to improve nutritional health of people infected and affected by HIV/AIDS and target populations • Take actions to support VRHB in developing mental health and addictions prevention/treatment plans that address the needs of people infected and affected by HIV/AIDS and target populations • Take actions to support increased co-ordination between federal, provincial, regional and municipal health authorities to address the needs of people infected and affected by HIV/AIDS and target populations • Take actions to increase the availability and accessibility of health care alternatives from a wide range of cultural perspectives

B. GLOSSARY OF TERMS

ABORIGINAL

Indian, Metis and Inuit people (*Constitution Act, 1982*)

AIDS (Acquired Immune Deficiency Syndrome)

AIDS is a constellation of various diseases indicative of an impaired immune system caused by the HIV virus.

ANTIRETROVIRAL

Antiretroviral refers to a type of drug, or pharmaceutical compound, that is specifically designed to prevent the reproduction of retroviruses, such as HIV. People usually use the simpler term “antivirals”. There are several types, or categories, of antiviral drugs currently approved by the US Food and Drug Administration to treat HIV: nucleoside analogs, non-nucleoside analogs and protease inhibitors. Only a few antivirals have been approved in Canada and these are still being evaluated. There has been a considerable amount of controversy about using antivirals because of their side effects and the fact that little is known about their long-term effects. (*Encyclopedia of AIDS: A Social, Political, Cultural and Scientific Record of the HIV Epidemic*)

FAS/FAE (Fetal Alcohol Syndrome and Fetal Alcohol Effects)

FAS/FAE are medical diagnoses that refer to a set of alcohol-related disabilities associated with the use of alcohol during pregnancy. The minimum criteria for diagnosing FAS are prenatal and/or post natal growth restriction, central nervous system dysfunction, and characteristic facial features.

GOAL

A goal is a statement of what is to be achieved at some point in the future. Strategic goals establish the overall direction of an organization. They focus more on an end-state than specific accomplishments (see Objective).

HEALTH STATUS

Health status is the state of health of an individual and, by extension, the state of health of the overall population. Health status has been traditionally measured by length of life (life expectancy), rates of disease and death (mortality and morbidity) and physical health and functioning. Today, health status is also measured by years of healthy life, quality of life and well-being, the impact of health problems on everyday life, and mental, social and emotional health (*Report on the Health of Canadians, Health Canada*).

HIV (Human Immuno-deficiency Virus)

HIV is a virus that causes AIDS. It attacks the cells of the immune system. HIV is passed from one person to another by the exchange of infected blood, semen, vaginal fluid or breast-milk. After infection, HIV gradually weakens the immune system and the body is unable to fight off infections. (Canadian Aids Society)

MISSION

A mission statement describes the fundamental reason for an organization's existence. It describes the nature of an organization's day to day business or operations. It establishes what an organization does, for whom and the major philosophical premises under which it operates.

OBJECTIVE

An objective is a specific and measurable description of what is to be achieved. Whereas a goal is broadly stated, an objective is more focused and narrowly stated.

PERFORMANCE INDICATOR

A performance indicator is a unit of information that measures or tracks an organization's success in achieving intended results. It is specifically worded to identify the characteristic or change that indicates a result has been achieved. A performance indicator identifies the statistic that will best summarize performance, usually a number, rate or percentage.

POPULATION HEALTH OUTCOME

A population health outcome is a desired or intended result for a given population group. It is usually concerned with the longer term or ultimate effects of a particular action on society, rather than the shorter term effects of a program or service on the participants.

QUEER FRIENDLY

Queer friendly refers to organizations, services and programs which are responsive to and aware of the issues facing gay men, lesbians, bisexual and transgendered persons.

SEROCONCORDANT

Seroconcordant refers to the relationship between two individuals of the same HIV serostatus, where both are HIV negative or both are HIV positive.

SERODISCORDANT

Serodiscordant refers to the relationship between two individuals where one individual is HIV positive and the other is HIV negative.

SEROPOSITIVE

Seropositive refers to an individual whose blood contains the Human Imuno-deficiency Virus (HIV)

SERVICE OUTCOME

A service outcome is the desired or intended result of a particular service or program. This type of outcome is usually directly attributable to the service or program. A service outcome primarily benefits the consumer or participant, although there may be secondary benefits to the larger community or population groups.

STRATEGY

A strategy is an action, pattern of actions or a plan to achieve a desired result. It can be used by an organization to marshal and allocate resources to support a position (or goal) based on internal competencies and anticipated changes in the operating environment.

TRANSGENDER

Transgender is often used as an umbrella term to describe people who do not fit into society's assigned gender roles. Transgendered people usually make the transition from male to female, or vice versa, either with or without the assistance of hormones and/or surgery. This term is sometimes used interchangeably with transsexual, although transsexuals usually transition with hormones and/or surgery. (The Centre--the Community Centre Serving and Supporting Lesbian, Gay, Transgendered, Bisexual People and their Allies)

TWO-SPIRIT PEOPLE

Gay, lesbian, bisexual and/or transgendered Aboriginal people (The Red Road; Pathways to Wholeness: An Aboriginal Strategy for HIV and AIDS in BC)

UNIVERSAL PRECAUTIONS

Universal precautions are general measures intended to prevent the transmission of blood-borne pathogens, especially HIV and the hepatitis-B virus (HBV), between health care workers and patients. They are designed to prevent contact between certain potentially infectious bodily fluids of one person and the mucous membranes or non-intact skin of others. Universal precautions focus on the avoidance of accidental punctures by used needles or scalpels and involve the use of protective barriers such as latex gloves, adherence to established procedures for use/disposal of sharp objects, and immunization of health care workers for HBV. Universal precautions are especially important in exposure-prone invasive procedures such as surgery. (Encyclopedia of AIDS: A Social, Political, Cultural and Scientific Record of the HIV Epidemic)

VALUES

Values are an expression of what an organization or individual stands for and who it will conduct itself. Values are a promise of action; they form the moral and ethical basis for decision making. It is critical that organizational values are not only seen to exist, but are demonstrably upheld by every member of an organization and by every policy, procedure, practice and process.

VISION

A vision describes what an organization is striving to become in the future. It paints a picture of an ideal world that an organization wants to help create. A vision is intended to galvanize an organization into greater action and co-operation.

VULNERABILITY

Vulnerability in the context of HIV/AIDS means having little or no control over the risk of acquiring HIV infection or, for those already infected with or affected by HIV, to have little or no access to appropriate care and support. Vulnerability is the net result of the interplay among many personal (including biological) and societal factors, and can be increased by a range of cultural, demographic, legal, economic and political factors. (United Nations Joint Programme on HIV/AIDS).

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Victor Peralta..... Vancouver Native Health Society
Doug Perry..... BC Persons With AIDS Society
Dr. Peter Phillips The John Reudy Immuno-deficiency Clinic, St. Paul's Hospital
Denise Price. Hummingbird Kids Society
Donna Raketti..... Correctional Services Canada (CSC)
Rosemary Riddell..... St. Paul's Hospital
Sharon Ritmiller Vancouver/Richmond Health Board
David Schneider UBC Dept. of Health Care and Epidemiology
Josephine Stebbings Youth Community Outreach AIDS Society (YouthCO)
Lou Stone..... BC Housing
Kerstin Stuerzbecher Portland Hotel Society
Marcie Summers Positive Women's Network
Susanna Tan..... Asia Society for Intervention of AIDS (ASIA)
Mark Townsend..... Portland Hotel Society
Geraldine Trimble..... Healing Our Spirit BC First Nations AIDS Society
John Turvey Downtown Eastside Youth Activities Society (DEYAS)
Brian Wardley Heart of Richmond AIDS Society
Catherine White Downtown South Community Health Centre
Jim Woodward..... BC Housing
Art Zoccole Red Road HIV/AIDS Network
Al Zwiers Gilwest Clinic, Westminster Health Centre, Richmond Hospital

D. DIRECTORY OF SERVICES

This directory contains a partial list of organizations in Vancouver serving people infected and affected by HIV/AIDS. For a more complete list of organizations and description of their programs and services, please consult Information Services Vancouver (the “Red Book”).

Addiction Services, Ministry for Children and Families: The network of services for people impacted by alcohol, drug and gambling problems, including outpatient, detox, residential, supportive recovery, day treatment and prevention programs. Information and counseling are provided to individuals, couples, families and groups.

AIDS Vancouver: The wide range of HIV/AIDS-related volunteer assignments coordinated by this organization provides hundreds of opportunities for those living with and affected by HIV/AIDS to contribute to the community while engaging in and building social support networks.

BC Persons With AIDS Society: A membership organization, BCPWA’s support department offers a range of participatory programs that build social networks among its more than 3,000 members.

Boys R Us: This drop-in for male sex trade workers operates out of the Downtown South Community Health Centre and is staffed by representatives and volunteers from nearly a dozen organizations.

DAMS: This harm reduction program offers outreach, case management, accompaniments and one-to-one and group support for women who have or have had a problem with alcohol or drugs and who are living with or at risk for HIV.

Dr. Peter Centre: This organization provides a unique health care service to individuals living with HIV/AIDS who face life threatening health deterioration. The day program offers a wide range of social, leisure, recreational and therapeutic day i, residence is a bright comfortable home offering 24 hour support, including palliative care, to 10 residents who are unable to manage independent living even with available community health care support.

Food for Thought: This organization provides nutritious meals and an opportunity for social support to persons living with HIV/AIDS in the Downtown Eastside neighbourhood.

Friends for Life: This organization provides more than 50 health and wellness programs without charge to its members. The goal of all programs is to help members cope with the anxiety and stress of living with a life threatening illness while improving their overall quality of life. Among the programs available are support groups, one-on-one counseling, a resource library, workshops on a wide variety of topics, massage therapies, social support and meals.

Heart of Richmond AIDS Society: This organization offers a support group for persons living with HIV/AIDS and raises the profile of AIDS issues within the Richmond community.

High Risk: This organization provides a social support network and health information to transgendered communities.

Hummingbird Kids Society provides a network of support and services to children living with HIV/AIDS and their families. The Society is for children up to 15 years of age and has three main programs. The Sunshine Program brings memories to children and families in the form of birthday recognition, recreational and event activities. The Katie Becker Family Support

Program matches volunteers with children to provide a buddy and companionship. The What About the Kids? Program offers a speaker's bureau, a newsletter and bringing awareness to the public about the unique problems facing children living with HIV/AIDS.

McLaren Housing Society provides housing for people living with HIV/AIDS through its Helmcken House program and portable housing subsidies funded by government and the private sector.

Neutron Café: This ongoing social event is designed to include seropositive gay men.

Positive Women's Network: This membership organization for women offers a wide range of programs designed to build social networks and decrease isolation, including a women's drop-in, lunch, support groups and outings.

Vancouver Native Health Society: Drop-in services, offered in conjunction with a clinic, provide a supportive setting for the development of social networks among area residents in the Downtown Eastside.

Vancouver and Area Network of Drug Users (VANDU): This consumer organization has taken a public stance advocating the development of supportive social environments for drug users that can lead to reduced harm and positive individual and societal change. Peer counseling initiatives have been designed to build social networks on a one-to-one basis.

Wings Housing Society: Wings is a provincial organization for persons living with HIV/AIDS. The organization currently administers 102 portable housing subsidies funded jointly by CMHC and BC Housing. Wings operates The Bonaventure, an apartment residence near St. Paul's Hospital for those who are able to live independently.

WISH: This organization provides a safe drop-in space for women who are street connected or involved in the sex trade, and provides some basic human supports such as food, showers, and foot care.

YouthCO AIDS Society, Positive Outreach Program: This program features outreach and social support for HIV-positive youth, with a particular focus on street involved young people and young gay men. Two part-time outreach workers are available for psychosocial support and plan regular social events and activities that address the isolation experienced by many seropositive youth.