10th Annual British Columbia Conference

HIV/AIDS

Learning from Each Other

Conference Syllabus

October 26-28, 1997

The Westin Bayshore Hotel
1601 West Georgia Street
Vancouver, British Columbia, Canada

Continuing Education
in the Health Sciences
The University of British Columbia

British Columbia Centre for
Excellence in HIV/AIDS

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Plenary Session

Welcome

Presenters:

Paula Braitstein
Francisco Ibañez-Carrasco
Irene Goldstone

• Notes •

Epidemiology of HIV/AIDS - International and National Overview

Presenter:
Michel Alary
Epidemiology Research Unit, Laval University

In this presentation, I will try to give an overview of the epidemiological situation of HIV/AIDS both at the international and national level. Because of the short length of the presentation, I will focus my talk on the following issues:

1. general epidemiology of HIV/AIDS worldwide;
2. success stories of HIV prevention in developing countries;
3. general situation concerning HIV/AIDS epidemiology in Canada;
4. epidemiology of HIV/AIDS among men who have sex with men (MSM) in Canada;
5. epidemiology of HIV/AIDS in injection drug users (IDUs) in Canada; and
6. I will try to cover briefly some additional issues related to the situation of the HIV epidemic in Canada.

It is currently estimated that over 21 million adults and children are infected by HIV worldwide. Of these, approximately two thirds live in sub-Saharan Africa and just under 5 millions in Asia. The corresponding number for the developed world is approximately 1.3 million. The HIV epidemic is still emerging with continuous progression in most African and Asian countries, with an increasingly important epidemic among women in Latin America, and with the development of a new epidemic in Eastern Europe. Furthermore, in developed countries, despite a real decline of HIV incidence among MSM and IDUs over the last decade, there is still evidence of active transmission in both these populations and of very active epidemics in some groups of IDUs.

In the developing world, there are however some encouraging observations that have been made over the last few years. Indeed, the STD-HIV interaction, that is the observation showing that other curable STDs enhance HIV transmission, provided an opportunity to improve interventions. For instance, in Kinshasa, Zaire, it has been shown that regular screening and treatment of STDs among female sex workers reduced incidence of HIV over a 3-year period[1]. In addition, in Mwanza, Tanzania, an STD intervention using a simple syndromic approach has reduced HIV incidence in a rural community by 43% over a 2-year period[2]. Although these results were obtained in highly controlled settings, recent data from a community-based program of STD control and prevention among female sex workers show a decrease in STD prevalence and levelling of HIV, thus suggesting that such strategies can really work in practice.

There are also examples that behavioural change is possible in developing countries. First, in Uganda between 1993 and 1995, HIV prevalence in pregnant women under 20 years of age declined from 20 to 13% in parallel with an increase in age at first sexual intercourse in these young women (from 13 to 16 years old) and increase of condom use among men. Secondly, in Thailand, the 100% condom use policy applied in brothels since 1992 has resulted in a spectacular decrease in STD incidence among prostitutes within a couple of years. Now, condom use is the norm within commercial sex transactions and HIV prevalence decreased among military conscripts from 3.6% in 1993 to 2.5% in 1995.

In Canada, there has been 15,101 AIDS cases reported as of June 30, 1997. Of these, the majority (72.5%) were MSM. However, since 1992, the proportion of women, of IDUs and of heterosexuals increased among AIDS cases in Canada. Whereas women accounted for only 6.1% of all cases reported between 1979 and 1992, they accounted for 10.8% of cases reported in 1996. Corresponding figures for IDUs were respectively 6.4% and 15.4% whereas they were respectively 8.6% and 16.9% for heterosexual transmission. It is currently estimated that approximately 39,000 Canadians are living with HIV and that 3,940 cases occur yearly[3].

Concerning MSM, available data show that the current prevalence of HIV is between 10 and 20%. Following a very acute epidemic at the beginning of the 1980s, HIV incidence has levelled up in that population. The recent data concerning HIV incidence among MSM show incidence rates of between 1.4 and 2.8 per 100 person-years.

Concerning IDUs, there are important regional variations. First in the province of Quebec, HIV prevalence has raised sharply from 3 to 4% in the late 1980s to 12 to 13% in 1991. Currently this prevalence is between 15 and 20%. During the same period, HIV prevalence has remained relatively stable at under 5% in Toronto. In Vancouver, whereas the prevalence was very low (1-2%) in the late 1980s, there was a sharp rise since 1994 and the VIDUS cohort has found a prevalence of 23.2% in 1996-97 with a very high incidence rate of 18.6 per 100 person-years[4]. In comparison, incidence rates in Montreal and elsewhere in the province of Quebec are estimated between 4.5 and 8 per 100 person-years whereas data available from Ontario estimate the incidence at approximately 1.2 per 100 person-years. Disturbing data from Vancouver and Montreal also indicate that prevalence and incidence of HIV is higher among IDUs attending needle exchange programs. This paradoxal situation could be explained by the fact that Canadian needle exchange programs seem to serve the IDUs the most at risk because of their socio-economic situation and risky behaviours.

Some other issues related to HIV epidemiology in Canada will be discussed at the presentation such as the possibility of wide spread transmission in the heterosexual population, the vulnerability of native people communities, the problem of HIV among inmates in Canadian prisons, as well as the importance of HIV primary infection and concurrency in sexual partnerships on HIV transmission dynamics.

In conclusion, the HIV epidemic is still highly dynamic everywhere in the world, including Canada. There is currently a special challenge to fully understand HIV transmission currently occurring among Canadian IDUs, especially in Montreal and Vancouver. Thus, this is not the time for complacency and there should be strong governmental commitment to ensure sufficient funding for research, interventions and treatment in relation with HIV in Canada. Finally, appropriate structures should be put in place to allow more important contribution of Canadian scientists, especially in the public health field, to the global fight against AIDS worldwide.

[1] Laga M, Alary M, Nzila N, et al. Condom promotion, sexually transmitted diseases treatment, and declining incidence of HIV-1 infection in female Zairian sex workers. Lancet 1994; 344:246-248.

[2] Grosskurth H, Mosha F, Todd J, et al. Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania. Lancet 1995;346;530-536.

[3] Archibald C, Remis R, Williams G, et al. Estimating current prevalence and incidence of HIV in Canada. Plenary address at the 6th Annual Canadian Conference on HIV/AIDS Research, Ottawa, May 22-25, 1997.

[4] Strathdee SA, Patrick DM, Currie S, et al. Needle exchange is not enough: Lessons from the Vancouver Injection Drug Use Study. AIDS 1997;11:F59-F65.

Biography:

Dr. Michel Alary completed his MD degree at the University of Sherbrooke in 1974. After several years as a family physician, he re-oriented his career towards public health. He has completed a MSc degree in epidemiology at Laval University in 1987 and a PhD degree in epidemiology at the same university in 1991. He completed his training as a post-doctoral fellow at the Institute of Tropical Medicine, Antwerp, Belgium with professor Peter Piot. He is currently associate professor at the Department of Social and Preventive Medicine, Laval University, and active researcher within the Epidemiology Research Unit at the Centre hospitalier affilié universitaire de Québec. He is also medical advisor at the Quebec City Public Health Centre, Dr. Alary focuses his research efforts on epidemiology and prevention of HIV and STDs among men who have sex with men and injection drug users in his work in Canada and with female sex workers in his work in Africa.

The Future of HIV Testing in Canada

Presenter:
Ralf Jürgens
Canadian HIV/AIDS Legal Network
4007 de Mentana, Montreal H2L 3R9
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ABSTRACT

Objective:

In the late 1980's, a "general principle governing HIV testing in Canada" was established according to which HIV testing shall only be done when (1) counselling and education before and following testing are available and offered; and (2) when confidentiality of results or anonymity of testing can be guaranteed. The objective is to analyze whether the principle governing HIV testing should be changed in light of new developments, including the availability of new treatments; the approval and marketing, in the US, of HIV home testing kits; and the shifting demographics of the epidemic.

Methodology:

(1) Existing resources have been researched and analyzed: (2) a literature review and annotated bibliography have been produced; (3) a discussion paper has been produced; (4) comments on it have been solicited; (5) a workshop has been organized.

Results:

The following questions have been analyzed in detail: (1) is specific informed consent to testing still necessary, or should general consent suffice?; (2) are anonymous testing facilities still required? (3) is pre- and post-test counselling still necessary? (4) should home testing for HIV be made available in Canada? (5) do the new developments warrant any exception(s) to the principle that testing always be voluntary; (6) should an approach emphasizing contact tracing be adopted? For each question, preliminary conclusions have been formulated.

Discussion:

Recommendations concerning HIV testing and confidentiality cannot be cast in stone. While the fundamental guiding principles are unlikely to change, specific considerations that underlie testing policies need to be constantly reevaluated, based on broad consultation with all stakeholders, including PLWHIV/AIDS and community-based organizations. Today, HIV testing should be strongly encouraged, but the trend towards "trivializing" it should be treated with great caution. AIDS remains different from other diseases and potential harms from testing continue to be significant.

Biography:

Ralf Jurgens, LL.M., Dr. Jürgens, is Project Coordinator of the Joint Project on Legal and Ethical Issues Raised by HIV/AIDS of the Canadian HIV/AIDS Legal Network and the CAS, Chair of the Interagency Coalition of AIDS and Development, Editor of the Canadian HIV/AIDS Policy & Law Newsletter, and co-founder of the Legal Network.

S:AM1 Interdisciplinary Care for Pregnant Women

A Multidisciplinary Team Approach to Caring for HIV Infected Pregnant Women and Their Infants

Presenters:
Lori Sheckter
Deborah Money
David Burdge
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ABSTRACT

Issues:
HIV infected women are faced with difficult reproductive choices. Women may put their male partners at risk by attempting to conceive, face treatment with multiple medications in pregnancy, the safety which often not known, and are faced with the possibility of having an infected infant. They also must address the reality that they may not be in a position to parent any children (infected or not) for prolonged periods, and if their partner is also infected, that any child born would become orphaned. If women are diagnosed as HIV infected in pregnancy, they have to deal with a new devastating diagnosis, as well as make rapid decisions regarding whether to continue their pregnancy. Management of women who have elected to continue pregnancies is complex, and requires careful balancing of concerns for maternal wellbeing (e.g. long term antiretroviral therapy options) with fetal wellbeing. Regardless of an individual woman's choice, extensive education, information, counselling support and medical care is required.

Description:
Optimal care of a woman considering a pregnancy, or already pregnant is complex. We will highlight the issues and our teams approach in this session. The social worker will address the counselling/support issues for women who are either considering a pregnancy, or pregnant and trying to decide regarding termination versus continuation of the pregnancy. The pharmacist will discuss challenges associated with complex medication regimens in pregnancy, and ensuring availability of antiretroviral drugs to women throughout the province.

The infectious disease and obstetrics specialist will address issues around obstetrical and medical management of pregnant women, and the pediatric infectious disease specialist outline the approach to management of infants born to HIV infected women. A review of pregnancy outcomes of women diagnosed in pregnancy in the last two years in BC will also be presented. All members of the multidisciplinary team, including the nutritionist, clinic nurse and outreach worker will be available to interact with the audience.

Conclusion:
A multidisciplinary approach provides women with optimal opportunity to make informed productive choices and receive optimal care.

Biographies:

David R Burdge, MD., FRCP(C), Co-Director, Oak Tree Clinic; Associate Clinical Professor, Division of Factious Disease, University of British Columbia

Lori Sheckter, Social Worker, Oak Tree Clinic

Deborah Money, MD., FRCP(S), Department of Obstetric and Gy.naecology, B.C. Women's Hospital, Oak Tree Clinic, University of British Columbia

S:AM1 Interdisciplinary Care for Pregnant Women

Interdisciplinary Care for Pregnant Women in Vancouver's Downtown Eastside

Presenter:

Annette Garm

• Notes •

S:AM2 Empowerment Through Information

AIDS & Disability Action Program: Bridging the Information Gap

Presenters:
Brian Thomas
Geoff McMurchy
BC Coalition of People with Disabilities
#204 - 456 West Broadway, Vancouver, BC V5Y 1R3

ABSTRACT

As late as 1988, people with disabilities were not getting appropriate and accessible information about HIV/AIDS. Following from the historic overprotection and denial of people with disabilities sexuality, there was a vacuum of sexual health information available to them.

In fact, we know that people with disabilities in general are more at risk for sexual abuse. They are often more isolated and have less opportunity to develop social skills. People with developmental disabilities, especially, may have poor decision making skills, poor impulse control, or be more vulnerable to pressure in order to gain acceptance.

One of the basic lessons in AIDS prevention that has been learned globally is the importance of delivering the message in an appropriate format. Sensitivity to language and culture can make or break a campaign. Creating educational materials that were appropriate and accessible to people with disabilities has been a priority for the AIDS & Disability Action Program (ADAP) team.

Working committees were formed for different disability sectors - mental health consumers, people with physical disabilites, those who are deaf, people with visual impairment or blindness and those with developmental handicaps. Both consumers and service providers were represented on the committees, and they developed content and formats for the educational materials, as well as distribution strategies.

High and low literacy pamphlets and booklets, Braille books and audio tapes have been distributed widely across Canada and elsewhere. The lower literacy materials have found niches outside the disability sector as well.

ADAP offers educational workshops and resource packages on both basic AIDS education for consumers, and policy development for directors and management of service-providing agencies. Along with its own materials, ADAP has developed a clearinghouse of disability-related AIDS materials and resources to faciliate prevention education, policy and program development, and partnership-building between AIDS and disability organizations.

Biographies:

Brian Thomas
Currently the Community Outreach Developer for the AIDS and Disability Action Program of the British Columbia Coalition of People with Disabilities; B.C. representative on the HIV/AIDS and Substance Use National Advisory Committee through the Canadian AIDS Society
Member of St. Paul's Neighbourhood Advisory Committee
Member of St. Paul's Diversity Committee
Member of Downtown Eastside Multi-Diagnosis Committee
Former Director of the British Columbia Persons with AIDS Society Board of Directors
Former Co-ordinator of the Speaker's Bureau at BCPWA Society
Presenter at the XI International Conference on AIDS

Geoff McMurchy
Geoff has been working in the disability advocacy field for approximately fifteen years. Most recently he has been employed by the BC Coalition of People with Disabilities AIDS and Disability Action Program as Director of Communications. He has a strong commitment to the principles of empowerment and self-determination, and his numerous past affiliations have included the Pacific Transit Cooperative, the BC NAMES Project Planning Committee, the West Coast Legal Resource Association for the Disabled, the Community Coalition for the Implementation of Adult Guardianship Legislation and the Canadian HIV/AIDS Legal Network.

S:AM2 Empowerment Through Information

Accessible Service Information: A Community Based Response

Presenters:
Evin Jones
Ingrid Kuran
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phone: 681-2122 ext. 284; fax: 893-2251; email address: evinj@parc.org

ABSTRACT

Objectives:

- as a result of the work we do in our capacities as advocate and intake worker, it became apparent that staff at both agencies have to repeat the same information to members/clients about what benefits and/or services are available to them both within PARC and the larger community. Also, members/clients identified a lack of succinct information about relevant resource information.
- accordingly we are in the process of creating an accessible, user-friendly info sheet; on at appropriate literacy levels and which utilizes pictures and symbols. The intention is to have the sheet produced in a variety of languages.

Methodology:

- research of the key themes under which poeple have made inquiries over the past year
- tracked and collected relevant statistics
- developed plan to create a resource which will assist staff in avoiding redundancy in information delivery while empowering service users
- consultative process including PARC agencies; literacy and ESL groups; and members/clients
- promotion of the information sheet as a tool for independence

Results:

At the problem session, we will share the process by which the sheet was created, the challenges we experienced in the consultative process, as well as our successes.

Conclusions:

To evaluate and assess the utility and accessiblity of the information sheet for both consumers and service providers.

Biographies:

Evin Jones (BaH,LL.B) has been working at the BCPWA Society since January '96. Began work as an advocate and is presently the Advocacy Services Developer, supervising staff and volunteers.

Ingrid Kuran (BSW) began working with AIDS Vancouver Island in January '95 in Support Services; joined AIDS Vancouver in June '95 Intake Worker with Project Sustain.

S:AM2 Empowerment Through Information

Reclaiming the Positive Voice

Presenter:

Michael Parsons

ABSTRACT

PHA = Person living with HIV/AIDS

Issues:

That all projects, programs, services and proposals are evaluated and where necessary modified by the HIV+ community to ensure that all initiatives are user friendly.

That all organizations (Governmental and Non-governmental) for PHA's offer their services holistically.

Description:

To resolve the above issues Saskatchewan has established an HIV issues caucus that consists of only HIV+ people. We have two facilitated conferences per year and make all decisions on a consensus model which ensures full voice for everyone.

The mandate of the program is to offer guidance to the above mentioned organizations. The caucus is diverse in its membership taking immediate family composition, race, gender, sexual orientation and geographic location into account. It has access to an outreach program to ensure parity on all of these levels.

The caucus evaluates existing programs, projects and services organizations offer. Suggestions for improvement are made to optimize accessibility. The caucus also provides an evaluation service for proposed projects, programs and services and after modification offers their endorsement for funding purposes.

The caucus also endeavours to network with PHA's within Saskatchewan to identify needed programs, projects, services and training. In addition the caucus solicits input on acceptable methods of implementation.

The caucus is a governing body for all organizations to guarantee all PHA's are being treated equitably.

Conclusion:

The caucus eliminates the problem of duplication of services. Only needed services, projects, and programs are implemented in the province in a user friendly way. It ties all organizations and health professionals together on a provincial level and dramatically improves the quality of life for all PHA's.

S:AM3 Men Who Have Sex With Men: Critical Points of Crisis

Psychologic Distress in a Cohort of Young Gay/Bisexual Men

Presenter:

Stephen Martindale

ABSTRACT

Acknowledgements:

We would like to thank the participants in the Vanguard Project, the member agencies of the Community Advisory Committee, and Sister C.

Objective:

To describe factors associated with psychologic distress among a prospective cohort of young gay/bisexual men (MSM).

Methods:

MSM aged 18-30 in Vancouver who had not previously tested HIV+ were recruited through physicians, clinics and outreach into the Vanguard Project starting May/95. These men underwent an HIV test and self-administered questionnaire at baseline and annually during follow-up. Both baseline and follow-up questionnaires included risk behaviours, social support, depression and nonconsensual sex. At follow-up, questions were included on suicide ideation and attempts, history of mental disability/mood disorder, drug/alcohol treatment, self-esteem, gay bashing ("physical abuse as a result of being gay or perceived as gay">, domestic violence ("ever being hit or assaulted by a partner or date"), age of "coming out" and level of comfort with self-identified sexual orientation.

Results:

As of Jan 31/96, a total of 147 MSM completed both baseline and follow-up questionnaires. To date, men returning for follow-up do not significantly differ from men who completed baseline questionnaires in terms of demographic characteristics. Median age of coming out was 19; most (77%) were comfortable with their sexual orientation. Prevalence of domestic violence was 18%, gay bashing: 11%, sexual abuse: 25%. Over half (55%) had seriously considered suicide, of whom 33% had attempted. Over one fifth (22%) had been diagnosed with a mental/mood disorder, most commonly depression. Despite high levels of recreational drug use, only 7% had ever been in drug/alcohol treatment. Psychologic correlates of sexual risk-taking are pending. *These findings will be updated for presentation at the 1997 BC AIDS Conference.*

Conclusions:

A disturbing proportion of young MSM report having considered suicide or made suicide attempts, which is consistent with high levels of depression. Various forms of violence appears to be common for young MSM, which could lead to heightened vulnerability to HIV infection. These factors require further investigation.

Biography:

Stephen Martindale coordinates the Vanguard Project for the BC Centre for Excellence in HIV/AIDS.

For more information, contact:

Steve Martindale, Vanguard Project Coordinator <stevem@hivnet.ubc.ca>, 608 - 1081 Burrard Street, Vancouver, BC, Canada, V6Z 1Y6 Tel: (604)687-2469 Fax: (604)631-5464, http: / /cfeweb.hivnet.ubc.ca/vanguard/project.html

S:AM3 Men Who Have Sex With Men: Critical Points of Crisis

Alcohol Use, Sex and Vulnerability to Contracting HIV in MSM

Presenters:
James Shedden
AIDS Coalition of Nova Scotia, 5675 Spring Garden Road - 6th Floor, Halifax, NS
Telephone: (902) 425-4882; Fax: (902) 425-6200; Email: rtipacns@auracom.com
John Schellenberg
Village Clinic, 668 Coryden Avenue, Winnipeg, MN
Telephone: (204) 453-0045; Fax: (204) 453-5214

ABSTRACT

Issue:

As a finding of the Men's Survey '91 and other research papers that have noted a link between alcohol use among men who have sex with men and possible HIV Infection. Prevention and Community Action Program funded 2 demonstration sites to plan, implement, and evaluate a variety of initiatives to address the issue of alcohol use and risky sexual practices among men who have sex.

Description:

Since it's inception these sites have implemented a variety of innovative approaches to address this issue. In Halifax G-Map (the Gay Men and Alcohol Project) has undertaken a variety of approaches including developing a peer education project aimed at educating Gay men about the issues of alcohol use, HIV and AIDS, and self esteem; developing an advisory body of local professionals to address the needs of MSM, educating staff of the AIDS Coalition of Nova Scotia and drug dependency services, developing print resources for MSM, alternative venues for socializing and participatory action research component to find out what the issues are regarding MSM and alcohol use. The Winnipeg demonstration site has also developed similar approaches including peer education, gay bar development, educational materials development, newspaper and telephone outreach, a self-assessment questionnaire and a similar advisory structure.

Conclusion:

The overall goal of the sites is to reduce the spread of HIV among MSM. In this presentation the presenters will talk about the results of their program activities, challenges they faced, effectiveness of the program initiatives, and results of the research components of the projects. While the projects will not have completed their research and programming, there will be numerous opportunities to talk about the innovative program.

Biographies

James Shedden is a community activist and AIDS educator who has worked in a variety of community development, health promotion and action research positions, including a Treatment Information Project, Regional Treatment Information Need's Assessment, and Gay menÕs Education and Support project (the Men Sex Project) at the AIDS Coalition of Nova Scotia for the past 5 years.

John Schellenberg

S:AM3 Men Who Have Sex With Men: Critical Points of Crisis

Sexual Abuse and Strategies for Intervention

Presenter:

Dimitry Noel-Bentley

• Notes •

S:AM4 Peer Education: Models for High Risk Youth

We Make a Difference – The Benefits when Peers Deliver HIV/AIDS Information to Homeless Youth

Presenter:
Mauricio Coronado
#6 - 1245 West 8th, Vancouver, B.C., V6H 1C7
(604) 739-0007

ABSTRACT

Homeless youth usually would like to find better ways of surviving. They can be reached faster and easier by other young people. The young volunteers of our project were effective, but it is important that they have a lot of knowledge about HIV/AIDS and other STD's in order to do this work effectively.

Homeless youth need more awareness of the dangers of HIV/AIDS and other Sexually Transmitted Diseases (STD's). This is as true here in BC as it is in Guayaquil, Ecuador, where I lived until recently. Throughout high school I volunteered to help youth on the street, and then I spent time with Fundacion Amigos por la vida ("Friends for Life Foundation") helping to make contact so that we could give them information about risk dangers. I will speak about our project and explain how many parts of it are equally important to similar work being done here in B.C., particularly youth from minority cultures.

Our project tried to locate the places where homeless youth gather (bus stations, parks, etc.) and then tried to make contact with them on a friendly basis in order to make them more aware of the health risks involved in being hustlers(sexual workers). We tried to explain how sexual promiscuity is the kind of risky behavior that could lead to the spread of HIV/AIDS and other STD's. Information on the HIV transmission forms by sexual contact was provided to those children and teens who already have become sexual workers.

They were also taught the proper way of using condoms as a way to reduce the risk of infection. They were also given pamphlets, information materials, and we let them know about the fact they can go to our information centre to get counselling, information and condoms, knowing that we would not force them back home or to a foster home unless they want to leave the streets and ask for our help.

During the first year of our project, we distributed almost 1,500 condoms and 2,400 information pamphlets, and 452 people received our information.

What we found was that risky sexual behaviour was reduced and ignorance concerning the facts about AIDS was reduced. Young people were more willing to listen and talk to people closer to their age, especially if from the same cultural group. They are much more open to people from non-governmental organizations (NGO's) than those who represent some agency from the government.

It was very clear that homeless youth would like to find better ways of surviving. They can be reached faster and easier by other young people who seem similar to themselves. The young volunteers of our project were effective, but it is important that they have a lot of knowledge about HIV/AIDS and other STD's in order to do this work effectively.

Biography:
Maurcio Coronada is from Ecuador, where he worked with homeless street youth from many different backgrounds. He is training in computers and human rights (especially AIDS activism), and has an interest in psychology and other cultures. Currently, he works with youth in Vancouver in a community development program.

S:AM4 Peer Education: Models for High Risk Youth

AIDS Outreach Program Targeting Aboriginal Street Involved Adolescents

Presenter:
Connie Fife

• Notes •

S:AM4 Peer Education: Models for High Risk Youth

Challenges of Providing Harm Reduction Education and Support in a Climate of Prohibition

Presenters:
Ken Quayle
Brian Mackenzie
Sandra Karpetas
MindBodyLove
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Telephone: (604) 215-0351; Email: brian_mackenzie@mindlink.bc.ca

ABSTRACT

The current climate of prohibition provides some challenges to the effective administration of harm reduction programs. Projects involving populations currently using illicit substances face difficulties in the areas of funding and receiving support from established agencies. People choosing to have sex or use drugs despite prohibitive messages need accurate information and effective tools to minimize the risks involved. MindBodyLove (MBL) is a peer-directed community-based project providing harm reduction education and support. MBL sets up tables at raves (dance parties attended by large numbers of primarily young people) providing condoms and information on safer sex, and on a number of legal and illegal drugs consumed by many of those attending. Support is provided for those having difficulties associated with drug use, such as "bad trips" or compulsive use, and training is available for security and health officials in effectively supporting people needing assistance. MBL also facilitates workshops on a variety of themes, including: self-esteem and relationship issues around safer sex and negotiating consent; accurate information on the effects and risks of drug use; understanding altered states of consciousness and non-drug methods of accessing them; and the historical, societal and legal implications of prohibition. This skills building session will provide an opportunity to discuss a number of important related issues. These will include strategies to provide effective harm reduction programs within the current legal and societal context, and efforts being made to change laws and policies in order to lessen the negative and dangerous aspects of prohibition.

Biographies:

Kenn Quayle has been working in community-based AIDS and drug education and support projects for twelve years. He is studying acupressure and Process Oriented Psychotherapy. He is co-founder of MindBodyLove, where his work involves program development, fund raising, volunteer training, community outreach and peer counselling.

Brian Mackenzie is a certified holistic bodyworker involved in developing ecological community in an urban environment. He has been investigating altered states of consciousness, ecstatic spirituality, and intentional community for over ten years. He is co-founder of MindBodyLove and is involved in developing educational materials and community networking.

S:AM5

The AIDS Informer

Presenters:
Jimmy Tait
Steven Hill
Patti Fraser

• Notes •

S:AM6 From the Ground Up: Supporting Injection Drug Users

Club Sandwich

Presenter:

Norman Edwards

• Notes •

S:AM6 From the Ground Up: Supporting Injection Drug Users

Celebrating Our Third Year: A Support Recovery House for HIV+ Addicts

Presenter:
Don Fraser
The Laurel House Project
Box 1152 Sechelt, BC VON 3A0
(604) 885-5112

ABSTRACT

The revelation that the HIV+ rate amongst the drug addicted population was about to surpass that of gay males, announced in 1994 at the 8th BC HIV/AIDS Conference, was well known to many working in the drug and alcohol field prior to any official announcement by the Health Ministry.
In response to this growing crisis, a small community based non-profit society, which had been formed years earlier to proved a residential supportive recovery house for alcoholics and drug addicts, took the unusual step of developing and then implementing it's own program of recovery from addiction specifically for those living with a compromised immune system - the Laurel House Project. This five man residential project was based on several simple and proven models. The project remains holistic - encompassing of mental (8 emotional), physical, and spiritual wholeness in it's approach to maximizing the "wellness" of each individual. This was the first project dealing with this dual problem in BC. From it's inception and to the present, the project has had the professional support of the local (Coast-Garibaldi) health unit.

After operation of the Project for over two years, the need for major structural renovations at the home forced a relocation of the Laurel House Project in May. The residents moved a block away into the Sunshine Coast Recovery Centre. It is hoped that by the time of this conference that a new home will again be functioning as a centre giving HIV+ addicts a home to change their lifestyles and a reason to live lives of dignity, strength and hope - free from addiction.

The project remains community based and continues to draw on the experience and support of the local community. This project has never been formally recognized by any level of government, nor has it received any taxpayer funding - an attributing factor to it's exceptionally high success rate. It is extremely cost effective and in its simplicity is applicable and transportable to anywhere in North American.

Bibliography:

D.Wm. (Don) Fraser, BA
Founder & Project Director, Laurel House Project
Executive Director, Sunshine Coast Recovery Centre

S:AM6 From the Ground Up: Supporting Injection Drug Users

Housing the Hard to House

Presenter:

Liz Evans

• Notes •

S:AM7

Loving, Healing and Surviving in the Meantime: Emotional, Spiritual and Mental (Psychosocial) Issues in Living with HIV

Presenters:
Georgia Clifton, Doreen Millman, Robert Millman
Alan Mousseau and Ken Ward

The goal of this workshop is to raise awareness and increase understanding about the feelings encountered in the mind, heart, and spirit of those living with HIV (and in those who care about them), and to learn how such feelings directly affect physical health.

We will explore how people's feelings about having HIV (or knowing someone who has it) make such a big difference not only in the quality of their life and relationships with others, but also how these emotional and spiritual parts of their inner life will directly affect how healthy their body stays and how long they might survive.

Participants will learn how it usually isn't the medical parts of AIDS that present the biggest problem in everyday life, but rather more it's what AIDS *means* inside each person's mind, feelings, and spirit that will affect the quality of their life and their interactions with others.

How people feel about having the virus, and how they cope with these feelings, will usually have a big influence on their actual physical health and how well their medical treatments will work. How people feel inside their heart when learning someone they love has the virus will determine how they treat this person, and whether they will trust to continue loving them, because if people are too frightened or ashamed to listen openly to factual information someone is trying to tell them about AIDS, this information will not be helpful or useful.

Facts about HIV won't matter if the emotions will not permit them to be believed.

Because this workshop will be open to those affected by HIV as well as those infected by it, participants will have the chance to explore these issues together, and learn from each other, as well as discover ways to help reduce the isolation and rejection experienced by those living with HIV.

They will begin to understand how everybody's secret unspoken fears and worries will directly influence their attitudes and treatment of others, even within their own family — and how this also affects how they behave in situations where they might be putting themselves at risk.

The instructor will explain how the immune system (which needs to stay as healthy as possible to fight HIV infection) is found at the center of each of us where the emotional, mental, and spiritual parts of us all intersect with the physical part, so it isn't enough to only treat someone's medical problems as a separate "thing".

If people want to stay healthy, their emotional, mental, and spiritual concerns, and feelings, must also be brought up for exploring and experiencing, not just once, but regularly enough that people become comfortable about having feelings and expressing them. This way, inner feelings will not become destructive to their health — and can also be understood and respected for the teachings they provide in better balancing each person's life, each day. This is why counsellors encourage people to examine and express their feelings, and help them do so in a way that's safe.

If people are more in touch with their feelings, they will likely stay healthier longer. This holds true not only for those who live with HIV themselves, but also for everyone else around them — this is a truth about *all* health concerns, not just only HIV. Understanding this interrelationship between feelings and health is especially important to remember when people consider their reactions to someone in their own family or community who is HIV-positive, and they aren't sure how to interact with them or be of help to them.

While doctors treat people's medical problems, counsellors help them deal with the other parts of their life, and this workshop will cover the wide range of issues that might come up, beginning with the very early stages when people first consider the need to get tested, all the way through to the numerous issues related to passing on or grieving losses — or, as has become increasingly more common, those unique issues special to long term survivors and their loved ones.

Participants will learn not only from the Instructor sharing her own experiences about specializing in counselling those infected or affected by HIV, but also from hearing about the experiences of several of her friends and clients, as well as from many people in the room speaking spontaneously about their own situations and feelings.

The Instructor will provide and discuss numerous handouts about topics like "Things that help long-term survival", "List of psychosocial issues arising in counselling HIV infected/affected", "What you need to know about HIV/AIDS counselling", etc., and so participants will be able to take away useful and practical factual information to absorb later at home and share with others, and thus they can more easily concentrate their immediate attention on the more emotional experiences being discussed and shared in the room, without having to worry about taking notes.

Further Readings:

Taking the Medicine Wheel to the street — Educating and counseling Aboriginal street youth about HIV/AIDS. By: J. Weiser; in: Rowe, B. and Ryan, B. (Eds.), Social work and HIV — The Canadian experience. (1997; *in press).*

HIV/AIDS psychotherapy — What psychologists need to understand. By: J. Weiser; in: The Canadian Health Psychologist, 1996, 4:1, 18-23.

Psychosocial consequences of living with HIV/AIDS — Or, "What I learned from my clients and friends". By: J. Weiser; in: The Social Worker, 1996, 64:4, Winter, 18-33.

Psychology and HIV/AIDS. By: J. Weiser; in: B.C. Psychologist, 1995, Spring, 5-6.

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S:PM1 Issues in Pregnancy Before and After

The Lived Experience

Presenter:
Kecia Larkin

• Notes •

S:PM1 Issues in Pregnancy Before and After

HIV Testing and Confidentiality: A Reexamination of the Issues

Presenter:
Louise Shap
Canadian HIV/AIDS Legal Network, 4007 de Mentana, Montreal H2L 3R9:
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ABSTRACT

Objective:
For many years, legislators and policy-makers have been debating how to offer HIV counselling and testing to pregnant women. Four main options have been considered: (1) HIV counselling and testing only in the presence of risk factors or on request; (2) routing HIV counselling and voluntary testing of all pregnant women; (3) routine testing of all pregnant women, with a possibility to opt-out; and (4) mandatory HIV counselling and testing of all pregnant women. The objective is to analyze which of these options best balances the interests of pregnant women, their babies, and public health.

Methodology:
(1) The legal and ethical issues raised by HIV testing of pregnant women, in Canada and internationally, have been researched and analyzed; (2) a review of the issues has been included in a discussion paper on HIV testing and confidentiality; (3) comments have been solicited; (4) a workshop has been organized.

Results:
An approach to testing of pregnant women is suggested that meets the challenge of ensuring that all HIV-positive women who desire to continue a pregnancy are offered effective means to reduce the risk of HIV transmission to their babies while respecting the rights of all pregnant women to decide for themselves whether or not not to be tested for HIV.

Discussion:
Now that a possible preventative treatment has been found, the pressure to test pregnant women is great. In the rush to respond to this innovative therapy, there is a serious risk that the basic rights of pregnant women will be swept aside. In all Canadian provinces and territories, all pregnant women - and not only those considered at risk of HIV - should be offered the opportunity to undergo an HIV test during pregnancy and counselled about the advantages and disadvantages of HIV testing. In contrast, coercive measures such as routine or mandatory testing of pregnant women involve an undue interference with the autonomy rights of pregnant women, and cannot be justified as a matter of law or medical necessity.

Biography:
Louise Shap MHSc., LL.B is a research assistant for the Joint Project on Legal and Ethical Issues Raised by HIV/AIDS of the Canadian HIV/AIDS Legal Network and the CAS and assistant editor of the Canadian HIV/AIDS Policy and Law Newsletter. She has an extensive background in palliative care, grief and bereavement and has worked in the area of biomedical ethics.

S:PM1 Issues in Pregnancy Before and After

Early Permanency Planning: Service Provision for Families Living With AIDS

Presenter:
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ABSTRACT

Issues:

Parent(s) infected with HIV/AIDS face the difficult task of planning for their children's future in the event of their incapacitation or death. Given the unpredictability and individualized nature of a family's experience with the disease process, service providers must be prepared to provide flexible, and multifaceted services when responding to the planning needs of HIV affected families.

Description:

Social service and health care providers are viable facilitators within the permanency planning process. In order to provide comprehensive services to HIV/AIDS affected families, emerging intervention strategies must acknowledge the numerous issues that families face in developing a permanency plan. The hurdles that families face include coming to terms with the terminal nature of the disease, disclosure to family members and friends, anticipatory grief reactions, and legal and financial planning. Early permanency planning is an emotional process that is carried out under the exhausting, and fluctuating nature of one's illness.

Conclusion:

Early permanency planning ensures a level of stability for children upon the parent(s) death, by ensuring advanced and reflective planning aimed at reducing the chance of unstable and emergency interventions. Planning should remain family centered, multifaceted, and flexible, in order to address the multiple and changing issues that families affected with HIV/AIDS confront. Inherent in this approach is the call for culturally sensitive and individualized services. Responsive protocol must be built cooperatively among all relevant sectors including medical providers, mental health services, community based agencies, child welfare organizations, financial service providers, and legal professionals.

Biographies:

Julie O'Neil is a candidate for the Master of Social Work Degree, from McGill University. Julie graduated with distinction from the Honours Bachelor of Social Work program, and has a Bachelor of Arts (Sociology) degree, both from the University of Western Ontario. She is completing a practicuum at The Centre for AIDS Services of Montreal (Women).

S:PM2 Empowerment Through Information

Empowering Youth to Confront HIV/AIDS: Models of Prevention Education

Presenters:
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ABSTRACT

Objectives:

1. To empower youth to identify and develop program models of youth-driven prevention education programs across Canada.
2. To build partnerships among youth, youth agencies, and community-based HIV/AIDS organizations.

Methodology:

With the help of the National Youth Working Group, the project coordinator:

1. Identified innovative youth-driven HIV/AIDS prevention education programs for positive youth and youth at risk.
2. Facilitated youth to evaluate the programs at five demonstration sites and to develop a model which describes the programming within the context of community development.
3. Will disseminate models to educators and health providers in youth agencies and community-based HIV/AIDS organizations.

Results:

Programs for youth must be developed and implemented by youth to be effective and responsive to their needs. Although a few programs have managed to develop successful youth-driven prevention education programs, there is currently a lack of such programs in Canada.

Discussion:

We must endeavour to involve youth in all prevention education efforts that target them. We must find appropriate and meaningful ways to achieve this goal. We can learn from the results of a national survey and consultation conducted among over 600 youth by the Canadian AIDS Society, and from the experience of successful existing programs.

S:PM2 Empowerment Through Information

Parent/Family Resource to Facilitate Talking Sex and Risk Prevention

Presenter:
Katharina Kovacs Burns
AIDS Network of Edmonton Society
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ABSTRACT

Issues:

In Edmonton, a direct approach was taken with groups of parents who became involved in discussions around their children and topics such as sex, sexuality, health risks including HIV and pregnancy. Parents either: (1) expressed concerns about their children getting the 'wrong' information about sex, abstinence, condoms, pregnancy, and diseases, or (2) offered their support for school sexual health education or other youth targeted campaigns in the community, particularly focused on teenagers or young adults who were becoming sexually active. Parents felt that they also needed the same age-appropriate information to be able to talk to their own children.

Description:

Surveys and focus groups involving 220 parents were conducted to find out their perceptions about children's risks around sexual activities, as well as comfort levels in talking with their children and what they felt they needed in order to do this. The results indicated that parents felt that their children are at greater risk today of getting HIV or other STDs. Parents also felt it was important for them to talk to their children about sex, sexuality, STDs and HIV prevention, and pregnancy. They indicated that in order to talk to their children they would need (1) more information about how and when to talk to their children about these sensitive issues; (2) skills, tools, and approaches to communicate effectively with their children, including age-appropriate materials; and (3) background information on sexual development processes with children and teens, on HIV/AIDS, STDs, and on other related issues. As a result of parents and family input, a 'Parent/Family Resource' was developed with the support of Alberta Health, the Alberta Community Health Nurses Association, and the AIDS Network of Edmonton Society. The purpose of this resource was to help parents and children break down barriers about talking more effectively and openly about the issues concerning sex, sexuality, and the prevention of STDs including HIV, and pregnancy.

Conclusion:

Since the release of this resource into the community through public health clinics, and parent groups, the feedback and response has indicated some favorable outcomes. To date, evaluations from 68 parents who received and utilized the resource indicated that 97% were impressed or very impressed with the contents and the information for them and their children. Indicators for how information was used was also obtained. Parents provided additional input and are becoming involved in discussions, workshops, and training to guide or assist other parents/families.

Biography:
Author & Presenter is currently Coordinator of Education Services and Administrative Director of the AIDS Network of Edmonton Society. She has been involved in community and public health promotion for over 15 years. In the past three years, most of her work has been in HIV prevention education with community groups such as families, parents, youth, and ethnocultural communities, and women. She has trained peer outreach educators in these communities, and has looked at other approaches around sustainability of community-based programs.

S:PM3 Men Who Have Sex With Men: Critical Points of Crisis

The Bisex Survey: Investigating Bisexual Men in Ontario

Presenters:
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ABSTRACT

Objectives:

The objectives of this roundtable session are

1) to describe the conceptual and physical methodologies which underlie the BISEX Survey, a recently completed community-based telephone study of bisexual men in Ontario;

2) to summarize some of the study's findings, including a) the sexual relationships and sexual behaviours of bisexual men and the characteristics associated with high risk behaviour with both men and women; b) the associations between alcohol, drug use and use of condoms during sexual intercourse with male and female, casual and regular partners; c) disclosure of bisexuality to male and female sex partners and the characteristics of men who disclose; d) the internalized homophobia of bisexual men; f) the validity of self-reported sexual identity as a measure of sexual orientation; and e) the associations between a history of nonconsensual sex and bisexual men's unsafe sexual behaviour;

3) to discuss with session participants recruitment strategies, bisexual communities and their role in the research cycle, the use and promotion of a 1-800 toll-free telephone number, questionnaire development, the interview process, and the advantages and limitations of the study prototype for the investigation of this and other hard-to-reach or 'hidden' populations.

Methods:

The Bisex Survey utilized extensive promotion to recruit behaviourally bisexual men (at least one female and one male sex partner in the last five years) in the province of Ontario. In-depth interviews were conducted by trained interviewers using a 1-800 toll-free telephone line over a four month period during the first and second quarters of 1996. The one hour interview investigated sociodemographic characteristics, sexual behaviour with (male and female) regular and casual partners, HIV testing, HIV status, disclosure of bisexual sexual activity to sex partners and others, internalized homophobia, use of alcohol and drugs, level of drunkenness, sexual coercion, nonconsensual sex, sexual identity, sexual orientation, and sexual fantasy and desire.

Results:

This is the largest known study of bisexuality in North America. Response to the survey was greater than anticipated: ultimately 1,314 men were interviewed. Previous research has demonstrated that the concept of bisexuality is not well understood and bisexual men differ in their response to their bisexuality and the way they communicate it. The findings of the Bisex Survey support this. Of note: ongoing data analysis reveals the recruited sample to be markedly different from previous samples of homosexually and bisexually-active men recruited through venue-based studies in Canada. Initial results suggest bisexual men put themselves and a sizeable proportion of their male and female partners at risk for HIV infection; that there are different trends and different associations found between alcohol and drug use and unsafe sex by partner type; that the experience of respondents with nonconsensual sex may have an impact on subsequent sexual behaviour; and that bisexual men tend towards greater disclosure within sexually intimate relationships than with family, friends, colleagues or health care practitioners.

Discussion:

The physical setup and day to day operations involved in conducting this type of study were complex and time-consuming. The promotion and use of the 1-800 telephone number provided unique challenges for the investigators and study staff. The technique of toll-free telephone interviewing is an important and effective tool for the HIV sociobehavioural study of 'hidden' or hard-to-reach populations.

Biographies:

Ted Myers is Director of the HIV Social, Behavioural and Epidemiological Studies Unit of the Faculty of Medicine, University of Toronto and an Associate Professor in the Department of Health Administration. He also is a National Health Scholar for AIDS Research. His work has involved a variety of community-based AIDS/HIV evaluation and research projects among gay and bisexual men, First Nations Peoples, injection drug users and prison populations. Currently, he is involved with the epidemiology of behaviour and HIV prevalence among gay men, the study of sexuality specifically focussing on bisexuality and theoretical work on community-based research and HIV. He has published numerous articles and presented papers at international conferences in the areas of addictions, HIV, health education, health promotion and health policy.

Dan Allman is a sociologist within the HIV Social, Behavioural and Epidemiological Studies Unit of the University of Toronto. His current work focuses primarily on methodological and theoretical aspects of sexuality and its study. He is author (with Ted Myers and Rhonda Cockerill) of Concepts, Definitions and Models for Community-based HIV Prevention Research in Canada (Toronto: HIV Studies Unit, 1997).

S:PM3 Men Who Have Sex With Men: Critical Points of Crisis

The Impact of Discrimination Against Gay Men on the Spread of HIV

Presenter:
Anne Vassal
Canadian HIV/AIDS Legal Network
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ABSTRACT

Objective:
To assess the various forms of discrimination that are manifest in the absence of positive social recognition of men who have sex with men, and that reduce the ability of individuals to take care of their health in general and the means of protecting themselves against HIV infection in particular.

Methodology:
(1) Existing resources have been researched and analyzed; (2) a literature review and annotated bibliography have been produced; (3) a discussion paper has been produced and widely distributed; (4) comments have been solicited; (5) a workshop has been organized.

Discussion:
More than a decade after the emergence of HIV, it has become clear that transmission of the virus is closely related to features that are characteristic of a given milieu, and that certain social conditions, including discrimination, increase individuals' vulnerability with regard to HIV infection. The issue here will therefore be the way in which discrimination is socially constructed today in Canada, and the various forms it can take. Although the social discourse around homosexuality has evolved, as evidenced in several well-known instances of progress on the legal front, discrimination - overt or otherwise - is still rife. It is evident, in particular, in limited knowledge and perspectives in several sectors, be it education, research or the health-care system. It will then be discussed how this attitude - if not frankly hostile, then at least not much inclined to recognize the existence of this group - permeates the social context that influences sexual orientation on the one hand and, on the other, whether or not safer behaviours are adopted.

Biography:
Anne Vassal has worked on HIV/AIDS issues since 1991, as a consultant in political strategies development for the Quebec Minister of Health and Social Services and, more recently, as a researcher for the Joint Project on Legal and Ethical Issues Raised by HIV/AIDS of the Canadian HIV/AIDS Legal Network and the Canadian AIDS Society. She currently works with the Scientific Director of the Reseau Sida et maladies infectieuses du FRSQ, Montreal, Quebec.

S:PM4 Peer Education: Models for High Risk Youth

HIV/AIDS Education for Youth: More Than Just AIDS 101

Presenter:
Sheri Foley
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ABSTRACT

While there is considerable evidence that youth have access to accurate information about HIV/AIDS, especially in relation to how the disease is transmitted, information alone does not effectively change behaviour. One of the challenges facing educators is to find ways to encourage and facilitate behaviour change among youth so that information is translated into safer practices, i.e., condom use, abstinence, and never sharing needles.

In addition, a number of barriers which prevent the behavioural changes necessary to prevent HIV transmission have been identified in the research. These barriers include: poverty; unstable housing; violence; homophobia/heterosexism; racism; sexism; lack of peer support and; lack of community or feelings of isolation (Resource Guide, Canadian AIDS Society, 1996).

A number of different tools have been identified and used which are reported to have a greater impact on behaviour change and reducing risk behaviours when they are used as a complement to traditional AIDS 101 presentations. These tools include: (i) a visual, participatory presentation of the rates of HIV transmission (to be demonstrated during the session); (ii) workshops that teach youth negotiation skills (which may be specifically related to condom use or abstinence); (iii) workshops which help young people become more comfortable in talking about and using condoms; and (iv) workshops that help young people recognize their rights as individuals and emphasize self esteem and self respect. The presenter will demonstrate and summarize these options for participants.

Participants in the session will be challenged to discuss and evaluate these options and to further explore how many of the factors that inhibit safer practices among youth may be reduced. While many of the barriers are systemic, it is critical that we attempt to address the need to provide youth with not only accurate and comprehensible information, but further to provide youth with the necessary skills to encourage behaviour changes that reduce risk activities. It is only through the elimination of the barriers inhibiting behaviour change, and providing youth with workshops that include negotiation skills and environments that promote and encourage self esteem and self respect, that we can hope to reduce the transmission of HIV within this group.

Biography:

Sheri Foley, M.A. (Criminology, Simon Fraser University), B.A. (Sociology/English, University of British Columbia) has worked as an HIV/AIDS Educator with the Lower Mainland Purpose Society for Youth and Families in New Westminster since October of 1995. Funded by the Ministry of Health, Ms. Foley also headed a research project examining the differences between traditional models of HIV/AIDS education and a peer created model.

S:PM4 Peer Education: Models for High Risk Youth

HIV/AIDS Beyond the Basics

Presenters:
Trevor Corneil
Allison Flannagen
YouthCO AIDS Society
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ABSTRACT

Issues:
Over the last two years, practical advances in the basic science and treatment of HIV/AIDS have changed gear, from slow and agonizing to fast paced and exciting.

Efforts made to manage HIV/AIDS within the community are inextricably linked to these advances. As such it is essential that members of the HIV/AIDS community not only learn this new information, but use it in their ongoing efforts to fight this disease and educate others.

Unfortunately members of the scientific, medical, and HIV/AIDS communities do not always speak the same language. Communication and thus understanding are limited. This is especially true for youth. As such it is essential that interfaces between these communities be strengthened and integration begin. Only then will we be able to fight the HIV/AIDS epidemic head on.

Description:
HIV/AIDS Beyond the Basics. In an integrated fashion, participants will review some of the more complex aspects of HIV/AIDS, its medical management, and the practical application of this information within the community setting. This will be accomplished by means of several large and small group activities, facilitated by members of YouthCO Aids Society representing the scientific, medical and youth community. During this process participants will learn simple educational tips and facilitation techniques which they can take with them to use in their own organizations and community settings.

Conclusion:
The successful management of HIV/AIDS requires the co-operation and integration of the scientific, medical and HIV/AIDS communities. Communication is the first step.

Biographies:

Dr. Trevor A. Corneil
Physician (Inner City Primary Care) and recent graduate of the St. Paul's UBC Family Practice Program. Involved in a variety of community projects including the Dusk to Dawn Youth Centre, and YouthCO Aids Society. Interests include community health infrastructure, HIV/AIDS education, and development work.

Allison Flannagen
A recent graduate of SFU and active volunteer with YouthCO Aids Society and AIDS Vancouver. Activities include materials development, outreach/education, AV Helpline, and a women's needs assessment.

S:PM5 The Costs of Living with HIV

Income (In)Security

Presenter:

Evin Jones
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It takes more than the right medications to keep persons living with HIV healthy. Government is to be commended for establishing universal access to pharmaceutical medications. At the same time, inadequate levels of financial support for persons forced to rely on systems of income assistance have profoundly negative repercussions on peoples' health. The lack of access to adequate housing, to a good diet and to a decent standard of living that many persons living with HIV/AIDS experience, has resulted in increased health care costs and higher rates of morbidity. Advocates at the BCPWA Society and other organizations attempt to realize positive change on both an individual and systemic level, however short-sighted government policies render this a tremendous challenge.

Biography:

J. Evin Jones (BaH, LL.B.) has been working at the BC PWA Society since January '96, beginning as an advocate and presently in the capacity of Advocacy Services Developer.

S:PM5 The Costs of Living with HIV

The Cost and Economic Impact of HIV/AIDS and The Economic Costs of HIV/AIDS to First Nations Persons in Vancouver

Presenters:

Robin Hanvelt

Phil Hall

David Schneider

• Notes •

S:PM6 Bodily Hazards, Emotional Risks: The HIV/AIDS Workplace

Profile of Persons Accidently Exposed to HIV in British Columbia

Presenters:
Alastair McLeod
Ann Beardsell
BC Centre for Excellence in HIV/AIDS
St. Paul's Hospital, 608 - 1081 Burrard Street, Vancouver, BC V6Z 1Y6

ABSTRACT

Objective:

To identify occupational and situational characteristics of persons accidentally exposed to HIV in British Columbia (BC).

Methods:

In 01/96 the BC Centre for Excellence in HIV/AIDS (The Centre) expanded their guidelines for the treatment of accidental exposures to HIV with antiretroviral therapy. The guidelines were established by a working committee and were intended to assist BC health care providers and other workers who have sustained exposure to blood and body fluids in the workplace or community setting. The committee recommended for persons with massive, definite or probable exposures that ZDV and ddC be taken in combination for a one-month period. Five-day starter kits were provided by the Centre to all emergency departments and eligible community health clinics to ensure that exposed workers province-wide would have universal access to treatment. An evaluation component to the program was added in 06/96. The Guidelines were updated in 02/97 to include triple therapy.

Results:

From 06/96 to 01/97, a total of 340 BC workers (194 women, 137 men, and 9 of unknown gender) sought treatment for accidental HIV exposure in BC. The median age of these individuals was 37 years (40 years in women and 36 years in men). Of the 239 exposures where occupation was known, 69 (29%) we attributed to nurses, 39 (16%) to police officers, prison and security guards, or paramedics, 27 (11%) to physicians or medical students, and 25 (10%) to janitors, housekeepers, or sanitation workers. The exposure was attributed to a cause in 316 (93%) accidents. Two-hundred and twenty-three (71%) of these accidents were due to a hollow bore needle stick injury. Other numerically important causes included body fluid splashes (n=18), sexual assaults (n=18), and bites (n=10). The site of the accident was noted in 268 (79%) of accidents. Of these 144 (54%) occurred in medical facilities. The rest of these accidents occurred in correctional facilities (n=12), bars, hotels, or motels (n=11), and other varied community settings (n=101). The city or town where the accident occurred was recorded in 319 (94%) cases. Of these 63 (20%) occurred in Vancouver, 21 (7%) in Surrey, 21 (7%) in Victoria, 14 (4%) in Burnaby, 12 (4%) in North Vancouver, and 13 (4%) in Nanaimo.

Conclusion:

This evaluation exercise highlights the large number of accidental exposures to HIV occurring in BC. Most importantly we have shown that accidental exposures in this province are by no means limited to Vancouver, medical settings, or to health care workers.

S:PM6 Bodily Hazards, Emotional Risks: The HIV/AIDS Workplace

TB and HIV: Ethical and Practical Questions in Developing Community Based Workplace TB Prevention Strategies

Presenter:
Elisse Zack
Canadian AIDS Society HIV/TB Project
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ABSTRACT

Objective:

To report on, and explore further, the process and problems encountered in the process of helping community based AIDS Service organizations develop workplace TB prevention policies.

Methodology:

a) The overall process of the workplace TB policy development process will be described briefly.
b) The main portion of the discussion will explore the ethical and practical considerations which arose during the process, e.g. the strengths and drawbacks of workplace policies in community based HIV/AIDS work, balancing the rights of the individual with the need for a safe workplace, problems dealing with airborne infections in an HIV/AIDS organization, legal considerations, "duty to accommodate" issues, balancing the role of public health with the philosophy, values and needs of community based HIV/AIDS organizations in relation to TB
c) Participants will have an opportunity to discuss these issues and learn what several community HIV/AIDS groups in Canada have done in relation to these questions.

Real, recent, examples of cases of TB in Canadian AIDS groups will be discussed anonymously, to help clarify the process which groups have undertaken and the issues/questions they have dealt with. Sample TB policies developed by community based groups across Canada will be available (with permission of the groups).

Biography:

The presenter, Elisse Zack, has been working for the Canadian AIDS Society with community HIV/AIDS groups across Canada for the past 4 years. The work involved teaching about HIV/TB and helping groups develop workplace policy strategies to make their organizations better able to prevent TB, care for people who may have TB, and, hopefully to prevent other airborne infections as well. This process has involved in-depth exploration of all the ethical, moral and practical questions that will be discussed in the above "Problem Session"
Current position: HIV/TB Project Coordinator, Canadian AIDS Society

S:PM6 Bodily Hazards, Emotional Risks: The HIV/AIDS Workplace

Creating Meaning in the Midst of Sorrow: Meeting the Challenges of Cumulative Grief in AIDS Service Organizations

Presenter:
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ABSTRACT

Issue:

Most HIV/AIDS service providers have experienced the deaths not only of numerous clients but also of colleagues and community members. These cumulative losses mark the distinct and crushing feature of bereavement in AIDS saturated communities. The AIDS Bereavement Project of Ontario uses the expertise of 2 community-based activists to work directly with the province's AIDS agencies. Grief, traditionally viewed as a personal matter, is presented as an occupational health and safety issue for workers. Through a holistic model incorporating support, education, action and ritual, agency personnel work collaboratively to investigate and respond to individual and organizational grief.

Description:

This workshop will examine the effectiveness and impact of work done with 33 agencies and 928 individuals during the Project's first 3 years. A recent evaluation of the Project tested the hypotheses that unaddressed grieving impacts on AIDS agencies in areas related to work performance, work relations and work attitude as well as general psychosocial functioning and health of workers. The evaluation also examined the specific ways in which the Project's interventions affected individual and agency ability to cope with multiple loss.

Conclusions:

While there were significant regional differences, respondents confirmed the following reactions to cumulative grief: blurring of boundaries, overworking, poor morale, emotional outbursts, anger, helplessness, despair and isolation. However, even though the impact of multiple loss has been "negative", there were also across-the-board "positive" results. People reported an enhancement in the meaning of and appreciation for life and a positive impact on their emotional and spiritual health. It is clear that workers are highly invested in their fight against AIDS. The positive effects of multiple loss should not be ignored as these responses can form the foundation for an effective, agency-wide response to grief.

The evaluation demonstrates that the Bereavement Project has had an indisputable positive impact on AIDS Service organizations in Ontario. The Project has developed both language and tools to assist personnel to work together in conceptualizing and communicate their individual and organizational " grief responses" and to build effective "coping strategies".

Biography:

Yvette Perreault is co-creator and currently coordinator of the AIDS Bereavement Project of Ontario. Prior to that, she spent 6 years with the AIDS Committee of Toronto as Director of AIDS upport. Yvette comes with extensive experience in community organizing, having spent 10 years in the field of violence against women.

AIDS Grief: "Out of the Closet and Into the Boardrooms" — The Bereaved Caregivers

YVETTE PERREAULT, AIDS Bereavement Project of Ontario, Toronto, Ontario, Canada

As of this writing, over 7,000 Canadians have died of AIDS. Each one of these deaths represents a life that touched countless networks of family members, loved ones, neighbors, co-workers, acquaintances, and the many paid and unpaid caregivers who accompanied these individuals through their battle with AIDS. With those 7,000 deaths comes the legacy of loss — the tens of thousands of bereaved among us who grieve, actively, quietly, publicly, and privately. The impact of grief is profound and pervasive, yet most of us lack accurate information about this fundamental human condition and were not taught coping strategies to help us heal. In many circles, grief is barely discussed, particularly if the loss is due to AIDS. Mourners are left isolated, confused, and scared.

The AIDS Bereavement Project of Ontario provides community-based AIDS agencies with concrete support in the area of AIDS grief. Funded by the Ontario Ministry of Health, the project is a resource for Ontario groups wishing to look explicitly at AIDS caregiver grief. The bereavement project works with groups to design workshops, train paid and unpaid workers, and assist management in assessing and enhancing individual and agency coping strategies. Now into its second year, the two project staff have worked with 20 agencies, presented to 800 individuals, and facilitated one-day and two-day workshops for 200 frontline workers.

Time Alone Does *Not* Heal All Wounds

Tragically, many of our workplaces and professional associations do not attend thoroughly to the occupation-related grief needs of caregivers. Without knowledge and appropriate interventions, workers are left suffering enormous stress, often believing they have a "burnout problem" that they cannot personally remedy with a "stress management" program. When we as caregivers are not supported in acknowledging and working through the impact of these deaths, our ability to perform effectively in our jobs becomes diminished. It is virtually impossible to be fully present to the many HIV/AIDS-related losses faced by our clients, colleagues, and communities when their stories strike at the chords of our own undealt-with grief.

Just as AIDS has challenged us to rethink much about palliative care, so too has the disease expanded our understanding of grief, particularly as it relates to multiple and continuing losses. While there seems to be a natural constellation of responses to death, there are unique factors associated with AIDS that increase the complexity of grieving. The impact of the social isolation, stigma, disenfranchisement, lack of spiritual support, fear of contagion, multiple loss, homophobia, illness-related complications, and survivor guilt is tremendous (1,2,3,4,5). Among the manifestations of grief associated with AIDS are a greater than usual amount of rage, fear, shame and unresolved grief (3), feelings of guilt, helplessness, loss of intimacy, increased physical symptoms, self-destructive behaviors, insecurity, numbness, and pessimism (5).

In any general study of bereavement, these symptoms might signal "pathology". But this type of reaction can also be seen as a *normal* response to *catastrophic* events rather than a *maladaptive* reaction to a normal stressor (6). It is not that AIDS grief is uncomplicated, but the application of yet another medical or psychiatric label to large segments of communities struggling valiantly for acceptance and legitimacy is simply not helpful. We have found it more useful to place the lived experience of grief into a conceptual framework consistent with the activist nature of the fight against AIDS. *However complex, AIDS grief needs to be understood as normal grief in an abnormal time.*

Multiple loss is a grief whose content and course differs from grief responses subsequent to a single death. It occurs when people are experiencing bereavement overload and have no time to fully express their loss before another occurs, resulting in each grieving process compounding the one before. Issues in multiple loss include: (7,8)

Grief
- unresolved and anticipatory grief
- learning to live with death as a constant companion
- preoccupation with one's own mortality

Survivor Guilt
- "Why am I here and they're not?"
- struggle to make meaning out of what one has witnessed

Individual Burnout
- loss of normal emotional responsiveness
- numbness and isolation
- uncontrollable emotional states

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- disassociative mental states, disconnection from self and others
- pessimism and fatalism, view of the world as hostile
- insecurity and despair, loss of safety in community

Workplace Burnout

- loss of interest and involvement in work
- decrease in productivity and morale
- increase in workplace absenteeism
- difficulty in setting limits
- "callused" worker unable to connect with others
- projection: avoid hearing the horror by interrupting people or distracting them from accounts of pain

Responses Similar to Post-Traumatic Stress Disorder

- wild swings between numbing and flooding
- nightmares and flashbacks, distressing, intrusive images of death
- relentless anxiety, uncertainty over who is next
- self-neglect, self-destructive behaviors

There is an emerging body of work related to therapeutic interventions for individuals bereaved as a result of an AIDS death (see references). We actively encourage grieving individuals to seek out therapists, mental health professionals, and community supports skilled in the specificities of AIDS grief and multiple loss. At the AIDS bereavement project our primary interest is the impact of sustained losses on *communities* and *groups* of people organized to respond to AIDS. We challenge boards and executive directors to view grief not simply as a "personal problem" but rather as an "occupational hazard". We ask:

- *What are the unique manifestations of grief in your workplace?*
- *How well are you preparing your workers to live with the eventuality of overwhelming loss and constant grief?*
- *What systemic responses, policies, procedures, and concrete supports are in place to offer paid and unpaid workers timely, appropriate interventions prior to burnout and diminished effectiveness?*

We often say, *"If you're managing an AIDS agency, you're managing a grief agency."*

Caregivers in AIDS agencies differ from other social service and palliative care workers in significant ways: (9)

- AIDS caregivers usually form a counseling relationship long before the point of death, unlike palliative care workers;
- It is more likely that AIDS counselors are in the same age cohort as their clients, whereas most palliative caregivers are not, since AIDS affects a younger population than cancer;
- Gay AIDS counselors share experiences and struggles around sexual and gender identity, social marginalization, and often a seropositive status — a host of issues not likely shared between palliative caregivers and patients;
- Unlike cancer, AIDS is often seen as a deserved punishment for immoral behaviors;
- Conventional training leaves AIDS workers painfully unprepared to deal with grief saturation;
- Classic stress reduction strategies (shorter work hours, fewer clients) do not address the central condition of those who provide psychosocial care to an HIV/AIDS population, namely the multiple deaths and related processes of grief for those who have died;
- AIDS caregiver grief is usually suppressed or appears in other contexts, such as continued organizational crisis/worker dissatisfaction. It has often snowballed into grief saturation, with problematic effects on the well-being of caregivers, staff continuity, and agency health.

Just as many in the palliative care community did not actively *choose* AIDS, most community AIDS workers did not choose to become so intimate with death and dying. As one support worker expressed it during a workshop:

> My area of expertise was not hands-on care with dying people — I came with an advocacy and social change background. Now I have tons of experience in palliative care, not as a chosen profession but because it was the logical conclusion to my longstanding relationships with sick friends. I believe our support services should respond to the entire spectrum of HIV/AIDS — including helping people die. I certainly would rather be cared for by people who know me as more than a patient! Here I am in my late 30s, forced to grapple with death in the same way as my grandparents — it is out of the order of things. This should not be happening to me at this stage of my life. What people don't understand is that this is not simply a job for me. As a gay man, it is about my community life as well. Eight guys in my building are sick. I am on a care team for one of my best friends. My co-worker is HIV+. Most of my political mentors are dead. My universe is full of holes. I have no idea how to plan for tomorrow, either personally or professionally. My whole world is AIDS. Even if I decided to leave, where would I go?

All too often, caregiver grief is confused with personnel issues or organizational development matters. These workers exhibit behaviors consistent with the effects of multiple loss:

- A compassionate support worker who is usually able to leave work behind has slowly become "without boundaries". She is taking work home and developing inappropriate friendships with clients.
- An executive director who once prided himself on running a tight, efficient ship now appears short-tempered, authoritarian, and seriously lacking visionary leadership.
- A volunteer coordinator, formerly a great planner, has become frantic —there is a lot of frenetic activity in the department but no measurable accomplishments and lots of detail falling through the cracks.
- A health promotion coordinator who seems to have lost his heart for the work — he uses the same script for every speech and no longer responds with humor and flexibility. He used to joke around a lot.

Costs of Unaddressed Agency-Wide Grief

These behaviors have collective and cumulative effects on AIDS organizations beyond the damage done to individuals. These negative organizational effects include the following:

- absenteeism, illness, high job turnover
- unpredictable results on the job
- decrease in productivity
- brittle, fragile, angry workers, emotional outbursts
- inability to set limits and say no, not using lieu days or taking vacations
- poor morale, flatness, lack of creativity
- employer costs: higher benefit premiums, costs of relief staff, costs of hiring and training
- disruption to clients and communities

While there are good reasons for AIDS caregivers to look at grief from an organizational perspective, we continue to encounter significant obstacles. We enumerate them below.

Grief Myths
- Grief not understood: "Isn't grief when you're crying over someone?"
- Impact minimized: "I hardly knew those clients — we weren't really intimate." "I'm sure my irritability has nothing to do with grief."

Grief in the Workplace Myths
- Not seen as relevant: no orientation to grief as part of training about HIV/AIDS. Seen only as an issue for support services.
- Will deal with grief once a critical number of deaths have made the impact noticeable — but no integrated response.
- Seen as a personal issue: "Professional objectivity and distance should keep workers from attaching. If they're having a reaction, it is an outside issue."
- "It's too big — a messy Pandora's box of emotions which doesn't belong in the workplace. If we open this up, it will take an unrealistic amount of time and money."
- "The current crisis within the agency has nothing to do with multiple losses nor with the recent death of our board chair —it is a side issue."

Specific to AIDS
- Many workers are also HIV+, making it difficult for people to rely heavily on colleagues to counteract stress.
- There is a concentration of losses in communities where people normally go for respite and replenishment.

We may summarize this section by repeating, *Short-term solutions are ineffective when working long-term with HIV.*

BUILDING A STRATEGIC RESPONSE TO AIDS GRIEF (10)

> We do not expect management to place workers in situations where they will be handling dangerous materials without proper training, equipment, and supervision. Should a worker hurt herself/himself on the job, agencies recognize their responsibility to support and accommodate that employee. Why is grief so different? Our sorrow and turmoil are directly related to stressors/losses experienced on the job. Surely workers could be better equipped and supported to respond to this element of risk and danger inherent in AIDS.
>
> — board member of an AIDS service organization

In the second section of this paper we consider how AIDS agencies may use prophylaxis and treatment at the organizational level when threatened with the risks of chronic and elevated grief as described above. Based on our experience with the AIDS Bereavement Project, we offer a series of recommendations divided among the following headings: planning process, assessment, acknowledgement of loss, training and skill building, support, structural and systemic changes, mechanisms of appreciation, and ongoing process.

Planning Process
- Include all staff and key volunteers. This counteracts the feelings of helplessness common to loss saturation.
- Set up a diverse team to canvass the agency about their bereavement needs.
- Leadership involvement is critical, as future organizational strategies may include revision of policies and benefits and other workplace changes.
- Every group has its organizational culture which must be acknowledged and respected.

Assessment
- What problems require solutions? Be realistic about the situation but also dare to dream. One of the most significant, albeit unexpected, outcomes of our work is the reported sense of team unity and mutual support which arises from the experience of looking at grief together.
- Identify confounding organizational issues to be dealt with separately. Workers may be reacting to downsizing and financial constraints. While the emotional impact of this can be dealt with in a session on grief and loss, the structural aspects are best kept for another forum.
- Clarify staff expectations of the organization; providing bereavement support is not intended to turn the agency into a therapy group for staff.

Acknowledgement of Loss
- Look at loss through the experience of people at all levels of the organization. What is the grief of the administrator? Of the receptionist? Of the volunteers? Note that loss is not only about death but relates to other transitions: staff turnover, program cutbacks, changing offices, expansion.
- Rituals are vital: notices, memorials, quilts, candle lighting. Create "shortforms" for discussing complex, painful issues in a way that allows workers to express themselves and yet continue with their work.

- Examine structures which impede the necessary flow of information for the acknowledgement of loss on an agency level, e.g. rigid confidentiality policies.

Training and Skill Building

- It is necessary to orient all workers to grief at some level, including the board.
- Recognize and appreciate a wide range of normal responses to loss: our responses are unique and culturally determined.
- Train workers to identify their individual patterns of grief. Do they know when they are grieving? How do they communicate that to others?
- Supervisors have a central role in creating a supportive environment.
- Training serves as a collective acknowledgement that grief is not a personal weakness. It also serves as a common framework for discussion and strategy development.
- Train on a holistic level. Include a broad range experiences such as working with emotions, with the body (massage), and with the spiritual aspects of grief and healing (visualization and hope systems).
- Present information on aspects of hardy personalities — those who successfully adjust to stress through "control, commitment, challenge, and connectedness" (11).
- Make grief and loss a part of the everyday discourse among caregivers.

Support

- Develop a range of supportive interventions: individual debriefings after a death, quality supervision, formal bereavement groups, team retreats, etc.
- Offer programs internally and on work time.
- Provide external support: employee assistance programs. Dealing with current losses can resurrect old losses.
- Encourage contained opportunities for emotional expression, including anger.
- Reconnect people to life-enhancing elements: joy, humor, celebrations.
- Attend to closures in a continual way. We tend to minimize the lesser losses and transitions and focus only on significant losses, but through attention to the smaller goodbyes we prepare for the greater ones.

Structural and Systemic Changes

- Requires commitment of the employer to accommodate acute and chronic stress of grief. Someone needs to champion this cause and keep grief on the agency's agenda.
- Redefine and review bereavement leave, mental health days, dependent-care leave policies.
- Evaluate benefits and internal support systems. Is supervision adequate?
- Look at stress-relieving practices: job variation, flex time, unpaid leave.
- Integrate grief awareness into the philosophy and core values of the agency: grief work is part of a holistic health strategy and promotes healthy workers and a healthy agency.

Mechanisms of Appreciation

- Death can too often feel like a failure. Balance the strain of loss by deliberately creating opportunities for positive interactions with workers.
- Set aside regular times to talk about accomplishments and goals.

Ongoing Process

- Develop a system for integrating grief awareness into the orientation process of all workers.
- Information to be distributed regularly and programs offered routinely to staff, volunteers, and board: do not wait for the crises.
- Provide for a regular review of bereavement strategies: What else do we need?

Ultimately, the goal of developing an agency response to multiple loss is the creation of healthy agencies and the creation of healthy, resilient, creative workers. Just as communities have mobilized to understand and respond to HIV/AIDS, we believe that communities can organize successfully to meet the emerging challenge of grief. But first "grief" has to come out of the closet as an identifiable individual reality, as an agency problem, and as a community norm.

The legacy of loss is both individual and communal. Grief work is bearing witness to our personal and collective stories. Grief work is "re-membering" together and building a connection with our sorrow and hope to sustain community vitality.

> *Heal the community by healing the individuals and in this way, resurrect the sense of community fundamental to the mental health of the individual.*
> — Herman Kaal (12)

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S:PM7

Traditional Healing and Wholeness: Gaining the Ability to Use the Virus as a Reconciliation with Self and Spirit

Moderator:
Robert Cross

This presentation focuses on the belief that, in order to heal our physical self, we must internalize and focus on the spiritual self. Traditional Native healing will be presented as reinforcement for awakening this spirit to achieve wellness. In the past, Native people survived epidemics, but there was not such a stigma attached to those infected or to their families and friends. Life had great value, and survival depended upon pulling together in times of crisis.

Looking to traditional value systems in response to HIV/AIDS provides a means to educate and strengthen both ourselves and our communities. To survive this disease, we must focus on finding a balance within ourselves and become aware of our spiritual value.

Biography:
Robert Cross, Oglala Lakota and Northern Cheyenne, is a traditional healer who has worked with Native people and their spiritual healing for over twenty years. Through serving as their "Scout", he helps them become better aware of what may be afflicting them physicially, emotionally, mentally, and spiritually, and he has a special interest in helping those living with HIV to find a balance within themselves and become more aware of their spiritual value.

For further information contact Robert Cross at (303) 430-8214.

Learning from Vancouver: Lessons for Canadian Cities

Presenter:
Steffanie Strathdee
BC Centre for Excellence in HIV/AIDS,
Department of Health Care & Epidemiology, University of British Columbia

Learning from Overlapping HIV Epidemics Vancouver: Lessons for other Canadian Cities

At a time when there is much optimism about new HIV therapies and for the first time, a declining HIV/AIDS mortality rate, it is a sobering fact that British Columbia is in the midst of an HIV public health crisis. The incidence of HIV infection is unacceptably high among many marginalized populations, including young gay men, Aboriginal peoples and women, but the situation is especially urgent for injection drug users (IDUs). In Vancouver, a state of emergency was declared in September, 1997 and a provincial harm reduction plan was unveiled in an effort to stem the wave of HIV infections which are concentrated in the Downtown Eastside of Vancouver.

This presentation will highlight findings from two ongoing prospective cohort studies of IDUs (VIDUS Project) and young men having sex with men in Vancouver (Vanguard Project). Currently, the rate of incident HIV infection in the VIDUS and Vanguard Projects are the highest known in North America in these respective populations. In both studies, there is evidence of ongoing high risk activities despite interventions. For example, a disturbing trend of relapse to unprotected sex is apparent among young men having sex with men who had previously reported consistent condom use. Also, among HIV-positive subjects who were aware of their serostatus, there were indications of continued needle lending to other IDUs, and unprotected sex in both study samples.

Unfortunately, these results are indicative of HIV prevention failure. A fundamental re-evaluation of prevention programmes is needed in Canada, which takes into account the changing dynamics of the HIV epidemic today, and involves the affected communities in every stage of the process. Prevention should take a broader approach to not only target HIV-negative persons, but to provide support, counselling and antiretroviral therapies to HIV-positive persons. It is important to recognize that identifying and removing barriers to receiving HIV therapies can extend quality of life and survival, and may lower the probability of transmission by lowering HIV viral load.

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Learning from Vancouver: Lessons for Canadian Cities

Presenter:

John Farley

• Notes •

Treatment Issues:
Where We're At and Where We're Going
Physician's Perspective

Presenter:

Julio Montaner

Professor of Medicine and Chair, AIDS Research
St. Paul's Hospital/University of British Columbia

There has been substantial progress in the field of HIV therapeutics during the last couple of years. This has been largely attributable to our better understanding of viral dynamics and the basic mechanisms responsible for the progression from HIV infection to disease. It is now perfectly clear that plasma viral load level correlates with disease activity and therefore rate of disease progression. Successful implementation of antiviral therapy should be aimed to suppress viral replication in order to abort this cycle.

Over the last year, it became clear that partial suppression of viral replication represents an undesirable strategy as this will ultimately promote the emergence of resistance. Given the limited number of therapeutic options, this strategy is to be discouraged. Current treatment guidelines recommend that antiretroviral therapy be aimed to fully suppress viral replication, as defined by achieving non-quantifiable plasma viral load levels using the most sensitive available test. In practical purposes this means aiming for plasma viral loads below 400 copies/mL in the clinic. More sensitive tests will soon become clinically available and this will allow us to further fine tune our therapeutic strategy.

At this time, there is evidence that full suppression of viral replication as defined above is associated with depletion of viral reservoirs, such as CSF, lymph node tissue, genital fluids, tonsillar tissue and gut associated lymphoid tissue. Preliminary data suggests that it may be possible to arrive to strategies of induction and maintenance therapy. Whether or not we will be ever able to achieve viral eradication and therefore discontinue therapy remains a controversial issue.

Antiretrovirals Therapy Guidelines
Adapted from CfE 1997

The field of antiretroviral therapy continues to evolve at a very rapid pace. This document represents an effort to provide guidance to prescribing physicians in order to facilitate ongoing care of HIV infected adults. Use of antiretrovirals in children, during pregnancy and following accidental exposure are covered in separate sections of The Guidelines. Inexperienced physicians are strongly advised to seek expert advice through the Centre before initiating or changing treatment.

Eligibility Criteria

- Documented HIV infection and
- Plasma viral load (pVL) greater than 5,000 copies/mL

or

- CD4 count below 500/mm^3 (or a CD4 fraction consistently below 25%) regardless of symptoms

Therapeutic Goals

- To decrease viral replication as much as possible for as long as possible.
- To prevent disease progression and through this to improve quality of life and prolong survival

Therapeutic Strategy

- Aim for high level suppression of viral replication (ie.: pVL below 400 copies/mL)
- If high level suppression of viral replication cannot be reached, the interim aim should be partial suppression of viral replication (i.e.: pVL below baseline and below 10,000 to 20,000 copies/mL, as long as the CD4 count remains stable and there is no clinical evidence of disease progression).
- High level suppression of viral replication may forestall (if not prevent) the emergence of drug resistant HIV variants.
- The duration of the antiviral effect is proportional to the maximal level of suppression (nadir).
- Only individuals who achieve high level suppression of viral replication can retain the antiviral response on a long term basis.
- High level suppression of viral replication may be more difficult to achieve and maintain among patients with very advanced immune deficiency (i.e.: CD4 count < $50/mm^3$)
- Do not use antiretroviral agents in monotherapy.
- Always use antiretroviral agents in combination.
- Given the drugs currently available, triple drug regimens are the standard of therapy.
- Favour combinations with additive to synergistic antiviral effect.
- Avoid combining agents with overlapping toxicities.
- When planning the treatment strategy, consider its downstream implications (i.e.: consider the impact of a given regimen on the remaining therapeutic options if the strategy fails due to viral resistance, tolerability or toxicity).
- Strict adherence to the therapeutic regimen is critical to maximize the magnitude and durability of the treatment effect.
- Underdosing can seriously compromise the magnitude and/or the duration of He antiviral response.
- pVL variability is about 3 fold or 0.5 log 10.
- CD4 variability is about 30%.
- pVL and CD4 variability may increase with illnesses, vaccinations, or other stimulants.

Initiating Therapy (Antiretroviral Therapy Naive)

- Triple drug therapy
    - two nucleoside reverse transcriptase inhibitors (NRTIs) plus either
    - a potent protease inhibitor (PI), such as indinavir (IDV) or ritonavir (RIV) and possibly nelfinavir (NFV) or
    - a non-nucleoside reverse transcriptase inhibitor (NNRTI), such as nevirapine (NVP)

Efficacy Monitoring

- Monitor initiation or change of therapy with viral load before and within the first 4-8 weeks to confirm expected effect.
- Monitor pVL (and CD4 count) every 3 to 4 months if stable.
- A change in pVL greater than 3 fold or 0.5 loglO should be considered clinically significant.

Safety Monitoring and Precautions

- Monthly to bi-monthly clinical follow-up.
- Monthly to bi-monthly blood work, including CBC and differential if taking zidovudine (ZDV) and/or lamivudine (3TC), and amylase if taking didanosine (ddI), zalcitabine (ddC) or stavudine (d4T) and possibly 3TC.
- AST, alkaline phosphatase, LDH, CPK, and CD4 count to be checked quarterly, regardless of regimen
- Be aware of multiple drug interactions when using protease inhibitors.
- Optimize hydration (i.e.: an extra 1.5 litres of bottled water) to decrease chances of nephrolithiasis when using IDV.
- Monitor fasting glucose quarterly if on PIs.
- Compliance and adherence to the recommended doses and schedules is critical.

Frequently Encountered Adverse Effects

- Abnormal liver function tests: AZT, d4T, PIs, NVP.
- Bone marrow suppression (anemia and neutropenia): AZT, less frequently 3TC.
- Circumoral paresthesias: RTV.
- Elevated CPK (+/- Myositis): AZT.
- Elevated triglycerides: RTV, ddI.
- Gastrointestinal upset: AZT, ddl, protease inhibitors (PIs).
- Glucose intolerance / diabetes: PIs, ddI.
- Kidney stones/flank pain/hematuria: IDV.
- Oral ulcers: ddC.
- Pancreatitis: ddI, d4T, ddC, rarely 3TC.
- Peripheral neuropathy: ddC, d4T, ddI.
- Rash: AZT, NVP, delavirdine (DLV).

Changing Therapy

I. Due to drug intolerance:
  - Consider possible overlapping toxicities.
  - Intolerance in the distant past does not preclude rechallenging under controlled circumstances.

II. Due to drug failure:
  - Confirmed pVL greater than 10,000 to 20,000 copies/mL on treatment: Change to three new drugs.

Drug failure is defined mainly in virological terms (i.e.: substantial and confirmed rebound of pVL in the absence of other likely reason). Whenever therapy is changed due to failure, a change to three new drugs should be encouraged. Avoid changing to a regimen likely to be cross resistant to previously failed agents. Changing a single drug within a failing regimen is strongly discouraged. Always consider the downstream implications of a given change in therapy. (i.e.: a change in therapy always increases future therapeutic constraints).

Antiretroviral Agents (as of 07/97)

Abbreviation	Generic Names	Trade Names
Nucleoside Reverse Transcriptase Inhibitors (NRTI)		
AZT	zidovudine	Retrovir
ddI	didanosine	Videx
ddC	zalcitabine	Hivid
d4T	stavudine	Zerit
3TC	lamivudine	Epivir
1592U89	TBA	TBA
Protease Inhibitors (PI)		
IDV	indinavir	Crixivan
RTV	ritonavir	Norvir
SQV	saquinavir	Invirase
SQV-EOF	enhanced oral form.	Fortovase
NFV	nelfinavir	Viracept
141W94	TBA	TBA
Non Nucleoside Reverse Transcriptase Inhibitors (NNRTI)		
NVP	nevirapine	Viramune
DLV	delavirdine	Rescriptor
DMP-266	TBA	TBA
Nucleotide Reverse Transcriptase Inhibitors		
AFV	adefovir	TBA

Dosing of antiretroviral agents available by prescription

- ZDV: 400 to 600 mg/day in at least 2 divided doses.

Note: 600 mg/day is the FDA approved dose; 3400 mg/day is effective; lower doses are not to be encouraged.

- **ddI**: 35 to 49 kg fi 200 mg/day
  (two 50 mg tablets twice daily).
  over 50 kg fi 400 mg/day
  (two 100 mg tablets twice daily).

Note: the full daily ddl dose can be taken once daily, however, the prescription should be altered to reduce the amount of buffer (i.e.: for 400 mg/day, use two 150 mg tablets and one 100 mg tablet taken at once). ddI must be taken on an empty stomach (ie. two hours after and one hour before meals and away from indinavir)

- ddC: 0.75 mg three times daily, for a total of 2.250 mg/day.

- 3TC: 150 mg twice daily, for a total of 300 mg/day.

- d4T: 40 to 60 kg fi 60 mg/day (30 mg twice daily).
  Over 60 kg fi 6O mg/day (40 mg twice daily).

- IDV: 800 mg every 8 hours orally, on an empty stomach
  (i.e. two hours after and one hour before meals).

- RTV: 300 to 400 mg orally BID for first two days, escalating to 600 mg orally BID within two weeks; however, RTV dose Should be reduced to 400 mg orally BID when combined with SQV.

- NFV: 750 mg orally TID with food.

- SQV: use not encouraged except in combination with RTV. When using RTV/SQV, dose should be 400 mg orally BID of each drug. When given without RTV, the dose of SQV is 600 mg orally TID.

- NVP: 200 mg orally once daily for two weeks, then increase to 200 mg twice a day.

- DLV: 400 mg orally TID).

Selected options for change in therapy due to treatment failure

Current Regimen	**Selected Options** ** only limited data available*
2 NRTIs	2 new NRTIs/PI
	2 new NRTIs/NNRTI
	*new NRTI/PI/NNRTI**
	*2 PIs/NRTI**
	*2 PIs/NNRTI**
2 NRTIs/PI	2 new NRTIs/NNRTI
	*new NRTI/PI/NNRTI**
	*2 PIs/NRTI**
	*2 PIs/NNRTI**
NRTIs/NNRTI	NRTIs/PI
	2 PIs/NRTI
2 PIs/NRTI	2 new NRTIs/NNRTI
2 PIs/NNRTI	*3 new NRTI*(?)*
NRTI/PI/NNRTI	*3 new NRTI*(?)*

Note: for up to date information on available experimental protocols contact the Regional office of the Canadian HIV Trials Network @ (604) 631-5036, or the Head office of the Canadian HIV Trials Network @ (604) 631-5327.

Treatment Issues: Where We're At and Where We're Going The Lived Experience

Presenter:
Tom McAulay

• Notes •

M:AM1 The Intersection of Violence and HIV

Safe "T" Lessons Transgender and HIV/AIDS

Presenters:
Sandra Laframboise
Deborah Brady
High Risk Project Society
449 East Hastings, Vancouver, BC V6A 1P5
(604) 255-6143; fax: (604) 255-0147

ABSTRACT

High Risk Project Society - oral history, services offered
presented by Deborah Brady

Statistics and demography of clientele served over the last year
presented by Sandra Laframboise

Oral question period from the participants

Viewing of Video on Safe "T" Lessons done by the Gay and Lesbian Centre of New York which addresses the transgender issues on the streets and in the ghetto.

Biographies:

Sandra Laframboise has been a street kid for17 years of her life before returning to school to complete post secondary studies in Psychiatric Nursing. Her unique life experience and her nursing theory is the strength that has inspired her to help co-found a peer consumer organization serving the needs of street active transgender individuals. In the last year Miss Laframboise has co-authored "Finding Our Place" a Transgender Law Reform Project sponsored by the Law Foundation of BC; co-authored a booklet entitled HIV & transgender and many other articles. She publicly speaks and advocates on behalf of the transgender community so that they may find their rightful place within the society.

Deborah Brady, an undergraduate of Queen's University, moved to Vancouver 24 years ago. She pursued a business career before becoming a public activist and advocate for human rights for transgender persons. Miss Brady is a Licensed Practical Nurse at Vancouver Hospital. Miss Brady has helped co-found High Risk Project Society in January 1995. She has co-authored "Finding Our Place" a Transgender Law Reform Project; co-authored a booklet entitled HIV & Transgender and many more articles.

M:AM1 The Intersection of Violence and HIV

The Intersection of Domestic Violence and HIV Disease in Women

Presenter:
Marcie Summers
Positive Women's Network, 1107 Seymour St., Vancouver, BC V6B 5S8
604-681-2122 ext. 286; Fax: 893-2256; Email: marcies@parc.org

ABSTRACT

Issue:

How does domestic violence relate to HIV? Both situations isolate women, both carry social stigma and shame and the conflicts of both are often played out in physical and sexual relationships. This session will present an overview of the continuum of domestic violence, placing this social issue within the broader context of women's health.

Description of Session:

A brief summary of the basic characteristics of domestic violence shall be presented as a foundation upon which to present the particulars of several case studies. The ramifications of domestic violence on women's ability to access health care and support services will also be discussed.

Conclusion:

As a result of this presentation, both service providers and people living with HIV will have a better understanding of the interconnectedness of HIV and domestic violence, resulting in innovative interventions and long term changes in policy development and service delivery.

Biography:

Marcie Summers has been the Executive Director of the Positive Women's Network since May 1993. She has worked as an Executive Director within non-profit agencies since 1982, including Planned Parenthood of BC (1982-1984), Big Sisters of BC Lower Mainland (1984-1990), and New Beginnings Shelter for Battered Women and Their Children (Seattle, 1990-1993).

Marcie Summers has worked for over 20 years as a volunteer in the women's health movement and the movement to end violence against women.

M:AM2 Living with HIV: New Dimensions

The Cocktail is Working: Now What Do I Do?

Presenters:
Harvey Bosma
Judy Krueckl
St. Paul's Hospital, Department of Social Work
1081 Burrard Street, Vancouver, BC V6Z 1Y6
(604) 631-5072; (604) 631-5268 (Fax)

ABSTRACT

Description:

The use of protease inhibitors, in combination with reverse transcriptase inhibitors, has changed the face of AIDS significantly. Many persons living with HIV and AIDS have experienced dramatic improvements in their health since starting the new medication "cocktails". These results have contributed to a growing sense of excitement, optimism, and hope that HIV disease can be a manageable and chronic illness. However, this "good news" has also evoked feelings of confusion, ambivalence, and anxiety for many PWHIV/A's about the possibility of living longer than expected.

Many persons living with HIV and AIDS have often invested much time and energy adjusting to a decline in health status with the belief that infirmity would likely increase, rather than decrease. This process has often included disengaging from many usual developmental tasks and activities, especially those related to careers and relationships. Now, suddenly, the rules are changing, and these same individuals are faced with the prospect of re-engaging in life, and the major challenges implied in that process. The purpose of this workshop is to identify some of these issues further, along with emotional reactions of long-term survivors to them. Interventions for providing support to PLHIV/A's as they grapple with this changing scenario will also be discussed.

Biographies:

Judy Krueckl and Harvey Bosma work as outpatient social workers at the John Ruedy Immunodeficiency Clinic at St. Paul's Hospital in Vancouver. They provide support services to PWHIV/A's, as well as to their partners, family, and friends. Judy has been a part of the AIDS Care Team at St. Paul's since 1987. Harvey worked previously as a counsellor at AIDS Calgary for several years, and joined the St.Paul's Care Team in 1993.

M:AM2 Living with HIV: New Dimensions

The Lived Experience

Presenter:

Hugh Matheson

• Notes •

M:AM3 Men Who Have Sex With Men Risk Reduction Across Canada: Understanding Sexual Choices

New Directions in Safer Sex Education among MSM

Introduction

ABSTRACT

Since the early 1980's, national education campaigns and innumerable community initiatives in Canada have encouraged safer sex amongst men who have sex with men (MSM). While these initiatives have contributed significantly to a reduction in the rate of new infections amongst MSM, our understanding of how sociological factors influence the (safer) sex choices and risk behaviours amongst MSM remains limited, posing a challenge to future HIV/AIDS education directed at the MSM population. To learn more about how social, personal and other circumstantial factors influence the sexual risk behaviours amongst MSM, Health Canada (through the National Health Research and Development Program (NHRDP)) funded four qualitative studies in very different parts of the country: the Atlantic region; Montreal; the metropolitan region of Windsor, Ontario; and the Vancouver Island region of British Columbia.

Biographies:

Grace Getty is a Professor in the Faculty of Nursing at the University of New Brunswick in Fredericton and coordinator of the UNB AIDS Program.

Alan Sears is an Associate Professor in the Department of Sociology and Anthropology at the University of Windsor in Ontario.

Stephen Samis is Coordinator, Research Projects at AIDS Vancouver Island in Victoria, and a private research consultant. He holds a Masters degree in Sociology from Simon Fraser University.

M:AM3 Men Who Have Sex With Men Risk Reduction Across Canada: Understanding Sexual Choices

New Directions in Safer Sex Education among MSM Atlantic Canada

Presenter:
Grace Getty
Faculty of Nursing, University of New Brunswick, Fredericton, N.B., E3B 5A3
(506) 453-4642 F(506)-447-3057 email: Getty@UNB.CA

Atlantic Community Based Study of the Determinants of Sexual Risk Behaviors for Men Who have Sex with Men: Interim Report

Objectives:

To explore the factors related to the sexual choices and risk behaviours of men who have sex with men (MSM), including: (a) the social contents in which sexual behaviour occurs, (b) the ways that men use to protect themselves from STD's (c) men's sense of self-efficacy in safer sex behaviours, (d) barriers to practicing safer sex behaviors consistently, (e) the relationship between sexual activity and self-esteem issues, and (f) men's experience with safer sex activities.

Methodology:

This study is a collaborative project in which MSM and AIDS educators from ASO's are engaged as equal participants in the research process with the principle investigator. Participants are engaged in a process to understand their own sexual experiences and concerns r/t safer sex practices through: (a) unstructured interviews, (b) return interviews to discuss the key themes identified in the data and to elaborate and clarify the processes from their own point of view, and (c) focus groups to discuss theoretical processes identified and to discuss key directions for prevention education, (d) interviews conducted through the Internet Relay Chat channel with very closeted men, e.g. Married men. The sample is a convenience sample acquired by the snowball technique. The study was advertised through university gay and lesbian groups, posters in gay bars, AIDS New Brunswick's toll-free phone line and word of mouth. Theoretical sampling has indicated the need to sample more men who are married, bisexual, older gays, dress in drag and who participate in S&M.

Analysis:

The interviews are transcribed and analyzed using the constant comparative analysis approach to identify the processes that are evident in the date (substantive coding). The research team listen to the tapes together, discuss the meaning of the data and code it together. The grounded theory method of clustering the codes into categories, determining their properties and relationships, and identifying the core variable or the basic social psychological process evident in the data will be carried out. At this stage in the study, the data is still being coded and these codes are being clustered into initial categories.

Findings:
Early sexual exploration of male adolescents who are attracted to other men consists of playing around, peeking, clueing in and looking for role models. Learning the sexual script of gay men was a major task, since positive role models were hard to find. Issues around the meaning of touch as practiced by other gay men and learning to navigate the culture of the gay bar continue to need exploration. One group of men who have shared their knowledge of a particular role are those who share the art of drag with others, by example or even overt teaching.

Unfortunately, at least 20% of these participants experienced being sexually molested as children, or young adolescents. Most of these men blamed themselves and tried to find meaning in this experience, including compartmentalization of these experiences into an area separate from safer sex practices. Cruising for sex in public places was common, especially among those who have been sexually victimized or were very closeted. While all of the participants were trying to be safe in their sexual activities, none were using condoms for oral sex. Learning to negotiate for safer sex activities was difficult; one group with extraordinary skills in communicating their sexual desires and negotiating for sexual activities were those who participated in S&M.

M:AM3 Men Who Have Sex With Men Risk Reduction Across Canada: Understanding Sexual Choices

New Directions in Safer Sex Education among MSM Windsor, Ontario

Presenter:
Alan Sears
Department of Sociology and Anthropology, University of Windsor,
Windsor, Ontario N9B 3P4
tel: 519-253-4232 (3494); fax: 519-971-3621; E-mail; asears@uwindsor.ca

Sex Talk: Understanding Gay Men's Sexual Choices

Safer sex education has typically concentrated on a model of sexuality that considers people to be rational. According to this view, information leads to changes in attitudes and behaviours. Although education programs based on this model have accomplished a great deal, they also face limitations. In some circumstances, information by itself does not appear to lead to changes in patterns of sexual behaviour.

This paper examines the process of sexual decision-making among men who have sex with men. It is based on qualitative interviews with 100 men and examines the aesthetic and affective aspects of sexual choices. The interviews emphasize frank discussion of aspects of desire in order to further our understanding of sexual satisfaction. Results from this project will assist the development of a second generation of safe-sex education programs, which will need to consider the ways that men actually talk, think, and feel about sex.

M:AM3 Men Who Have Sex With Men Risk Reduction Across Canada: Understanding Sexual Choices

New Directions in Safer Sex Education among MSM Vancouver Island

Presenter:

Stephen Samis

Coordinator, Research Projects, AIDS Vancouver Island
302-733 Johnson Street, Victoria, BC V8W 3C7
(250) 384-2366; fax: (250) 380-9411; e-mail: ssamis@avi.org

HIV/AIDS and the Meanings of (Safer) Sex in Men's Lives: Preliminary Results from the M.A.R.S. Research Project

Objective:

To better understand the personal and social issues/factors that influence the sexual behaviors of men who have sex with men (MSM) in the Vancouver Island region.

Methods:

Based at AIDS Vancouver Island (AVI) in Victoria, B.C., the M.A.R.S. project is a collaborative effort between AVI's Education Services Department and Dr. Marilyn Walker in the Faculty of Human and Social Development at the University of Victoria. Participants include a variety of MSM across Vancouver Island and the Gulf-Islands. In-depth and unstructured interviews lasting 1-2 hours are conducted in-person, over the telephone or over the internet. Taking a narrative-based approach, the interview format enables MSM to share their stories and provide researchers and HIV/AIDS educators with a deeper understanding of the factors that influence safer sex practices of MSM. Participants have been recruited through a variety of means, including a prominent promotional campaign, outreach at gay community events, snowball sampling and targeted efforts to reach closeted gay/bisexual men and MSM who self-identify as straight.

Results:

Data will be drawn for 75-100 interviews (projected – 50 completed to date). The initial interview data suggest that issues such as self-identify, self-esteem, social and internalized homophobia, familial and other forms of social support and early childhood sexual abuse are among the many factors which impact significantly upon the safer sexual practices amongst MSM. The interview data also indicate that qualitative research methods proved an excellent tool for exploring the complex nature of men's understanding of, and choices around, safer sex.

Discussion:

The presentation will focus on the following three themes; first, a brief introduction to, and exploration of, the use of narrative-based methodology and its significance for research relating to HIV/AIDS and MSM; second, a demographic profile of the research participants, and third, an analysis of the most prominent findings to date.

M:AM4 Palliative Care: Still a Reality

Making It OK to Go Home

Presenters:

Lois Brummet
BC Centre for Excellence in HIV/AIDS
Hélène McCuaig
National Coordinator for CPCA AIDS Project

Without fear, HIV would be just another disease.
Author Unknown.

HIV/AIDS has challenged Palliative Care. The complex dynamics of the disease process, the treatments, the social circumstances, including stigmatization, have all brought new dimensions to the provision of Palliative Care. Historically, most Canadian Hospice Palliative Care programs and services did not respond quickly to meet the needs of persons living and dying with AIDS.

We now accept that dying of AIDS is qualitatively different from dying of other illnesses. Not only is there an excess burden on young people, but dying of AIDS remains a highly stigmatizing and socially isolating experience for the individual and his/her caregivers.

In the mid 1980s, governments were challenged to develop palliative care services for persons with AIDS and their families. By the early 1990s AIDS palliative care programs were well established in Montreal, Toronto, and Vancouver.

It became clear that AIDS palliative care, like palliative care for persons with terminal cancer, was not universal. In 1994, the Interdisciplinary Palliative Care Training Program conducted a pilot project aimed at improving the quality of palliative care for terminally ill persons with cancer and/or AIDS in rural areas. The evaluation of this project lead to the current series of workshops on AIDS *Palliative Care* built around the *Health Canada Module 4: A Comprehensive Guide for the Care of Persons with HIV Disease.* The goals of the Canada wide workshops are to explore the participants' current experiences in HIV AIDS and/ or Palliative Care in order to decrease the gap between palliative caregivers' services and the needs of persons living with HIV/AIDS.

Workshop participants are asked to identity the barriers to AIDS palliative care in their communities and to identify strategies to reduce or eliminate such barriers. Local, provincial, and national resources are identified. Each workshop participant receives a "tool kit" of resources

M:AM5 Community-Based Research

Social Research Skills and the Health Promotion Capacities of the Community AIDS Workforce

Presenters:

Catherine Hankins, Ted Myers, Steffanie Strathdee
Arn Schilder, Mai Nguyen and Albert McLeod

• Notes •

M:AM6

Changing HIV Risk Related Behaviour: A Model for Preventive Practice

Moderators:
Stephen Hotz
Lynn Leonard
Community Health Research Unit,
Department of Epidemiology and Community Medicine, University of Ottawa,
451 Smyth Road, Ottawa, Ontario K1H 8M5
Voice: (613) 562-5800 ext. 8284; Fax: (613) 562-5465; E-mail: hotz@ zeus.med.uottawa.ca

ABSTRACT

Issue:
It is generally recognized that behaviour change is the most effective focus for prevention interventions. However, enabling people to change behaviour that confers high risk infection and transmission of HIV remains a challenge for workers in the HIV/AIDS field.

Description:
Recent research concerning the causes of behaviours that undermine health and well being and new insights into how people actually change their behaviour have led to effective strategies that are readily applicable to diverse intervention setting. This skills training workshop will present techniques based on the Transtheoretical model of Behaviour Change and motivational enhancement therapy to provide participants with a comprehensive set of skills to increase motivation and facilitate the adoption and maintenance of risk-reduction behaviour change. Participants in this workshop will have the opportunity to learn an integrated, dynamic model explaining the determinants of health behaviour change.

Conclusion:
By the end of the workshop participants will have had the opportunity to extend their skills in the following areas: assessing the barriers to risk reduction; evaluating the factors which support behaviour change

Biographies:
Dr. Steve Hotz is an Assistant Professor in the Department of Epidemiology and Community Medicine at the University of Ottawa, Director of the Centre for Advances in Health Behaviour Change, a principal investigator with the Community Health Research Unit, and a consulting psychologist at the University Of Ottawa Heart Institute Prevention & Rehabilitation Centre. He is a psychologist whose current activities include health promotion research, program development, and clinical service delivery in such areas as heart health, smoking cessation, prenatal health, physical activity and exercise, healthy sexuality, HIV-risk behaviour, dietary change, stress and coping, and depression.

Dr. Hotz has a Ph.D. in Clinical Psychology from the University of Ottawa. He undertook further clinical training at the University of Manitoba Health Sciences Centre, the Ottawa Civic Hospital, the University of Ottawa Heart Institute, and the Rehabilitation Centre in Ottawa. He is a very active researcher with more that 1.5 million dollars in research funding to date. He is currently conducting research on the determinants of fat-related dietary behaviour, condom use, smoking cessation, exercise adoption and maintenance, family stress and coping with heart disease, HIV risk behaviours, and depression. He is recognized as a Canadian authority on applications of the Transtheoretical Model. In addition, he has become widely recognized as an innovator in extending the use of Motivational Enhancement Therapy to new areas of health service delivery, program planning and evaluation.

Over the last several years he has developed a unique continuing education program for health care professionals which trains skills in building motivation for behaviour change among patient groups with multiple behavioural risk factors. In addition, with his colleague Dr. Rob Nolan, he developed and delivers an advanced training program for modifying behavioural risk factors for heart disease sponsored nationwide by the Canadian Register of Health Service Providers in Psychology. He has earned an international reputation for conducting stimulating and energetic workshops which convey practical clinical skills to health care practitioners from divergent backgrounds. His training approach blends the presentation of relevant conceptual material with experiential skill building exercises.

Dr. Hotz has had many years of experience providing individual, couple and group interventions concerning health behaviour change, adaptation to chronic illness, psychotherapy and stress management. He has trained psychologists, social workers, residents and medical students in effective clinical skills for health behaviour change. He has developed health promotion intervention programs for government, business, hospitals, public health and community agencies.

M:AM7 Multiple Diagnosis: Creative Approaches to Providing Care to IDUs

HIV/AIDS in Injection Drug Users: Challenges to Effective Treatment

Presenters:
Chris Fraser
Downtown Community Health Clinic, 412 East Cordova St., Vancouver, BC
Tel: 255-3151
Stanley de Vlaming
Gastown Medical Clinic, 30 Blood Alley Square, Vancouver, BC
Tel: 669-9181

ABSTRACT

While recent epidemiological studies and clinical experience have indicated the alarming rise in HIV incidence and prevalence rates among injection drug users (IDUs), availability of widely-proven, effective treatment modalities such as methadone maintenance therapy and appropriate counseling remain inadequate throughout B.C., particularly in Vancouver's Downtown Eastside.

With a focus on the Downtown Eastside, this presentation will:

- briefly outline the present state of IV drug use
- review HIV data
- describe shortcomings of current treatment approaches
- propose means urgently increasing appropriate services for IDU's

The presentation's goal is for exchange between providers (community and hospital-based workers, nurses, social workers and physicians) and policy-makers with a view to establishing an active dialogue on improving HIV prevention and treatment in the IDU community.

M:AM7 Multiple Diagnosis: Creative Approaches to Providing Care to IDUs

Challenges of Providing Care for Individuals with HIV/AIDS Mental Illness and Substance Abuse

Presenters:
Doreen Littlejohn, Geri Bailey, Bob McRae
Jeannine Bianco and Sri Pendakur
#6 - 520 Powell Street, Vancouver, BC V6A 1G9
(604) 255-7859; fax (604) 255-6156

ABSTRACT

Issue:

Individuals with mental illness, substance misuse and HIV/AIDS bring unique challenges to service providers. Social, personal, medical, behavioural, and organizational issues complicate care givers' attempts to provide comprehensive service. Mental health service providers are challenged by their clients' lack of affordable housing, poverty, chronic physical and mental illness, isolation, and polysubstance abuse. These clients frequently use services inappropriately which leads to fragmented care. These clients require an Assertive Outreach model of service delivery which meets the wide spectrum of needs.

Description:

We will examine the issue of HIV/AIDS and chronic mental illness from the point of view of Assertive Case Management. Assertive Community Treatment is intended for use with people with serious mental disorders, medical problems and substance use who are frequent users of hospitals, emergency rooms, and crisis services, and who are unable to function well in the community between crises. Assertive Community Treatment is designed to be a mobile intensive intervention with lower staff to client ratios, shared caseloads, and direct provision of services, as well as brokerage of services to include a multi-agency approach to care coordination. Assertive Community treatment includes mobile crisis management, crisis intervention services, counselling, medication management, and advocacy and help to develop skills needed in everyday life. This model also provides a cross boundary service throughout Vancouver to complement the existing comprehensive mental health services that are already available.

Conclusion:

Assertive Community Treatment provides high quality care and can prevent expensive crisis-driven hospitalizations. Assertive case managers not only coordinate fragmented care, but have developed a cohesive health management plan which provides the multi-diagnosed client with a much enhanced quality of life.

News from Canada's National Task Force on HIV and Injection Drug Use

Presenter:

Catherine Hankins

Recommendations from Canada's National Task Force on HIV and Injection Drug Use

Published by the Canadian Centre for Substance Abuse and the Canadian Public Health Association, 1997

POLICY AND LEGISLATION:

1. *Leadership and commitment to action must be enhanced.*

› In view of the seriousness of the problem and the multi-sectoral nature of the solutions required, the federal Minister of Health should take the lead in ensuring a coordinated and integrated response to all recommendations in this National Action Plan.

› Continue or renew national strategies to address HIV, AIDS and substance use with appropriate levels of funding, directed primarily at community-based initiatives.

› Foster formal linkages and permanent mechanisms for consultation and communication among all relevant players, including the criminal justice and health systems, as well as social services.

› Ensure funding exists for alternative programmes in prevention, drug treatment and diversional sentencing to community programmes, including those implemented under Bill C-41 (Alternative Measures). Existing funds should be allocated to these programs and, in addition, funding should be increased through innovative options such as the following:

  1. 50% of the revenues produced through Anti-Drug Profiteering/Proceeds of Crime cases,
  2. A 25% surcharge placed on all fines to drug traffickers,

  Use of these funds should be overseen by a partnership of key involved Ministries, federally and provincially.

› Ensure all provinces become signatories to Bill C-41, and develop nationally coordinated implementation strategies.

› Ask that the Health and Enforcement in Partnership (HEP) Steering Committee consider all recommended policy issues and facilitate implementation within their respective departments.

2. *The Criminal Code must be changed.*

› Provide specific exemptions under the legislation to ensure that physicians may prescribe narcotics (e.g., heroin, cocaine) to drug users in an effort to medicalize drug use and reduce harm associated with obtaining drugs on the street (e.g., U.K. Model). Research to assess the feasibility of this approach should be undertaken on a pilot basis.

› Decriminalize the possession of small amounts of currently illegal drugs for personal use.

› Institute heavy penalties for the commercial trafficking of any drug to minors.

› Initiate discussions among judges, prosecutors and police officers to address the lack of national consistency in the application of laws. For a variety of reasons, but not the same reasons, these sectors are now exercising the maximum of discretion to the point that, while the use of currently illegal drugs is intended to be addressed by statute laws, the existing national laws no longer deal with the reality of a nationwide problem. (This discussion is made all the more necessary by the increasing use of diversion in the justice system and new initiatives by the health service aimed at drug users.)

3. *Conditions in correctional settings must be improved.*

- Allow prisoners who have been in a methadone maintenance programme prior to incarceration to continue to receive such treatment in prison.
- Ensure methadone treatment is available to opiate-dependent prisoners who were not receiving it prior to incarceration.
- Institute programmes to evaluate the need for methadone maintenance therapy prior to prison release, and ensure priority transfer to community programming on the outside at release.
- Conduct pilot programmes of needle exchange in federal and provincial correctional settings.

4. *Since sound policy decisions rely on solid research data and directions, research activities must be recognized, utilized and enhanced.*

- Involve IDUs in all aspects of research.
- Continue to monitor HIV rates and use this information fully in developing new policies and programmes.
- Investigate local transmission patterns of HIV in IDUs.
- Fund additional research to determine the extent of diversion of prescription opiates to the black market.
- Include quantitative, qualitative and ethnographic methodologies in research designs in order to increase the usefulness of data to policy and programme development.
- Use the "Guidelines on Ethical and Legal Considerations in Research on AIDS and Drug Use at the Community Level" when conducting community-level research.

PREVENTION/INTERVENTION:

1. *Discriminatory attitudes toward drug users living with HIV or AIDS must be addressed, with a view to elimination, both in the general public and within professional groups.*

- Actively involve drug users in policy development, programme planning and implementation for prevention, care and support, as well as in evaluation.
- Create community-based peer-support and advocacy groups for drug users, and integrate drug users into existing organizations.
- Develop programmatic inter-agency and inter-disciplinary links (mental health, addiction, acute care, community hospitals, HIV treatment).
- Promote awareness, recognition and acceptance in the justice system and in law enforcement that addiction is better dealt with as a health and social issue than a criminal one.
- Improve diagnostic and treatment capabilities of physicians, nurses, pharmacists, etc., through

focused, cross-disciplinary education at the undergraduate level and through continuing education.

- Provide training and information to the judiciary and others in the criminal justice system on the link between HIV and AIDS, and IDU, as a health issue.
- Promote harm reduction as a necessary component of a range of strategies when developing programmes and policies.
- Enhance intersectoral responsibility at all levels of government, recognizing that HIV/IDU encompasses health, social and corrections considerations.
- Examine, and change where necessary, policies and procedures of professional bodies (e.g., physicians, pharmacists) to make sure they facilitate harm reduction and encourage the involvement of members in caring for injection drug users.
- Involve all partners and especially community organizations in promoting needle exchange and disposal as health and safety issues (e.g., availability of needle exchange programmes and appropriate, accessible disposal facilities reduces the likelihood of injury to children, janitorial staff, and others, that can result when needles are improperly discarded in playgrounds and other locations).
- Develop other partnerships to enhance this process (e.g., persons with diabetes and their organizations).

2. *Services involving the exchange of needles must be improved.*

- Provide access to needle exchange in the community, and integrate with a broad range of health services (including health promotion, nutrition, self-esteem training, safe injecting practices) rather than marginalize this one service. Expansion of alternative sites such as hospital Emergency Rooms, Public Health clinics, community-based clinics and pharmacies must be considered in order to achieve decentralization.
- Encourage every pharmacy in the country to sell needles, advertise needle exchange services in the community, and offer disposal services in conjunction with local health authorities.
- Consider giving community awards to pharmacists for their support in order to encourage their continuing involvement, as well as that of their peers.
- Purchase needles for community programming in bulk for an entire city, as in Montreal, or for a whole province, as in B.C. This is a cost-cutting measure which would allow more needles to be made available.
- Offer needles on their own and as part of a package including alcohol swabs, condoms, lubricant, pamphlets, pharmacy addresses, etc.

3. *Access to methadone treatment must be improved.*

- Revoke the need for physicians to have authorization from the federal minister of Health to prescribe methadone. Revoking the need for authorization will allow physicians to prescribe methadone like any other drug, making methadone more accessible.

- Make appropriate training available to physicians to encourage their involvement in providing methadone treatment to injection drug users.
- Dramatically increase the availability of methadone treatment, at a minimum increasing the total number receiving treatment from the current 3,600 to 7,200 within 18 months.
- Reduce and eliminate other barriers to being on methadone, and base decisions regarding methadone carrying privileges on reliable and responsible behaviour of the individual.
- Create a central coordinating agency to link users and doctors at the local level so that users know how to access methadone services.
- Encourage programme planners to undertake study visits to innovative and cost-effective methadone programmes such as those in Vancouver, Halifax and Edmonton, with a view to replication at other sites across the country.
- Add a product monograph for methadone to the Compendium of Pharmaceuticals and Specialties (CPS) for quick physician access.
- Communicate the results of research on the effects of methadone on pregnancy and breast-feeding to practitioners and the general public, especially women (e.g., enter information in the Compendium of Pharmaceuticals and Specialties).
- Investigate other alternative drug therapies, beyond methadone, such as buprenorphine, naltrexone and LAAM (L Alpha Acetylmethadol).
- Set up a low threshold maintenance programme as a pilot project in one or more sites with the explicit goal of reducing injection frequency in heroin users.

4. *Needle disposal services must be improved.*

- Make pharmacies a focus of disposal efforts. Incentive for this could be built through collaborating with the appropriate governing bodies for pharmacists and pharmacy owners directly.
- Consider installing community disposal containers which are secure from tampering and strategically located for the injecting community.
- Analyse locations where there are more returns than needles distributed to shed light on what information might assist sites with less successful return rates.
- Inform IDUs how to safely dispose of needles in case they are unable or unwilling to bring them back to the available service or other location.

TREATMENT:

1. *The continuum of available services and information must be enhanced and expanded.*

- Provide treatment options which do not require total abstinence from all drugs. Evidence of drug use should not, alone, be a barrier to drug or HIV treatment. Treatment can be supplemented by incorporating complementary harm reduction approaches to address the ongoing drug use, such as teaching safer injection practices, how to care for abscesses, and improved nutrition.

- Ensure the availability of treatment services where providers are knowledgeable about both substance use and HIV.
- Coordinate services currently addressing only one aspect of the treatment issue (i.e., HIV, AIDS, or substance use).
- Ensure each person seeking treatment is evaluated and offered anti-retroviral drug therapies meeting current standards of care.
- Develop cocaine-specific treatment options.
- Investigate the potential health risks of individuals using combinations of pharmaceutical/therapeutic and recreational drugs. Although there is some information available concerning their interactions (Ciraulo et al., 1989), more research and information is required.
- Conduct clinical trials of prescription morphine, heroin and cocaine as alternative approaches, such as are being done in other countries (United Kingdom, Switzerland).
- Involve all partners in a client-centred, integrated service delivery approach, in order to facilitate higher quality, comprehensive, consistent and cost-effective care.
- Develop alternative delivery systems for drug treatment in comprehensive care clinics, designed with community participation, and licensed by the province (this can be accomplished outside legislative changes, through Statutory Amendments to the Criminal Code). For instance, methadone programmes could be provided at community health clinics rather than only through fee-for-service physicians.
- Enhance continuing education programmes for primary care physician networks of prescribers.
- Ensure a full spectrum of treatment options, including anti-retroviral drugs, are available to those in corrections facilities.
- Educate health care workers in prisons about the side effects of HIV medications and other related issues.

2. *The quality of professional training must be improved.*

- Encourage each community to develop a "best practice" guideline for physicians, adapted to local community needs and resource availability, and linked to cost-effectiveness (e.g., Halifax has created a Community Methadone Advisory Committee composed of users, health care professionals and methadone clients, which contacts physicians and pharmacists to inform them of the need and value of the Community Methadone Service).
- Establish a mentoring system/programme for physicians, nurses and related professionals.
- Provide regular and ongoing training to those providing services at health centres, substance use programmes, HIV/AIDS programmes, etc.

ABORIGINAL PEOPLES:

1. ***Data describing the situation must be routinely gathered, and quality must be improved.***

- Provide training opportunities to Aboriginal people to ensure that Aboriginal communities can design and undertake research initiatives for their own people.
- Learn from Aboriginal communities and apply teachings in non-Aboriginal agencies, since many Aboriginal people may opt to access these organizations.
- Obtain information concerning Aboriginal origin, and ethnicity, at all data-gathering sites and in all studies.
- Supplement existing AIDS data with HIV prevalence and incidence information.
- Conduct research to address the unique concerns of Aboriginal peoples, such as the younger than average age at which they become infected, the higher incidence of injection drug use as a mode of transmission, steadily increasing HIV rates, and over-representation in correctional settings.

2. ***Unique cultural factors must be acknowledged and addressed.***

- Convene a meeting of spiritual leaders from different Aboriginal communities, and elders in particular, to address the harms associated with injection drug use and to consider harm reduction approaches.
- Recognize cultural diversity within Aboriginal populations (First Nations, Inuit, Métis) and account for it when developing any policies, programmes and research.
- Recognize that many adults–including current Chiefs and elders–may have been affected by factors such as alcoholism and childhood sexual abuse, which will often affect responsiveness to the current crisis and recommended approaches.
- Encourage communities to use existing cultural practices to mobilize the community and address its problems.
- Provide training to all existing service providers, Aboriginal and non-Aboriginal alike, to heighten cultural sensitivity to, and awareness of, the overlapping risk-factors for this population, such as racism and homophobia.
- Acknowledge the unique needs of Aboriginal women and develop appropriate responses for issues such as their role as caretakers of the culture, the relationship between high rates of sexually-transmitted diseases and HIV, the need for anonymous, confidential HIV testing.
- Promote information sharing about Aboriginal initiatives and AIDS education programmes which are successful.

3. *Efforts to address the complex issues must be coordinated.*

› Provide support, financial and otherwise, for the Canadian Aboriginal AIDS Network (CAAN).
› Address jurisdictional issues regarding who is entitled to services delivered by different levels of government, as well as the "on versus off reserve" issue. HIV does not respect this arbitrary division of service provision. Access must be facilitated.
› Link native HIV, AIDS and IDU programmes with provincial services to lessen the over-reliance on reserves which has been the trend until the present.

WOMEN:

1. *Key players must be educated concerning the unique problems facing women, and how to address them.*

› Train health care professionals regarding diagnosis, treatment and prevention of HIV in women IDUs.
› Inform health care professionals of the special risks for young women working in the sex-trade.
› Provide self-esteem training and skill-development for IDU women and non-IDU women who are sexual partners of IDU men.
› Focus on transferring knowledge on reproductive choices to professionals and women (sexuality, conception, pregnancy termination, use of HIV medications in pregnancy).
› Convey information on effects of methadone treatment while breastfeeding.
› Provide resources to assist women IDUs in the care of their children and families while dealing with HIV and/or AIDS, especially outreach programmes.
› Facilitate the development of accessible peer support groups for street-involved women so they can share practical strategies for protecting themselves.

2. *Research must be enhanced to fully understand the nature and extent of HIV and AIDS in women, and to develop appropriate responses.*

› Include IDU women in the development of policy, programmes and research.
› Promote sensitivity to gender issues and gender balance as part of all research.
› Conduct research into the relationship between sexual abuse and HIV, as well as the intersection of physical abuse, substance use and HIV.
› Develop and make available women-controlled methods of HIV prevention (e.g., female condom, microbicides).

M:PM1 Problem Solving: Ethical Issues

Criminalization of HIV Transmission

Presenter:
Craig Jones

• Notes •

M:PM1 Problem Solving: Ethical Issues

New and Emerging Legal and Ethical Issues

Presenter:

Ralf Jürgens

Notes •

M:PM2

Ethnocultural Issues in HIV/AIDS: An Un/Common Vision

Presenters:

Moffat Clarke, Claudia Fanton, Edward Lee, Jeea Saraswati
Juanita Smith and Maria Stanborough

• Notes •

M:PM3 Boystown: The Male Sex Trade

Male Sex Work and HIV/AIDS in Canada: Research, Outreach and Advocacy

Presenters:
Dan Allman
HIV Social, Behavioural and Epidemiological Studies Unit, University of Toronto
3rd Floor, 12 Queens Park Crescent West, Toronto, Ontario M5S 1A8
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Karin Linnebach
Street Outreach Project, The Village Clinic 668 Corydon Ave. Winnipeg, Manitoba R3M 0X7
Tel: (204) 453-0045; Fax: (204) 453-5214
Andrew Sorfleet
Sex Workers Alliance of Vancouver (SWAV) E:mail handyman@walnet.org;
Website: http://www.walnet.org/csis/

ABSTRACT

Issue:

This roundtable session will

1. describe current understandings of male sex work and HIV/AIDS in Canada through the presentation of a summary of research findings;
2. outline the design, assessment and evaluation of Winnipeg Village Clinic's Street Outreach Project for male sex workers and their clients;
3. explore the viewpoints and experiences of male sex workers and sex worker alliances with HIV/AIDS research and outreach.

Description:

In Canada, we often consider sex work in terms of female sex workers and their male clients. This round table session will shift the focus of discussion to highlight the understudied area of male sex work.

Questions to be addressed include:

a) What are the experiences of service providers, HIV/AIDS educators and researchers with male sex workers? What are the service, outreach and research needs?
b) What are the experiences of male sex workers and sex worker alliances with service delivery, HIV/AIDS outreach and HIV/AIDS research? What works? What doesn't work?
c) What are common biases and misconceptions regarding male sex work and HIV/AIDS?
d) How can session participants join male sex workers and sex worker alliances in advocating for a safe occupation? How can further dialogue between stakeholders be established and maintained?

Conclusion:

In Canada, 80% of all sex workers are female. However, male sex workers may be at higher risk for HIV infection and transmission. What is known of male sex work in Canada derives mainly from interventions for, and the investigation of, street-based

populations. Little is known in terms of other areas of male sex work. The conception and delivery of HIV/AIDS research and outreach may be more effectively targeted through a greater understanding of male sex work and sex work advocacy. This may be facilitated through the joint participation and cooperation of sex workers, researchers, outreach and advocacy.

Biographies:

Dan Allman is a sociologist within the HIV Social, Behavioural and Epidemiological Studies Unit of the University of Toronto. His current work focuses primarily on methodological and theoretical aspects of sexuality and its study. He is author (with Ted Myers and Rhonda Codcerill) of Concepts, Definitions and Models for Community-based HIV Prevention Research in Canada (Toronto: HIV Studies Unit, 1997).

Karin Linnebach is Street Outreach Coordinator at the Village Clinic, Winnipeg, and has been involved in the clinic's Living Room project, a dropin for male sex trade workers and PHAs. She got her start doing outreach at POWER (Prostitutes and Other Women for Equal Rights), where she volunteered as an outreach, advocacy and drop-in worker. She also held the position of Drop-In Coordinator at POWER. Currently she is also involved with Street Connections Outreach which provides mobile needle exchange at a street level.

Andrew Sorfleet was a sex worker for seven years. His experience includes street work, escort, independent ads, and pornography performance. He has worked in Vancouver, Toronto, Ottawa, Halifax, Boston, New York, Denver and Amsterdam. He was the Educational Materials Coordinator and an outreach worker for Maggie's, the Toronto Prostitutes' Community Service Project for three years (from 1992 to 1995). He was a founding member of the Sex Workers Alliance of Toronto (SWAT), and today coordinates the Sex Workers Alliance of Vancouver (SWAV). He is currently on sabbatical from sex work. His website: The Commercial Sex Infommation Service (CSIS) can be found at: <http://www.walnet.org/csis/>.

M:PM3 Boystown: The Male Sex Trade

Characteristics of Male Sex Trade Workers Enrolled in a Prospective Study of HIV Incidence

Presenter:

Mary Lou Miller

ABSTRACT

Acknowledgements:

We would like to thank the participants in the Vanguard Project, the member agencies of the Community Advisory Committee, and Sister C.

Objectives:

To compare demographics, sexual and drug using behaviours among male sex trade workers relative to other gay/bisexual men enrolled in a prospective cohort study.

Methods:

Gay/bisexual men aged 18-30 who enrolled in the Vanguard Project between May/95 - Dec/96 underwent HIV testing and completed a self-administered questionnaire on an annual basis. Data were collected on demographics, sexual and drug-using behaviours, depression, social support, and whether or not men had provided sex in exchange for money, goods or drugs, ever or in the previous year. Similarly, men were asked if they had paid another male for sex. Contingency table analysis was used to compare men who had been paid for sex in the previous year to those who had not.

Results:

Of 501 men at baseline, 120 (24%) had ever been paid for sex, 71 (14%) in the previous year, and 10% had ever paid another male for sex, 4% in the previous year. Relative to the remainder of the cohort (N=430), men who were paid for sex in the last year (N=71) were significantly more likely to be: HIV+ at baseline (4% vs 2%), younger, non-White (44% vs 23%), less educated, live in unstable housing, and earn less than $10K/yr. These men were significantly more likely to: identify as bisexual (46% vs 6%), report non-consensual sex (47% vs. 31%), report first having sex with both men and women at younger ages ($P<0.001$), report use of coke/crack, heroin, poppers, or injection drugs (23% vs 3%, $P<0.001$), and have less social support and higher depression scores. These men were more likely to use condoms for oral sex with regular or casual partners compared to the remainder of the cohort, but they were less likely to report condom use during insertive anal sex with casual partners ($p<0.001$); 16% reported being paid more to have sex without condoms. To date, of 20 men with follow-up HIV tests within the last year, 3 seroconversions have occurred. *These findings will be updated for presentation at the 1997 BC AIDS Conference.*

Conclusions:

Male sex trade workers are vulnerable to HIV infection due to unfavourable living conditions and high rates of recreational drug use. Since these men often do not self-identify as gay, they may not be reached through conventional prevention programmer.

For further information, contact:
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608 - 1081 Burrard Street, Vancouver, BC, Canada, V6Z 1Y6; Tel: (604)687-2469;
Fax: (604)631-5464; http://cfeweb.hivnet.ubc.ca/vanguard/project.html

M:PM4 Rehabilitation: Rebuilding an Active Life

HIV Rehabilitation: Effective Quality of Life Interventions for PWAs

Presenter:
Gerry Bally
Care, Treatment and Support Program, Health Promotion and Programs Branch
Health Canada, Tower "A", 2nd Floor, 11 Holland Avenue
Postal Locator: 3002A, Ottawa, ON K1A 1B4
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ABSTRACT

Objectives:

- to describe the state-of-art in HIV rehabilitation
- to describe the HIV rehabilitation continuum from health promotion initiatives, to fitness programs, to multidisciplinary rehabilitation
- to describe a community based model of HIV rehabilitation, POZfit, a model which is portable to other communities in Canada, and other countries
- to describe the benefits of HIV rehabilitation

Methods:

POZfit, a pilot HIV rehabilitation research project began with an extensive literature review of the field of HIV rehabilitation. This pilot research study on HIV rehabilitation uses a participatory research action model as the basis for the collection and analysis of data.

Data was collected using qualitative and quantitative research methods, including survey, key informant interviews and focus group methods. All data was collected by community researchers trained in rehabilitation options, the research method, data collection, interview skills, and the use of these measurement tools.

Rehabilitation services were delivered by a consortium of public and private service providers. Public care providers were part of a multidisciplinary rehabilitation team.

Results:

More than 88 HIV positive adults were recruited by community researchers in the Victoria Capital Region. These subjects underwent pre, mid, and post key informant interviews using two standardized rehabilitation assessment tools, telephone follow-up on a monthly basis, and a subset participated in a focus group.

Conclusions:

HIV rehabilitation fits within the context of HIV becoming a more manageable, chronic disease. As PWA's live longer, quality of life interventions continue to play an increasing focus in the priorities established by the HIV-affected communities. HIV rehabilitation services are not dependent on high technology, and subsequently, are appropriate to both individuals with access to extensive health care and to those with less, both PWA's who live in urban and rural settings, and countries which are developed and those in-development.

M:PM4 Rehabilitation: Rebuilding an Active Life

Positively Fit: Dynamic Community Organizing for HIV and Rehabilitation

Presenters:
Blair Lischeron
Katherine Gayle
Pozfit, VARCS, Victoria BC

ABSTRACT

Positively Fit began as a Health Canada funded, community driven research project to investigate the impact of rehabilitation activities on quality of life for persons living with HIV. With 83 participants, and five participant researchers, Positively Fit has grown into a community development, capacity enhancement process for persons living with HIV. This transformation has been accompanied by issues of power and control, the line between insiders and outsiders, the desire for creative partnerships amidst diversity and the realization that "participatory" is a term with many different meanings to many different constituent groups. Within Positively Fit, persons living with HIV have been encouraged to become active in their own lives in a way that is meaningful to them. This may be a short daily walk, an intensive weight training session, changing diet, learning yoga, or steering the Project. The role of the Project has been to facilitate linkages between persons living with HIV and existing community resources. Positively Fit has NOT created new services or programs. Instead, Positively Fit has negotiated access for its members to participate as citizens in a program of their own choice, in their own neighborhood. The struggle now is to sustain this unique organizational model that struggles to keep the locus of control with participants.

M:PM5 Community-Based Research

Mens Survey Action Plan

Presenter:
Rodney Kort
Canadian AIDS Society, #400 - 100 Sparks Street, Ottawa, ON K1P 5B7
Telephone: (613)230-3580 ext. 113; Fax: (613)563-4998; Email: rodneyk@mail.cdnaids.ca

ABSTRACT

Objectives:

To assist in evaluation skills development for men who have sex with men (MSM) educators; to assist with program evaluation data analyses; to collect and review data on the work experience of MSM educators; to prepare and disseminate the findings of the MSAP project.

Methodology:

The project coordinator worked with ASO-based MSM demonstration sites and:

1. provided training and support on MSM program evaluation and data analysis to MSM educators
2. conducted interviews with 24 MSM educators from across Canada, in person and by telephone.

Results:

Current weaknesses of MSM program evaluation include a lack of evaluation skills/ expertise among educators coupled with few opportunities for skills development. Barriers to appropriate MSM program development include a lack of employee orientation to agency, integration and support of MSM programs at agency, community relations problems, and sustainability of MSM prevention education due to high staff turnover and funding instability.

Discussion:

Managers, educators and funders need to address the above issues with respect to MSM programs to ensure the skill sets/expertise of MSM educators are appropriate, supportive personnel/workplace policies and procedures are in place, employees are oriented to the agency and the work required of MSM educators, information flow to the community is enhanced and maintained, and MSM program sustainability issues are addressed through a long-term strategy that includes ongoing evaluation of prevention education efforts.

Biography:

Rodney Kort is a National Programs Consultant at the Canadian AIDS Society. His current position encompasses a wide range of activities on HIV/AIDS prevention education, treatment and social policy issues at the national level. Prior to accepting the position at CAS, Rodney coordinated the National Health Promotion Project at AIDS Vancouver, a project which conducted research on health promotion activities across Canada and developed a resource on health promotion directed at community based AIDS organizations.

M:PM5 Community-Based Research

Using Community Capacity Inventories to Meet the Growing HIV/AIDS Challenge in Resource Strapped Communities

Presenters:
Mary Ann Sandrelli
Denielle Elliott
AIDS Society of Kamloops, 523 Victoria Street, Kamloops, BC V2C 2B1
(250) 372-7585; 1-800-661-7541; (250) 372-1147; e-mail: ask@mail.netshop.net

ABSTRACT

Issues:

Meeting the growing HIV/AIDS Challenge in resource-strapped communities has become an overwhelming undertaking for under-funded AIDS Service Organizations. Many workers are feeling isolated, burned-out and frustrated. Moreover, our traditional approach to community response using a needs oriented focus has created a deficit orientation and further feelings of incompetency.

Description:

In response to this desperate situation, a visionary shift is required to begin the process of community development using a community capacity inventory. By developing policies and activities based on the capabilities, assets and skills of a community, one can access organic resource sharing opportunities, identify communication networks, harness non-traditional resources and increase a community sense of efficacy. This session will provide participants with a step by step guide to designing a community capacity inventory and an opportunity to explore and practice strategies in small group exercises. Methods for using this tool for cost-effective HIV/AIDS support and education program planning will be discussed.

Conclusion:

Using capacity inventories can increase the number of community partnerships and program coordinators while keeping program costs contained. Furthermore, this approach can replace individuals' feelings of alienation, isolation and incompetency with vast amounts of creativity, intelligence and community ownership.

Biography:

Mary Ann Sandrelli, Presenter
For the past two years, Mary Ann Sandrelli has been the Executive Director of the AIDS Society of Kamloops. With over 10 years experience in community development and program planning, Mary Ann has worked in a variety of urban and rural settings including the Ontario government's New Dimensions in Health Initiative.

M:PM5 Community-Based Research

Planning for a Change: Reflections on a Community-Based Evaluation Model

Presenter:
Stephen Samis
Research Projects, AIDS Vancouver Island
302 - 733 Johnson Street, Victoria, BC V8W 3C7
(250) 384-2366; fax: (250) 380-9411; email: ssamis@avi.org

ABSTRACT

Objective:
To better understand the important role of community-based Evaluation research for service delivery planning in a local AIDS organization.

Methods:
The Evaluation project involved the use of quantitative and qualitative research techniques, extensive community consultation, and extensive participation of volunteers. A combination of survey, interviews, focus groups and voicemail were used to determine the general knowledge of AVI's Education Service, the usefulness and relevance of these services, and the ways in which these services can be improved for a variety of communities across Vancouver Island.

Results:
The AVI Education Evaluation represents one of the most significant community-based evaluations of its kind to date in Canada. While the Evaluation results represent important feedback on present Education Services as well as a blueprint for future Education initiatives at AVI, the Evaluation process is as significant as the results. By creating linkages with new communities, as well as strengthening in those already established, the Evaluation model represents an effective tool for program planning and building and strengthening community partnerships.

Discussion:
The presentation will discuss the form and significance of the Education Evaluation model used at AIDS Vancouver Island in Victoria. The session participants will be encouraged to provide feedback and discussion on various aspects of this model in particular and on the importance of community-based evaluation research in general.

Biography:
Stephen M. Samis is presently in the second year of a two year contract as Coordinator, Research Projects at AIDS Vancouver Island in Victoria, where he has been responsible for the AVI Education Evaluation and the M.A.R.S. Research Project. He is also an independent research consultant, whose other current projects include co-Principal Researcher on the First National Survey on Same-Sex Relationships and Violence Against Lesbians, Gay Men and Bisexuals in Canada. He holds a Masters degree in Sociology from Simon Fraser University.

M:PM6 Multiple Diagnoses:
Creative Approaches to Supporting Access to Care

Treatment Information Program:
Satellite Office on Downtown Eastside

Presenter:

Jeff Gray

This presentation is going to discuss how to provide treatment information in the Downtown Eastside of Vancouver. This is one of Canada's poorest neighbourhoods with the highest rate of HIV seroconversion. There are several marginalized communities living here including natives, transsexuals, street workers, latinos and IDU's. There is presently one satellite treatment information location in this area at 30 Blood Alley, in Gastown. This clinic has a high population of needle drug users who are HIV positive and who take methadone as treatment for heroin addiction.

To be discussed:

- Methadone maintenance as harm reduction in HIV care.
- The clients of the clinic and their multifaceted needs.
- How best to provide treatment information to the diverse group of people requiring this service in the neighbourhood.

M:PM6 Multiple Diagnoses:
Creative Approaches to Supporting Access to Care

Applying Harm Reduction Strategies to Treatment Information Services for Substance Users Living with HIV/AIDS

Presenter:
Brent Patterson
Community AIDS Treatment Information Exchange (CATIE)
420 - 517 College Street, Toronto, ON M6G 4A2
1-800-263-1638 ext. 223; fax: (416) 928-2185; email: bpatterson@catie.ca

ABSTRACT

Issues:

Harm reduction strategies pose challenges to health promotion for substance users living with HIV/AIDS. Harm reduction strategies have not been adequately incorporated into approaches to health promotion for substance users living with HIV/AIDS. Existing treatment information and care guidelines for people living with HIV/AIDS often neglects issues affecting substance users. The session will address the application of harm reduction strategies to treatment information services and identify issues for substance users living with HIV/AIDS.

Description:

Treatment information services need to recognize the many barriers which substance users living with HIV/AIDS face in attempting to access health care. Information about potential interactions between pharmaceutical treatments and recreational drugs needs to be collected and disseminated. Other health issues such as treatment compliance, pain management, reinfection with different strains of the HIV virus, bacterial infections, hepatitis, TB, malnutrition, multiple diagnoses (HIV, mental health problems, and substance use), affects of substance use on the immune system, and adequate housing all need to be addressed. Comprehensive standards of care which incorporate a harm reduction approach need to be developed for health care professionals treating substance users living with HIV/AIDS.

Conclusion:

Substance users living with HIV/AIDS need treatment information which incorporates harm reduction strategies and addresses the different issues which affect them. The information must offer a variety of pragmatic options to choose from and must actively involve substance users living with HIV/AIDS in making decisions to optimize their health care.

Biographies:

Brent Patterson has been working at CATIE for the last 6 years. He is co-author of Managing Your Health. He has written a pamphlet on harm reduction for substance users. He is currently in the position of Advocacy Coordinator. He is a member of the HIV/AIDS Subcommittee of the Harm Reduction Coalition of Ontario. He has also been active with AIDS Action Now!

M:PM7 Falling Through the Cracks, Picking Up the Pieces: Communities Respond

Resolving Conflicts Between Different Population Groups in a PHA Drop-In Centre

Presenters:
Jim Young
Maggie Johnston
Jackie Haywood
"The Living Room", AIDS Committee of Ottawa
179-B Rochester Street, Ottawa, Ontario K1R 7M5
Tel: (613) 233-3817; Fax: (613) 233-4291; E-mail: jcyoung@sympatico.ca

ABSTRACT

Issues:

Conflict exists among the different population groups using PHA drop-in centres, resulting in verbal and physical arguments, a tense atmosphere, and reduced participation by certain groups

Description:

The common thread of HIV among the very diverse group of people who come to a PHA drop-in centre is not sufficient to unite all PHAs. Real and perceived conflicts of interest, lifestyle, culture, etc. — such as those between middle-class and street people, between people in recovery and active users — pose serious challenges for PHA drop-centres striving to meet the needs of all PHAs.

Conclusion:

Successful strategies to reduce conflict and increase inclusivity within a PHA drop-in centre can be implemented.

Biographies:

Jackie Haywood. Support Manager, British Columbia Persons With AIDS Society (BCPWA), 10 years experience as front-line worker and co-coordinator of "The Lounge", a PHA drop-in centre; founding member of Wings Housing Society and Positive Women's Network

Maggie Johnston. Coordinator of "The Living Room", a PHA drop-in centre (program facility of the AIDS Committee of Ottawa), 6 years experience as front-line worker.

Jim Young. author, Making Space for PHAs: A Manual for Setting Up and Operating a Drop-in Centre for Persons Living with HIV/AIDS (1997); Coordinating Committee member of "The Living Room", with 6 years experience as a front-line volunteer.

M:PM7 Falling Through the Cracks, Picking Up the Pieces: Communities Respond

Delivering Support to HIV+ Street Youth

Presenter:

Josephine Stebbings

• Notes •

HIV: Into the Next Millenium

Presenter:

Linda Shackelly

• Notes •

HIV: Into the Next Millenium

Presenter:

Albert McLeod

• Notes •

So You Want to Know About Indians and AIDS!

Presenter:

Tuma Young

• Notes •

T:AM1 Surviving: HIV+ Aboriginal Women

HIV/AIDS Amongst Aboriginal Women in Canada: An Increasing Concern

Presenters:
Mai Nguyen
Sandra Laframboise

ABSTRACT

Objective:

To examine data on HIV/AIDS for Aboriginal women in Canada.

Methods:

AIDS data are derived from the Canadian AIDS Case Reporting and Surveillance System. HIV testing data are obtained from the British Columbia (BC) Enhanced HIV Surveillance Study and the Northern Alberta (NA) HIV clinic. HIV prevalence and risk behaviour data are derived from the Alberta study among STD clientele with Aboriginal identifiers.

Results:

As of 30/09/96, 14 185 AIDS cases were reported in Canada; 210 were among Aboriginal people. About 12.6% (26/206) of the adult Aboriginal AIDS cases (>age 15) were in women. Half of these women were <30 years of age at diagnosis. Exposure categories for adult Aboriginal women with AIDS were: injection drug use (IDU) 46% heterosexual contact 35% receiving blood/clotting factors 2%. The proportion of female adult AIDS cases attributed to Aboriginal women has increased from 3.2% before 1990 to 4.7% (1990-92) and 7.6% (1993-95). Recent HIV testing data in BC and NA found Aboriginal women to comprise 26-30% of newly diagnosed female HIV+ cases; IDU and heterosexual contact were their main risk factors. In addition, 52% (16/31) of children born to HIV+ mothers in NA to June 1996 were Aboriginal. Other findings from the Alberta STD study indicated a higher HIV prevalence rate among 226 Aboriginal women that 2 677 non-Aboriginal women (1.3% vs 0.07%, $p<0.01$); that the Aboriginal women had an average of 14 sexual partners in the last 12 months but only 12% always used a condom with their regular partners and 30% with their casual partners; 54% had a history of an STD and 18% had ever injected drugs. Most of them were heterosexual (94%) and <30 years of age (72%).

Conclusion:

HIV infection among Canadian Aboriginal women appears to be a growing problem. Evidence suggests that aboriginal women are infected at a young age and that IDU and unprotected sex are the most important modes of transmission. Targeted HIV/ AIDS programs for Aboriginal women need to be developed with active Aboriginal involvement in the process.

T:AM1 Surviving: HIV+ Aboriginal Women

The Lived Experience

Presenter:

Kecia Larkin

Notes •

T:AM2 Multiple Diagnoses: Creative Approaches to Providing Care

Multi-diagnosed Clients and Community Health Systems: A Case-Based Look at Challenges

Presenters:

Warren O'Briain, Kathleen Cummings, Evanna Brennan, Susan Giles, Catherine White and Peter Granger

AIDS Vancouver, 1107 Seymour Street, Vancouver, B.C. V6B 5S8

tel: (604)681-2122 x231 fax: (604)893-2211 email: warreno@parc.org

ABSTRACT

Issue:

Increasing numbers of multiple diagnosed individuals are turning to community health agencies for assistance and care. Providing community-based care and support to individuals who are living with HIV, injection drug use or other substance use, and who are also living with either a pre-existing psychiatric diagnosis or a severe, AIDS related, neuro-cognitive deficit can present tremendous challenges to existing health systems. Lack of stable housing, poor nutrition, and compromised neuro-cognitive function make it difficult for multiple diagnosed individuals to maintain the organized schedule needed to access available systems of care.

Description:

This session will present two case scenarios based on the experiences of multiply diagnosed individuals who requested assistance from AIDS Vancouver and the Downtown South Community Health Centre. The Vancouver Health Board home care nursing program also became involved in care delivery. In these instances, all service providers struggled with the conflicts between the multi-disciplinary care issues presented, and existing areas of service expertise which were poorly equipped to respond. Service providers were able to respond with short-term "Band-Aid" solutions, systems issues and lack of resources prevented a comprehensive program of coordinated care from being fully developed with the individuals in the case scenarios.

Conclusion:

Lessons were learned on many fronts, including:

- increased awareness of the issues presented by multiple diagnoses;
- the importance of increasing the availability of mental health support at the community level;
- the importance of structuring systems of care which can respond based on the client's need rather than the systems' respective mandates;
- that many services flow from stable housing, and this issue has not been addressed;
- that medication management can be overwhelming for individuals in this situation and systems must be developed and strengthened to provide better support;
- and, that the development of a day care centre can assist in addressing some of these issues.

Biographies:

Warren O'Briain, Director of Support Services at AIDS Vancouver, co-chairs the Multiple Diagnoses Committee of Vancouver, as well as the Vancouver HIV/AIDS Care Coordinating Committee.

Evanna Brennan, RN and Susan Giles, RN are home care nurses with the Vancouver Health Board, North Health Unit, and have been working in Vancouver's Downtown East Side for the past 12 years.

T:AM2 Multiple Diagnoses: Creative Approaches to Providing Care

Community Psychiatric Care for Individuals with HIV/AIDS, Mental Illness and Substance Abuse

Presenters:
Palmira Brouwer, Simon Davis, Angelo Leo and Doreen Littlejohn
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Doreen: 255-7859

ABSTRACT

Issue:
Individuals with mental illness, substance misuse and HIV/AIDS have a variety of treatment needs which challenge health care providers. Psychiatric symptoms can impair the client's perceptions of their own HIV risk and therefore reduce their ability to alter high risk behaviours. Social, medical, behavioural, cognitive and organizational issues can complicate care givers' attempts to provide education and comprehensive services. As well, a lack of adequate resources, such as housing, make service provision difficult. Poverty, chronic mental illness, poor physical health, isolation, polysubstance misuse and multi-service utilization are all factors impacting on these individuals.

Description:
We will examine the issue of HIV/AIDS and chronic mental illness from a community mental health perspective. The GVMHS HIV/AIDS and Mental Health Interest Group will briefly be discussed and the activities described. Case management will then be discussed from a variety of perspectives: Mental Health Team, Assertive Community Team and the Interministerial Program. Case management involves counselling psychiatric assessment, crisis intervention, client education, housing, promoting medical care, advocacy, service coordination – this will be discussed as currently provided. The pros and cons of case management will be discussed in terms of managing clients who may have a number of case managers and also what seems to work and what is needed.

Conclusion:
There are unique needs when providing case management to multi-diagnosed individual. This presentation will provide information on case management issues with this population.

T:AM3 Rural Outreach: Connecting Communities

When Numbers are not Enough...Creative Rural Community Outreach Strategies

Presenters:
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ABSTRACT

We shall present our experiences and challenges encountered in developing creative outreach strategies in the rural, lower prevalence areas of the Thompson and West Kootenay/Boundary regions in British Columbia.

Issue:

- Locating and developing trusting relationships with rural residents who engage in behaviours that put them at risk for HIV infection. How do we find people who do not want to be found, such as injection drug users?
- Mobilizing people in lower prevalence areas - also known as Living Here Won't Protect Us From HIV/AIDS?
- Maintaining momentum in rural communities through capitalizing on inherent assets and local abilities? Specifically, how do we survive hot and cold spells of community interest in HIV/AIDS?
- The best laid plans...How to turn negative publicity to your advantage - lessons learned from children, parents, school boards, and BC Report Magazine.

Description:

Using actual practice case examples, we will be sharing our experiences and observations in addressing the above issues. Workshop participants will have an opportunity to critically examine our proven strategies and lessons learned through hand-outs and interactive discussion. Moreover, participants will be able to practice applying creative rural community outreach and mobilization strategies through small group skills building exercises including influencing decision-makers, working with small town media, finding and building trusting relationships with rural residents engaging in high risk behaviours.

Biographies:

Mary Ann Sandrelli is the Executive Director of the AIDS Society of Kamloops. Kathleen Beechinor is the Community Care Team coordinator and Claire Davidson is the Volunteer and Event Coordinator, both with ANKORS serving the West Kootenay/ Boundary Region.

T:AM3 Rural Outreach: Connecting Communities

Fostering and Sustaining Regional Rural Projects

Presenters:
Paula Veinot
Project Coordinator, Atlantic Regional HIV/AIDS Treatment Information Project
Jane Allen
Project Coordinator, Women and AIDS Project
c/oAIDS Coalition of Nova Scotia, 5675 Spring Garden Rd., Suite 600, Halifax, N.S., B3J lH1;
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ABSTRACT

Issues:

Health Canada is sponsoring two regional HIV/AIDS health promotion projects: The Women and AIDS Project and the Atlantic Regional HIV/AIDS Treatment Information Project (ARTIP). These projects were designed to enhance the strengths of the region including "traditional" communication networks and community participation. The Atlantic region is predominantly rural, economically disadvantaged, geographically disperse and politically diverse with health and community services being coordinated in various ways from province to province. These projects focus on enhancing and supporting the existing skills and resources within peer networks and communities using sustainable health promotion and community development models.

Description:

The ARTIP aims to provide treatment information services that are sensitive to the needs of PHAs in the Atlantic region. Treatment continues to be one of the most important ways a PHA can exude a sense of control over his/her health. This project is unique in that, to date, there has been no regional effort on the part of the four provinces to work together to provide PHAs with treatment information. To achieve the goals of the project member AIDS organizations are providing Internet access to PHAs, conducting Internet training and developing peer treatment counselling skills so that PHAs can become peer treatment information counsellors.

The Women and AIDS Project aims to enhance the accessibility and quality of HIV/AIDS education and support programs for women. Using health promotion and community development models, the project engages and supports community members in peer support, regional retreats and skills-building in the areas of self-care, leadership and advocacy are helping create supportive social environments women living with HIV/AIDS.

Conclusion:

Regional rural work presents a challenge because of the socioeconomic and physical barriers inherent in the region and the perceptions of others that Atlantic Canada is uniform. Successful community-based networks work to eliminate the inherent barriers by using "traditional" networks and ways of working.

Biographies:

Paula Veinot, BScHE, MHSc, is the Project Coordinator for the Atlantic Regional HIV/AIDS Treatment Information Project. She is a health promoter with program planning and research experience in a variety of health issue areas including HIV/AIDS, cardiovascular health, women's health and multicultural health. She was born and raised in rural Nova Scotia and has lived in Halifax for several years.

Jane Allen, BSW, is the Coordinator for the Women and AIDS Project. She has been working in community-based women and AIDS work for the past seven years. Her interest continues to grow in community-based health promotion, community development and adult education. Her dream is to integrate her fiddle playing into safer sex demonstrations.

T:AM4 Communities of Faith

There are No Pills to Help These Issues

Presenter:

Phil Sestak

• Notes •

T:AM4 Communities of Faith

New Hopes, New Fears

Presenters:

Harvey Bosma

Judy Krueckl and Dena Kasdors

The experience of living with HIV/AIDS means adjusting to ongoing changes and losses. These changes can touch many aspects of a person's life, and new challenges often emerge for PLWHIV/A in the areas of physical and mental functioning, employment and livelihood, relationships, social attitudes and reactions, and facing one's own mortality and that of family and friends.

With the introduction of protease inhibitors and combination therapy, comes a new set of challenges as PLWHIV/A, and their family and friends, adjust to the possibility of living longer and cope with the challenges implied in a subsequent shift back to re-engaging in the tasks of living. Throughout this experience, PLWHIV/A often deal with a range of emotional reactions and grapple with finding new meaning and purpose for themselves. The purpose of this presentation is to describe these issues further and will include a personal narrative by a mother who cares daily for her adult son who lives with AIDS.

T:AM5 HIV Prevention: National Strategies, Local Implications

HIV Prevention: National Strategies

Presenter:
Ron de Burger
Canadian Public Health Association, AIDS Program
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Email: rdeburger@cpha.ca, nhammell@cpha.ca

ABSTRACT

Objectives:

- To describe the HIV prevention work being done by public health professionals across Canada
- To match professional development needs with resources and resource people

Methodology:

- A survey was mailed, in January 1997, to all medical officers of health in Canada inviting them to respond for their jurisdictions or to have the replies come directly from front-line units.

Results:

- To be compiled and analyzed. Results will be available at the session.

Discussion:

- Describe (compare and contrast where possible) the HIV Prevention roles played by public health professionals in Canada by the size of community or population centre, and by region.
- Describe the professional development needs, the kinds of resources and resource people identified by the survey.
- Seek feedback from the BC HIV/AIDS Conference participants regarding the role descriptions, the implications of the information and the possible approaches to matching development needs and resources to support front-line work beyond the end of Phase II of the National AIDS Strategy.

Biographies:

Ron de Burger has been Director of the Canadian Public Health Association (CPHA) AIDS Program since 1991 and also represents CPHA on other issues related to blood borne pathogens, infectious diseases and public health practice, policy and organization. His background includes experience as Assistant Deputy Minister of Health in British Columbia, Dean of the Faculty of Health Professions at Dalhousie University and Chairman of the Environmental Health Department at Ryerson Polytechnical Institute. Mr. de Burger has been a member of the Canadian Public Health Association for over 25 years.

HIV Prevention: Local Implications

Presenter:

Elizabeth Whynot

• Notes •

T:AM6 Empowering Strategies for Effective Treatment

Treatment Information Program: A Community Care Model for Consumer (PWA) Empowerment in Treatment and Health Promotion Decision-making

Presenter:
Glen Hillson

ABSTRACT

Background:

Prior to the AIDS pandemic the western model for health care has consisted primarily of relationships between physicians and patients focused on interventions to treat and manage diseases, conditions and symptoms. Information-sharing typically consisted of patients describing their symptoms and doctors offering advice and treatment options. Patients relied almost exclusively on doctors for guidance relating to their medical needs and trusted them to have complete, accurate and up-to-date information. In the area of scientific research, patients seldom advocated for their own needs or participated in the development of research agendas. These processes were controlled by governments, industry and academics.

In the early 1980's community responses to AIDS were mostly concerned with addressing the various needs of people who were sick and dying. There was a strong tendency for AIDS sufferers to become isolated in their communities because of the combined stigmas associated with AIDS including homophobia, injection drug use, physical disability and disfiguration, as well as disease and death phobia. Despite the challenges of illness and discrimination a political movement of AIDS activists evolved in the late 1980's. People living with HIV disease organized to fight for more and better research and treatments. They also asserted the right of the patient population to participate in all levels of decision-making with other stake-holders.

Activists soon recognized that in order to use their political clout effectively they needed to educate themselves in the areas of science and medicine. The movement evolved from marching in the streets to sitting down at the table. It was no longer enough to say "we want action". Advocacy took the form of participating meaningfully and productively in tasks such as defining research agendas, designing clinical trials, creating and implementing compassionate and expanded access programs for experimental drugs to name a few.

A community of treatment experts has evolved within the AIDS movement. These are people with HIV disease who are not only powerful advocates but experts with a unique perspective who participate in the ongoing tasks and decisions which affect all of us.

Challenge:

Recognition has developed within the HIV/AIDS community that expanded knowledge of treatment information was not only an essential tool for activists, but would likely benefit individual patients. Across North America a number of community programs have developed to respond to the needs of PWA's to empower themselves with medical and scientific information about treatment options in order to fully participate in their own health care decisions.

Issues:

Most treatment information services provide standardized information in a linear fashion, from service provider to service receiver. Information about conventional and alternative therapies, or even off-label usage of pharmaceuticals is often conflictual, technical, or promotional in scope. Many persons living with HIV disease lack the necessary skills of critical and analytical thinking to assess various treatment modalities. Major health-care decisions are being made on site at the doctors office, without being properly informed, and in isolation from the context of the life situation of the individual.

Project:

The Treatment Information Program, located within an HIV-specialized library, is a peer-driven project. Peer Treatment Counselors work together with clients to help answer questions, assist in gathering and evaluating information to address health-related concerns. The philosophy of the program is to emphasize individual control, power and autonomy while building upon essential skills. Low self-esteem and dependence on others are frequent complicating factors, inhibiting many people from becoming educated about treatment options and preventing them from being assertive with their primary health-care providers. Based on a self-help model, peer Treatment Counselors assist individuals in advocating for themselves, using a combination of education and support strategies.

Lessons Learned:

HIV is a disease that is very complicated and can manifest itself in patients in a vast assortment of ways. Information about disease pathogenesis and treatment strategies is changing and increasing at a rapid pace. There is seldom broad consensus among experts as to what's right and what's wrong. Strategies which made sense only a year ago have been discarded in favor of newer options. Decisions made by an individual today will very likely affect their future treatment options and may need to be evaluated in the context of a long-term plan. Options which are appropriate and beneficial for one individual may be useless or even harmful for another. Individual needs are influenced by a wide variety of factors including medical considerations, emotional and physiological issues, living conditions and habits, financial, available support, and individual beliefs. In order to evaluate treatment information in the context of these factors a collaborative, interactive process helps individuals to personally tailor strategies to fit their own specific needs. Emphasis on skills building and enhancement of self-esteem enables persons with HIV disease to advocate for their own health needs and to respond to the challenges of future changes in their needs and options.

T:AM6 Empowering Strategies for Effective Treatment

Partners in Care: Communication Skills in the Treatment Decision Making Process

Presenter:
Robert St-Pierre
Canadian Hemophilia Society, 625, President Kennedy Avenue
Suite 1210, Montreal, Quebec H3A 1K2
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ABSTRACT

Issues:
For most persons with HIV/AIDS, informed treatment decision making and treatment advocacy often begins with one's own struggle in negotiating adequate treatment and care. Many persons with HIV/AIDS find themselves dissatisfied with one or more aspects of their relationships with their health care providers. The first step in developing a good relationship with your doctor is to identify the role you wish to play in this relationship.

Focus:
Communication skills in the relationship between a person with HIV and the treating physician

1. Simulations (3) of "doctor/patient encounters" with an emphasis on demonstrating common attitudes and skills found in the doctor/patient relationship. An effort will be made to balance the positive and negative aspects in the simulations.
2. Small working groups. The above simulations will set the background for small groups discussion and problem solving.
3. In a plenary, each group will present its recommendations to the large group for a discussion over outcomes of potential solutions.

T:AM7 HIV/AIDS in Prisons: Needle Exchange, Methadone and Other Issues

The Correctional Service's Response

Presenter:
Judy Portman

Notes •

Update on HIV/AIDS in Prisons Around the World

Presenter:
Ralf Jürgens

• Notes •

An HIV+ Prisoner's View: Five Years Later

Presenter:
Michael Linhart

• Notes •

Risk Reduction Strategies in Prisons: A Collaborative Approach

Presenter:
Peter Ford
Clinical Immunology Outpatient Clinic, Kingston General Hospital,
76 Stuart St., Kingston, ON
Tel: (613) 548-6078; Fax: (613) 548-6080; e-mail: Fordp@post.queensu.ca

ABSTRACT

Issues:

In order to enhance the transfer of information and increase the likelihood of behaviour change in the prison setting, interdisciplinary teaching teams must interact with the prison community in accessing the prison system, developing risk reduction strategies and teaching tools, and delivery of the education program

Description:

The presenters will describe the development of a proposed safe tattooing program at a medium security prison for men in Ontario from accessing the Lifer's media group, Big House Productions, to developing an awareness and teaching video.

Participants will view the video made in Joyceville Institution, Tattoo: The Art Beneath the Skin. The presenters will discuss with the participants other methods of risk reduction in prison settings and the development of useful strategies for success, drawing on the participants' experiences and knowledge of risk reduction strategies with prison population.

Biography:

Dr. Peter M. Ford graduated St. Mary's Hospital Medical School, London University 1964. Postgraduate training at St. Mary's and the Royal Postgraduate Medical School, London, England. Currently Professor of Medicine at Queen's University and Director of the Clinical Immunology Outpatient Clinic (HIV/AIDS Clinic) at the Kingston General Hospital, Kingston, Ontario.

T:AM7 HIV/AIDS in Prisons: Needle Exchange, Methadone and Other Issues

HIV Education and Support for Incarcerated Women: A Collective Approach

Presenters:
Margreth Tolson
Deana Auger
Dina Tomei
AIDS Vancouver, 1107 Seymour St., Vancouver, BC., V6B 5S8,
phone: (604) 681-2122 (ext. 229), fax: 893-2211, e-mail: Margreth@parc.org

ABSTRACT

Issues:

Women are quickly growing in HIV infection rates in BC. Their risk for infection is increased in the prison setting due to limited access to HIV prevention information, and methods of reducing risk when using injection drugs in prison. As well, stigma associated with being HIV- causes women to be isolated and feared in prisons. Staff and residents of Burnaby Correctional Centre for Women (BCCW) wanted to develop an HIV education and support program for residents, in order to counter these problems

Description:

In February 1996, a group of residents and staff at BCCW gathered with community workers (from agencies both inside and outside the institution) to develop an integrated program of HIV education and support. An innovative feature of this program would be the focus on peer education. Staff and residents of BCCW initiated and developed their own training program with the support of AIDS Vancouver Women's Outreach, and created a program suited to the specific needs of incarcerated women. The philosophy common to all three groups was a strong commitment to women's health combined with a harm reduction focus. This educational initiative comprises residents training other residents in HIV prevention, but also providing 1-1 support for HIV- women, staff providing 1-1 support to residents, as well as staff educating their peers in the institution.

Conclusion:

An informal evaluation of the program has indicated that both residents and staff report a number of benefits to BCCW, such as reduced stigma for those women living with HIV, greater awareness of HIV prevention and harm reduction methods in the resident population, and increased potential for development of other peer-support programs related to women's physical and emotional health. A formal evaluation is scheduled for the Spring of 1997. This integrated approach, of staff, residents, and community agency representatives working together, is an unusual innovation for the prison environment, and a model that has worked very well. However, to ensure continued risk reduction and support for change when women are released from prison, linkages must be established with communites, including families, friends, community workers and health professionals. We believe many communites may find this program information useful in their support of women prisoners and women in transition from prison back to their home community.

Biographies

Margreth Tolson is Coordinator of Women's Outreach for AIDS Vancouver, and has worked in women's health organizations since 1992. She currently provides HIV related support and information to women in the Downtown Eastside of Vancouver, and does education work at women's centres throughout the Lower Mainland. She has been with BCCW residents and staff since February 1996.

T:PM1 Our Own Designs: First Nations Education Strategies

Culturally-Appropriate Visual Teaching Tools Developed for Aboriginal People in Canada

Presenter:
Albert McLeod
Manitoba Aboriginal AIDS Task Force, 181 Higgins Avenue, Winnipeg MB R3B 3G1
(204) 957-1114; fax: (204) 942-6308

ABSTRACT

Issue:

The language and content of standard HIV/AIDS resources are not effective for reaching Aboriginal populations.

Project:

In the past five years Aboriginal and non-Aboriginal educators in western Canada have been trained to promote HIV/AIDS awareness to Aboriginal communities. Standard teaching methods deemed inappropriate or ineffective were discarded and culturally-appropriate training resources were developed. These newly created resources adapt HIV/AIDS information into much easier to understand formats which are based in the traditional and cultural values of Aboriginal people.

Results:

Through interagency collaboration these new resources are now becoming available to larger numbers of Aboriginal and non-Aboriginal trainers. The AIDS 101 teaching posters are a series of eight primarily visual posters which explain the different stages of HIV infection. The AIDS Bingo Game was developed to reach people in a popular gathering place. The HIV/AIDS Wheel and the Teaching Turtle incorporate the traditional teachings of the Aboriginal Medicine Wheel and provide a holistic view of the physical, emotional, mental and spiritual stages of HIV disease. These resources are transferable to such hard to reach populations as prisoners, street-involved people, people with low-literacy levels and non-English speaking populations.

Lessons Learned:

In order to reach specific hard to reach populations, the complex scientific and medical language of HIV/AIDS can be adapted and presented in a way which is both understandable and respectful of cultural diversity.

Biography:

Albert McLeod is of Cree and Scottish descent. He was born in 1955 and raised in northern Manitoba. Prior to working in the HIV/AIDS Field he was a commercial artist. He became involved in the AIDS movement after his friend, Paul Packo, died in 1988. Mr. Packo was the first known Aboriginal person in Manitoba diagnosed with AIDS. In 1991, Albert and two other AIDS advocates, Myra Laramee and Dorland McKay founded the Manitoba Aboriginal AIDS Task Force. Since that time he has worked for the task force in the positions of HIV/AIDS educator, project coordinator and resource developer. Mr. McLeod is a representative of the task force on the following committees: Manitoba Regional AIDS Steering Committee (1991-present); Manitoba Health

Minister's Advisory Committee on AIDS (1993-present); Canadian Aboriginal AIDS Network (March 1994-present); Canadian AIDS Society - Ethnocultural and Diversity Committee (Feb.95-Mar.95). In addition to working in HIV/AIDS, Mr. McLeod has participated in the annual Two-Spirited Peoples' Gathering since 1988. He promotes awareness of two-spirited people and advocates for their open participation at all levels of the Aboriginal community and for their rights as indigenous people.

T:PM1 Our Own Designs: First Nations Education Strategies

Teaching Awareness and Advocacy Through Learned Experience

Presenters:
Alex Archie
5561 Bruce Street, Vancouver, BC V5P 3M4
Phone (604) 322-2156 Fax: 879-9926
Barb McKinnon
Gitksan-Wetsu'wet'en Nation, Moricetown, BC

ABSTRACT

Objectives:

Healing our Spirit - BC First Nations AIDS Society has completed the Circle of education, prevention and awareness by offering a support and care team to help Aboriginal PHA's deal with HIV infection or full blown AIDS. Education and prevention includes awareness of opportunistic infections, current treatment options that include holistic and traditional medicines.

Continued promotion of issues faced by First Nations people living with HIV and AIDS (PHA's). Raising awareness and understanding of the needs of PHA's who are both urban and rural based; living on or off reserve and are status and nonstatus, Inuit or Metis. BC First Nations AIDS Society's membership includes Aboriginal people from many nations across Canada who live in BC.

Methodology:

Healing Our Spirit opened a sub-office for APHA's to access services provided by Aboriginal people including one Peer Counselor and a Community Health Coordinator. Both positions were created to compliment the Advocacy Worker in place. Intake information was taken at initial visits with stress on confidentiality and personal safety. Other visits included follow up visits to homes and hospitals. Consultations with APHA's took place on a regular basis and as a result workshops were set up to deal with care, treatment and support issues. After the first APHA consultation there was an obvious need for meetings with support people, including family members, friends and other care team players. One of the primary goals was to set up a safety net for APHA's to return to their home communities.

Treatment, care and support for First Nations people living with HIV/AIDS (PHA's) whether they live on or off reserve, includes prevention and education as well as harm reduction and health promotion. Current systems and policies are driven by community based response to PHA care and support needs as well as personal safety issues. Aboriginal people deserve service from their people, these services have been designed and implemented by their people.

Results:

All information will be gathered between now and the 10th BC HIV/AIDS Conference. Through experiences of other Aboriginal AIDS service organizations as well as Aboriginal PHA's and communities we will have a clearer picture of the number of people infected and affected by HIV and AIDS. We will also build partnerships and

coalition with other ASO's, First Nations communities and their leadership as well as focus on the diversity of these communities. We also hope to express some of the overlying issues to help understand the complexity of Aboriginal HIV/AIDS issues in care, treatment and support.

Discussion:

Discussion will focus on accomplishments of two new positions that Healing Our Spirit has advocated for Ken Clement, Community Health Coordinator and Alex W. Archie, Interim Educator/Peer Counselor. We will recognize obstacles and barriers faced along the way and how they were overcome.

Biographies:

Alex W. Archie is from the Tseqescan Nation at Canim Lake, BC. He is currently employed at Healing Our Spirit - BC First Nations AIDS Society as an HIV/AIDS Educator and Peer Counselor for Aboriginal PHA's. Mr. Archie has been an active volunteer for AIDS Service organizations and First Nations communities throughout BC for the past six years. Mr. Archie is currently serving on the Board of Directors of the NAMES Project/Le projet des NOMS - Canada and is a member of the BC AIDS Focus Group of Health Canada Medical Services Branch; the Pacific AIDS Network (PAN); the AIDS Society of Kamloops (ASK); and the Canadian Aboriginal AIDS Network.

Barb McKinnon's employment history involves working with First Nations people in various areas including the Gitksan-Wetsu`wet`en Tribal Council and for the Moricetown Band for several years. Barb has also worked in the medical field as a Licensed Practice Nurse in Smithers, BC as well as with Vancouver Para Med, Mount St. Joseph's Hospital and Vancouver General Hospital for a number of years. Barb enjoys working with a wide range of people in general. Barb has excelled in her previous position as an Educator for Healing Our Spirit from 1993 to January. Her current position is Education Program Coordinator since September 1997. Barb provides services in "informational workshops" as a facilitator throughout the province.

T:PM2

Theatre of the Oppressed

Presenters:
Olivia Candille
Robyn Gitelman
Robert Little
Jennifer Mani
YouthCO Theatre Troupe, #240, 440 West Hastings, Vancouver, BC V6B 1L1
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ABSTRACT

Issues:

After approximately a decade of HIV/AIDS educational initiatives, youth continue to sero-convert at increasing rates. Young people who are living with HIV/AIDS continue to live with their disease in isolation. In order to increase effectiveness, AIDS educators and outreach workers must go beyond conventional educational tools. Our educators and outreach workers must develop a dynamic set of skills that can be used to engage, communicate, and impact the thoughts and behaviours of other young people.

Description:

YouthCO has taken a group of interested youth and have formed a theatre troupe to present/provoke issues around HIV/AIDS and youth. Through using a highly-interactive style of theatre known as forum theatre, we have been able to address and "role-play" issues that are sometimes uncomfortable for youth to discuss in traditional education formats. In our presentation we will be outlining the origins and direction of the peer-driven YouthCO theatre troupe, as well as to present a short forum theatre piece.

Conclusion:

The YouthCO theatre troupe hopes to allow not only youth and youth educators a chance to openly discuss the issues surrounding youth and HIV/AIDS, but also describe a highly interactive and effective method of education and learning.

T:PM3 Women and Prevention

Addressing HIV Transmission and Diversity among Women who Partner with Women

Presenter:
Maria Stanborough
1107 Seymour Street, Vancouver, BC V6B 5S8
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ABSTRACT

Issues, Description, Conclusion:

Women who have sex with women are becoming infected with HIV at an ever-increasing rate. To be effective, HIV education for women who partner with women must acknowledge the diversity of this population. Education needs to focus on the activities that put women who have sex with women at risk (needles use, sex with men, sharing sex toys) rather than the basing information on labels or identities (lesbian, dyke, bisexual, and so on).

The workshop will present two educational formats developed for women who have sex with women: a printed resource and a community forum. Both the printed resources and the community forum recognized the variety of marginalizations that put women at risk, while educating women who partner with women about the routes of HIV transmission, including needle use and sex with men.

The printed resource and the community forum have been highly successful, demonstrating the urgent need for basic HIV transmission information for women who have sex with women. In doing so, attention must be given to issues such as literacy, inclusiveness, and diversity of representation. By presenting inclusive HIV prevention information, health educators can assist women who have sex with women toward making positive changes to reduce their risk of HIV infection.

Biography:

Maria Stanborough works as the Community Outreach Educator with AIDS Vancouver. She works actively on sexual health issues for women, childhood sexual abuse survivors, and other marginalized populations.

T:PM3 Women and Prevention

Women, Womyn, Wimmin: Different People, Different Styles

Presenter:

Juanita Smith

• Notes •

T:PM3 Women and Prevention

Fighting the Tide, Changing the Current: Rural Women Respond to HIV in Nova Scotia

Presenter:

Jane Allen

• Notes •

T:PM3 Women and Prevention

Social Roles of Women and HIV

Presenter:

Barb Cowan

• Notes •

T:PM4 Men Who Have Sex With Men Prevention/Education: Moving Forward?

Victor Vancouver: A Multi-Media Health Promotion and Research Campaign for Gay Youth

Presenter:

Vicki Vancouver

ABSTRACT

Victor Vancouver:
A multi-media health promotion and research campaign for gay youth

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Issues:

Vancouver is a major HIV epicenter and has one of the highest sero-incidence rates among 19-30 year old gay/bisexual men in Canada. Designing a HIV prevention and health promotion campaign for this group must be dynamic, non-traditional and must reflect this population's social realities.

Description:

The Victor Vancouver campaign utilizes several media elements:

1. a weekly cartoon strip published in the alternative press
2. weekly distribution of the cartoon in poster/postcard form
3. internet site
4. sidewalk outreach/street level surveying
5. voice-mail voting
6. discussion groups
7. a compilation comic book issued quarterly.

One of the most dynamic features of this campaign is the research and evaluation component. The campaign works in partnership with the Vanguard Project (a prospective cohort study of young gay/bi men in Vancouver) and utilizes a variety of survey techniques to better understand the social contexts and realities of this target population.

Conclusions:

The Victor Vancouver campaign has received overwhelming support from it's participants and the gay community at large, many of whom have begun to discuss the various themes and issues depicted in the cartoon with their peers and sexual partners. It has been shown that the close collaboration between research institutes and community-based groups allow for innovative, responsible and successful health promotion and HIV prevention programs.

T:PM4 Men Who Have Sex With Men Prevention/Education: Moving Forward?

Prevalence, Incidence and Risk Behaviours among a Cohort of Young Gay/Bisexual Men

Presenter:

Steffanie Strathdee

ABSTRACT

The objective of the Vanguard Project is to describe HIV prevalence, incidence, and risk behaviours among a cohort of young gay/bisexual men (MSM). Beginning in May/95, MSM aged 18-30 living in Vancouver who had not previously tested HIV+ were recruited through physicians, clinics and outreach. On an annual basis, men undergo an HIV test and complete a self-administered questionnaire. Data collected include demographics, social support, depression, sex with men and women, paid sex and nonconsensual sex.

As of September 1, 1997, a total of 603 men completed baseline test results and questionnaires, and 285 men had completed annual follow-up visits, for a follow-up rate of 75%. At baseline, median age was 26, and the majority had completed high school (85%) and were employed (70%). Ethnic diversity was as follows: 73% Caucasian, 10% Asian/South Asian, 8% Aboriginal, 2% Latino, 7% other. The majority (77%) were single; 23% were living common law with a male partner. Most reported recent sex only with men (83%), 13% with both sexes, and 4% were currently celibate. Median numbers of regular (> once per month) and casual male partners (< once per month) in the last year were 2 and 5, respectively. At baseline, the proportion of men reporting unprotected anal sex in the previous year was 46% with regular partners and 24% with casual partners. At follow-up, among 283 men who had previously reported consistent condom use during anal sex at baseline, the odds of "relapse" to unsafe sex were two-fold, for both insertive and receptive anal sex with regular partners, and insertive anal sex with casual partners. These disturbing trends highlight the urgent need for targetted prevention programmes among young MSM.

With respect to HIV testing data, baseline HIV prevalence was 2% (95% CI: 1. 12.9). Based on 9 HIV seroconversions among 365 men with follow-up HIV test results, HIV incidence is estimated at 2.4% per year; however, these finding are likely to be underestimated since men who have thus far not returned for follow-up tended to be higher risk. Preliminary HIV incidence estimates are twice as high as expected, and are higher than several reports from U.S. cities. Of concern was the fact that several of the men who had seroconverted reported knowingly having had unprotected anal sex with a partner they knew at the time was HIV-positive. This suggests that serodiscordance is a reality in many relationships, and supports need to be in place for both HIV-negative and HIV-positive MSM.

Acknowledgements:

The Vanguard Project is grateful to the ongoing support of participants, the Community Advisory Board, and Sister C. For more information, visit the study Web Site at http://www.hivnet.ubc.ca/

T:PM5 Communities of Faith

Rejection and Loss and Getting On With Your Life

Presenter:
Michael Forshaw
703-1075 Comox Street, Vancouver, BC V6E 1K2
604-682-4540

ABSTRACT

Issues:

Besides the obvious medical issues of HIV/AIDS the rejections and losses from the culture can amplify and distort feelings about self-worth and personal values. And if they are not recognized and dealt with - dealt with honestly - by making an internal and external journey this will hurt the physical issues of HIV/AIDS. So, if one continues to ignore the reality of life, does not break the patterns, learn the lessons, bless the past and let go, the great relief will not be experienced - mentally, emotionally, spiritually and physically. And most important with all the new drugs available lives are being extended and as a result there is now even greater need to come to wholeness.

Description:

To deal honestly with the past. To deal with the problem of rejection and loss. Not by drowning it out in a sea of numbness. But by confronting the monsters head on. By realizing once and for all - that we are good - that shame has no place in our lives. That no one can take away how we feel about ourselves - not even HIV/AIDS.

Conclusion:

The whole process of dealing with the monsters that confront us allows us to be. To be happy, more joyous, more free. It allows us even if there are setbacks to CHOP WOOD; CARRY WATER.

Biography:

- Age 56
- on disability pension
- HIV+
- Employed by Office of Public Trustee prior to this
- Prior to that spent 4 years in Catholic Seminary
- Ordained Priest in 1987
- Pastoral Assistant and Chaplain at Vancouver Hospital
- Left Church in 1991
- No longer in Active Ministry
- Positive Diagnosis made me look at my journey.
  Hence this proposal.

T:PM5 Communities of Faith

Creating Meaning in the Midst of Sorrow

Presenter:

Yvette Perreault

ABSTRACT

Issue:

Most HIV/AIDS service providers have experienced the deaths not only of numerous clients but also of colleagues and community members. These cumulative losses mark the distinct and crushing feature of bereavement in AIDS saturated communities. The AIDS Bereavement Project of Ontario uses the expertise of 2 community-based activists to work directly with the province's AIDS agencies. Grief, traditionally viewed as a personal matter, is presented as an occupational health and safety issue for workers. Through a holistic model incorporating support, education, action and ritual, agency personnel work collaboratively to investigate and respond to individual and organizational grief.

Description:

This workshop will examine the effectiveness and impact of work done with 33 agencies and 928 individuals during the Project's first 3 years. A recent evaluation of the Project tested the hypotheses that unaddressed grieving impacts on AIDS agencies in areas related to work performance, work relations and work attitude as well as general psychosocial functioning and health of workers. The evaluation also examined the specific ways in which the Project's interventions affected individual and agency ability to cope with multiple loss.

Conclusions:

While there were significant regional differences, respondents confirmed the following reactions to cumulative grief: blurring of boundaries, overworking, poor morale, emotional outbursts, anger, helplessness, despair and isolation. However, even though the impact of multiple loss has been "negative", there were also across-the-board "positive" results. People reported an enhancement in the meaning of and appreciation for life and a positive impact on their emotional and spiritual health. It is clear that workers are highly invested in their fight against AIDS. The positive effects of multiple loss should not be ignored as these responses can form the foundation for an effective, agency-wide response to grief.

The evaluation demonstrates that the Bereavement Project has had an indisputable positive impact on AIDS Service organizations in Ontario. The Project has developed both language and tools to assist personnel to work together in conceptualizing and communicate their individual and organizational " grief responses" and to build effective "coping strategies".

Biography:

Yvette Perreault is co-creator and currently coordinator of the AIDS Bereavement Project of Ontario. Prior to that, she spent 6 years with the AIDS Committee of Toronto as Director of AIDSupport. Yvette comes with extensive experience in community organizing, having spent 10 years in the field of violence against women.

AIDS Grief: "Out of the Closet and Into the Boardrooms" — The Bereaved Caregivers

YVETTE PERREAULT, AIDS Bereavement Project of Ontario, Toronto, Ontario, Canada

As of this writing, over 7,000 Canadians have died of AIDS. Each one of these deaths represents a life that touched countless networks of family members, loved ones, neighbors, co-workers, acquaintances, and the many paid and unpaid caregivers who accompanied these individuals through their battle with AIDS. With those 7,000 deaths comes the legacy of loss — the tens of thousands of bereaved among us who grieve, actively, quietly, publicly, and privately. The impact of grief is profound and pervasive, yet most of us lack accurate information about this fundamental human condition and were not taught coping strategies to help us heal. In many circles, grief is barely discussed, particularly if the loss is due to AIDS. Mourners are left isolated, confused, and scared.

The AIDS Bereavement Project of Ontario provides community-based AIDS agencies with concrete support in the area of AIDS grief. Funded by the Ontario Ministry of Health, the project is a resource for Ontario groups wishing to look explicitly at AIDS caregiver grief. The bereavement project works with groups to design workshops, train paid and unpaid workers, and assist management in assessing and enhancing individual and agency coping strategies. Now into its second year, the two project staff have worked with 20 agencies, presented to 800 individuals, and facilitated one-day and two-day workshops for 200 frontline workers.

Time Alone Does *Not* Heal All Wounds

Tragically, many of our workplaces and professional associations do not attend thoroughly to the occupation-related grief needs of caregivers. Without knowledge and appropriate interventions, workers are left suffering enormous stress, often believing they have a "burnout problem" that they cannot personally remedy with a "stress management" program. When we as caregivers are not supported in acknowledging and working through the impact of these deaths, our ability to perform effectively in our jobs becomes diminished. It is virtually impossible to be fully present to the many HIV/AIDS-related losses faced by our clients, colleagues, and communities when their stories strike at the chords of our own undealt-with grief.

Just as AIDS has challenged us to rethink much about palliative care, so too has the disease expanded our understanding of grief, particularly as it relates to multiple and continuing losses. While there seems to be a natural constellation of responses to death, there are unique factors associated with AIDS that increase the complexity of grieving. The impact of the social isolation, stigma, disenfranchisement, lack of spiritual support, fear of contagion, multiple loss, homophobia, illness-related complications, and survivor guilt is tremendous (1,2,3,4,5). Among the manifestations of grief associated with AIDS are a greater than usual amount of rage, fear, shame and unresolved grief (3), feelings of guilt, helplessness, loss of intimacy, increased physical symptoms, self-destructive behaviors, insecurity, numbness, and pessimism (5).

In any general study of bereavement, these symptoms might signal "pathology". But this type of reaction can also be seen as a *normal* response to *catastrophic* events rather than a *maladaptive* reaction to a normal stressor (6). It is not that AIDS grief is uncomplicated, but the application of yet another medical or psychiatric label to large segments of communities struggling valiantly for acceptance and legitimacy is simply not helpful. We have found it more useful to place the lived experience of grief into a conceptual framework consistent with the activist nature of the fight against AIDS. *However complex, AIDS grief needs to be understood as normal grief in an abnormal time.*

Multiple loss is a grief whose content and course differs from grief responses subsequent to a single death. It occurs when people are experiencing bereavement overload and have no time to fully express their loss before another occurs, resulting in each grieving process compounding the one before. Issues in multiple loss include: (7,8)

Grief
- unresolved and anticipatory grief
- learning to live with death as a constant companion
- preoccupation with one's own mortality

Survivor Guilt
- "Why am I here and they're not?"
- struggle to make meaning out of what one has witnessed

Individual Burnout
- loss of normal emotional responsiveness
- numbness and isolation
- uncontrollable emotional states

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- disassociative mental states, disconnection from self and others
- pessimism and fatalism, view of the world as hostile
- insecurity and despair, loss of safety in community

Workplace Burnout

- loss of interest and involvement in work
- decrease in productivity and morale
- increase in workplace absenteeism
- difficulty in setting limits
- "callused" worker unable to connect with others
- projection: avoid hearing the horror by interrupting people or distracting them from accounts of pain

Responses Similar to Post-Traumatic Stress Disorder

- wild swings between numbing and flooding
- nightmares and flashbacks, distressing, intrusive images of death
- relentless anxiety, uncertainty over who is next
- self-neglect, self-destructive behaviors

There is an emerging body of work related to therapeutic interventions for individuals bereaved as a result of an AIDS death (see references). We actively encourage grieving individuals to seek out therapists, mental health professionals, and community supports skilled in the specificities of AIDS grief and multiple loss. At the AIDS bereavement project our primary interest is the impact of sustained losses on *communities* and *groups* of people organized to respond to AIDS. We challenge boards and executive directors to view grief not simply as a "personal problem" but rather as an "occupational hazard". We ask:

- *What are the unique manifestations of grief in your workplace?*
- *How well are you preparing your workers to live with the eventuality of overwhelming loss and constant grief?*
- *What systemic responses, policies, procedures, and concrete supports are in place to offer paid and unpaid workers timely, appropriate interventions prior to burnout and diminished effectiveness?*

We often say, *"If you're managing an AIDS agency, you're managing a grief agency."*

Caregivers in AIDS agencies differ from other social service and palliative care workers in significant ways: (9)

- AIDS caregivers usually form a counseling relationship long before the point of death, unlike palliative care workers;
- It is more likely that AIDS counselors are in the same age cohort as their clients, whereas most palliative caregivers are not, since AIDS affects a younger population than cancer;
- Gay AIDS counselors share experiences and struggles around sexual and gender identity, social marginalization, and often a seropositive status — a host of issues not likely shared between palliative caregivers and patients;
- Unlike cancer, AIDS is often seen as a deserved punishment for immoral behaviors;
- Conventional training leaves AIDS workers painfully unprepared to deal with grief saturation;
- Classic stress reduction strategies (shorter work hours, fewer clients) do not address the central condition of those who provide psychosocial care to an HIV/AIDS population, namely the multiple deaths and related processes of grief for those who have died;
- AIDS caregiver grief is usually suppressed or appears in other contexts, such as continued organizational crisis/worker dissatisfaction. It has often snowballed into grief saturation, with problematic effects on the well-being of caregivers, staff continuity, and agency health.

Just as many in the palliative care community did not actively *choose* AIDS, most community AIDS workers did not choose to become so intimate with death and dying. As one support worker expressed it during a workshop:

> My area of expertise was not hands-on care with dying people — I came with an advocacy and social change background. Now I have tons of experience in palliative care, not as a chosen profession but because it was the logical conclusion to my longstanding relationships with sick friends. I believe our support services should respond to the entire spectrum of HIV/AIDS — including helping people die. I certainly would rather be cared for by people who know me as more than a patient! Here I am in my late 30s, forced to grapple with death in the same way as my grandparents — it is out of the order of things. This should not be happening to me at this stage of my life. What people don't understand is that this is not simply a job for me. As a gay man, it is about my community life as well. Eight guys in my building are sick. I am on a care team for one of my best friends. My co-worker is HIV+. Most of my political mentors are dead. My universe is full of holes. I have no idea how to plan for tomorrow, either personally or professionally. My whole world is AIDS. Even if I decided to leave, where would I go?

All too often, caregiver grief is confused with personnel issues or organizational development matters. These workers exhibit behaviors consistent with the effects of multiple loss:

- A compassionate support worker who is usually able to leave work behind has slowly become "without boundaries". She is taking work home and developing inappropriate friendships with clients.
- An executive director who once prided himself on running a tight, efficient ship now appears short-tempered, authoritarian, and seriously lacking visionary leadership.
- A volunteer coordinator, formerly a great planner, has become frantic —there is a lot of frenetic activity in the department but no measurable accomplishments and lots of detail falling through the cracks.
- A health promotion coordinator who seems to have lost his heart for the work — he uses the same script for every speech and no longer responds with humor and flexibility. He used to joke around a lot.

Costs of Unaddressed Agency-Wide Grief

These behaviors have collective and cumulative effects on AIDS organizations beyond the damage done to individuals. These negative organizational effects include the following:

- absenteeism, illness, high job turnover
- unpredictable results on the job
- decrease in productivity
- brittle, fragile, angry workers, emotional outbursts
- inability to set limits and say no, not using lieu days or taking vacations
- poor morale, flatness, lack of creativity
- employer costs: higher benefit premiums, costs of relief staff, costs of hiring and training
- disruption to clients and communities

While there are good reasons for AIDS caregivers to look at grief from an organizational perspective, we continue to encounter significant obstacles. We enumerate them below.

Grief Myths

- Grief not understood: "Isn't grief when you're crying over someone?"
- Impact minimized: "I hardly knew those clients — we weren't really intimate." "I'm sure my irritability has nothing to do with grief."

Grief in the Workplace Myths

- Not seen as relevant: no orientation to grief as part of training about HIV/AIDS. Seen only as an issue for support services.
- Will deal with grief once a critical number of deaths have made the impact noticeable — but no integrated response.
- Seen as a personal issue: "Professional objectivity and distance should keep workers from attaching. If they're having a reaction, it is an outside issue."
- "It's too big — a messy Pandora's box of emotions which doesn't belong in the workplace. If we open this up, it will take an unrealistic amount of time and money."
- "The current crisis within the agency has nothing to do with multiple losses nor with the recent death of our board chair —it is a side issue."

Specific to AIDS

- Many workers are also HIV+, making it difficult for people to rely heavily on colleagues to counteract stress.
- There is a concentration of losses in communities where people normally go for respite and replenishment.

We may summarize this section by repeating, *Short-term solutions are ineffective when working long-term with HIV.*

BUILDING A STRATEGIC RESPONSE TO AIDS GRIEF (10)

> We do not expect management to place workers in situations where they will be handling dangerous materials without proper training, equipment, and supervision. Should a worker hurt herself/himself on the job, agencies recognize their responsibility to support and accommodate that employee. Why is grief so different? Our sorrow and turmoil are directly related to stressors/losses experienced on the job. Surely workers could be better equipped and supported to respond to this element of risk and danger inherent in AIDS.
>
> — board member of an AIDS service organization

In the second section of this paper we consider how AIDS agencies may use prophylaxis and treatment at the organizational level when threatened with the risks of chronic and elevated grief as described above. Based on our experience with the AIDS Bereavement Project, we offer a series of recommendations divided among the following headings: planning process, assessment, acknowledgement of loss, training and skill building, support, structural and systemic changes, mechanisms of appreciation, and ongoing process.

Planning Process

- Include all staff and key volunteers. This counteracts the feelings of helplessness common to loss saturation.
- Set up a diverse team to canvass the agency about their bereavement needs.
- Leadership involvement is critical, as future organizational strategies may include revision of policies and benefits and other workplace changes.
- Every group has its organizational culture which must be acknowledged and respected.

Assessment

- What problems require solutions? Be realistic about the situation but also dare to dream. One of the most significant, albeit unexpected, outcomes of our work is the reported sense of team unity and mutual support which arises from the experience of looking at grief together.
- Identify confounding organizational issues to be dealt with separately. Workers may be reacting to downsizing and financial constraints. While the emotional impact of this can be dealt with in a session on grief and loss, the structural aspects are best kept for another forum.
- Clarify staff expectations of the organization; providing bereavement support is not intended to turn the agency into a therapy group for staff.

Acknowledgement of Loss

- Look at loss through the experience of people at all levels of the organization. What is the grief of the administrator? Of the receptionist? Of the volunteers? Note that loss is not only about death but relates to other transitions: staff turnover, program cutbacks, changing offices, expansion.
- Rituals are vital: notices, memorials, quilts, candle lighting. Create "shortforms" for discussing complex, painful issues in a way that allows workers to express themselves and yet continue with their work.

- Examine structures which impede the necessary flow of information for the acknowledgement of loss on an agency level, e.g. rigid confidentiality policies.

Training and Skill Building

- It is necessary to orient all workers to grief at some level, including the board.
- Recognize and appreciate a wide range of normal responses to loss: our responses are unique and culturally determined.
- Train workers to identify their individual patterns of grief. Do they know when they are grieving? How do they communicate that to others?
- Supervisors have a central role in creating a supportive environment.
- Training serves as a collective acknowledgement that grief is not a personal weakness. It also serves as a common framework for discussion and strategy development.
- Train on a holistic level. Include a broad range experiences such as working with emotions, with the body (massage), and with the spiritual aspects of grief and healing (visualization and hope systems).
- Present information on aspects of hardy personalities — those who successfully adjust to stress through "control, commitment, challenge, and connectedness" (11).
- Make grief and loss a part of the everyday discourse among caregivers.

Support

- Develop a range of supportive interventions: individual debriefings after a death, quality supervision, formal bereavement groups, team retreats, etc.
- Offer programs internally and on work time.
- Provide external support: employee assistance programs. Dealing with current losses can resurrect old losses.
- Encourage contained opportunities for emotional expression, including anger.
- Reconnect people to life-enhancing elements: joy, humor, celebrations.
- Attend to closures in a continual way. We tend to minimize the lesser losses and transitions and focus only on significant losses, but through attention to the smaller goodbyes we prepare for the greater ones.

Structural and Systemic Changes

- Requires commitment of the employer to accommodate acute and chronic stress of grief. Someone needs to champion this cause and keep grief on the agency's agenda.
- Redefine and review bereavement leave, mental health days, dependent-care leave policies.
- Evaluate benefits and internal support systems. Is supervision adequate?
- Look at stress-relieving practices: job variation, flex time, unpaid leave.
- Integrate grief awareness into the philosophy and core values of the agency: grief work is part of a holistic health strategy and promotes healthy workers and a healthy agency.

Mechanisms of Appreciation

- Death can too often feel like a failure. Balance the strain of loss by deliberately creating opportunities for positive interactions with workers.
- Set aside regular times to talk about accomplishments and goals.

Ongoing Process

- Develop a system for integrating grief awareness into the orientation process of all workers.
- Information to be distributed regularly and programs offered routinely to staff, volunteers, and board: do not wait for the crises.
- Provide for a regular review of bereavement strategies: What else do we need?

Ultimately, the goal of developing an agency response to multiple loss is the creation of healthy agencies and the creation of healthy, resilient, creative workers. Just as communities have mobilized to understand and respond to HIV/AIDS, we believe that communities can organize successfully to meet the emerging challenge of grief. But first "grief" has to come out of the closet as an identifiable individual reality, as an agency problem, and as a community norm.

The legacy of loss is both individual and communal. Grief work is bearing witness to our personal and collective stories. Grief work is "re-membering" together and building a connection with our sorrow and hope to sustain community vitality.

> *Heal the community by healing the individuals and in this way, resurrect the sense of community fundamental to the mental health of the individual.*
> — Herman Kaal (12)

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T:PM5 Communities of Faith

Religious Issues and Community Organizing

Presenters:
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Paul Couillard
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ABSTRACT

"Faith Communities and the Changing Face of HIV/AIDS."

New therapies and hopeful prognoses for people living with HIV/AIDS pose interesting and important issues regarding the relationship between HIV/AIDS communities and those of religion and faith.

The magnitude of the AIDS epidemic and the critical life-and-death issues attending it have created an environment where some underlying concerns of each of these communities have been subsumed by the pressing issues of assisting those living and dying with HIV/AIDS. People with AIDS – many who regard traditional religion with suspicion – have accepted the help of faith communities, particularly conservative ones, unresolved issues of morality, dialogue, and participation of people with HIV/AIDS within faith communities have taken a back seat to the basic needs of providing comfort and support.

With effective new drug therapies, increased lifespan for those who are HIV-positive and increasingly diverse populations who are HIV-infected, what needs are there for new AIDS education within faith communities? What kinds of ministry and programs will be needed to respond to the changing face of HIV/AIDS in North America and abroad? Will the perceived abatement of the threat of AIDS alter the response of faith communities to HIV/AIDS?

T:PM5 Communities of Faith

Religious Issues and Community Organizing

Presenter:
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ABSTRACT

Challenges of Doing HIV/AIDS Work in the Bible Belt

Despite efforts to be inclusive, particularly in the initial phase of forming the network, parts of the community frequently perceive the Valley AIDS Network to be a religious organization. At times our response to that perception has taken much of the group's energy. Splitting of the original Abbotsford HIV/AIDS group, and its reforming, diverted, for a time, the group from its original purpose of providing education and support for people infected and affected by HIV/AIDS in the Abbotsford area. Other issues faced include the difficulties of finding the HIV infected and affected in the community; funding; networking with Vancouver and other agencies; attempting/ wanting to stay out of politics of AIDS but still benefiting from what the other groups have to offer; determining the needs of PLHA and deciding what we as a group can provide; and the challenges of being a volunteer and attempting to keep in touch with other agencies and volunteers.

To foster informal networking among workshop participants and presenters, we will have introductions of all present. The formal presentation will begin with a historical background to the Valley AIDS Network, outlining how the issues named above have affected who we have become. Participants are asked to note which issues resonate with them, for small group discussion.

Biography:

H. Ruth Thiessen, a founder member of the Valley AIDS Network Society in Abbotsford, has worked as HIV/AIDS coordinator for Mennonite Central Committee BC for the past seven years. She works primarily in support services and education.

T:PM6 Environments of Care

The AIDS Ward Experience at St. Paul's Hospital

Presenters:
Bonnie Gabel
Pamela Miller
Peter Phillips
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ABSTRACT

Issues/Description:

In February 1997, St. Paul's Hospital, Vancouver, B.C. changed it's model of care for patients with HIV/AIDS with a move from a decentralized structure to a centralized AIDS ward. The previous model involved care and treatment for patients who were placed throughout the hospital. The new ward offers dedicated staff in a close team environment which focuses on specialized care for patients with AIDS.

Conclusion:

This presentation will discuss the organizational structure, client responses and the results of the program evaluation.

Biographies:

Bonnie Gabel has a background in health services planning, administration and social work. She is currently administrative coordinator, AIDS Program, St. Paul's Hospital.

Pamela Miller is currently the Patient Care Manager for the AIDS ward as well as geriatrics and palliative care. Pamela has a background in community and hospital nursing, administration and teaching.

T:PM6 Environments of Care

Dr. Peter Centre: A Day Program for HIV+ Persons

Presenter:

Maxine Davis

• Notes •

T:PM6 Environments of Care

First Nation's Perspective on HIV/AIDS and Their Explanatory Model

Presenters:
Ross Albert, Kathy Churchill
Joanne Oppenheim and Malcolm Swan
St. Paul's Hospital/Vancouver Native Health Society
1081 Burrard Street, Vancouver, BC V6Z 1Y6
Phone 631-5234

ABSTRACT

Issue:
Discussion on Kleinman's Explanatory Model as a way of looking at illness and treatment that are used by practitioners and patients.

We will discuss Kleinman's Explanatory Model as a useful way in looking at illness and treatment, this model suggests that there are five aspects of illness. We propose to discuss these aspects and show how they may or may not relate to First Nation's people living with HIV/AIDS.

We propose to explore First Nation's people living with HIV/AIDS and their Explanatory Model through personal experience, qualitative research findings, work, and statistics kept at St. Paul's Hospital and Vancouver Native Health Society in this particular area.

The goals are to stimulate discussion in this area, to educate professionals and persons concerned and to consider incorporating Explanatory Model techniques. Their repertoire of skills in intervention strategies within the current medical, social system structure may be enhanced.

We will target the general population for this session.

Biographies:

Ross Albert and Joanne Mussell Oppenheim are MSW Candidates that have worked in the capacity of HIV/AIDS social workers at St. Paul's Hospital and Vancouver Native Health since May 1995.

Kathy Churchill RPN has worked for Vancouver Native Health Society as HIV/AIDS Home Health Care Coordinators since May 1, 1995

Malcolm Robert Swan is a 37 year old First Nation's male that is HIV positive since August 1994 from Grand Prairie, Alberta.

T:PM7 Empowerment and Enablement:
Alternative Roads, Complementary Paths

Vipassana (Insight) Meditation and Its Role in HIV Care

Presenter:
Gordon Waselnuk
Treatment Information Project, c/o Pacific AIDS Resources Centre
1107 Seymour St., Vancouver, B.C. V6B 5S8
Office: 681-2122 Ext. 239; Home: 873-4953; Fax: 893-2251

ABSTRACT

Introduction:

The themes under my proposal are treatment (psychoneuroimmunology) community based response and research (references). The most suitable would possibly be a Round Table Session with presenters discussing various stress reduction methods or alternative and complimentary therapies

Issue:

Meditation as a viable and practical tool in HIV/AIDS care and maintenance.

Description:

I have been studying and practicing Vipassana (insight) meditation since 1993. I have participated in three intense ten-day retreats in Thailand. I have followed it up with a daily practice and investigation. I have found this practice very beneficial to me, as a person living with HIV. I have investigated various research studies in regards to meditation and its long term benefits on the psychological and physiological aspects of a person. Certain Buddhist philosophies such as impermanence in life, reflections on death, and laws of nature have helped myself and others cope with life threatening illnesses.

Conclusion:

Meditation is a valuable tool and its benefits are far reaching. This is a relatively new field of study and is of growing interest to health practitioners. I would like to share my personal experiences as a person who is living with HIV since 1989 and how Vipassana (insight) has benefited my life. The audience that this presentation is targeted would ideally consist of a blend of medical practitioners, persons living with HIV/AIDS, and any other interested lay people.

Biography:

Artist and AIDS Activist
Volunteer Treatment Information Officer 1991-
Therapeutic Guidelines Committee at B.C. Centre for Excellence
Official Languages Committee at Canadian AIDS Society - Ottawa, Ont.
Contributions to "Positive Living Manual" (BCPWA Society)
Contributions to "Managing Your Health" (CATIE)

T:PM7 Empowerment and Enablement: Alternative Roads, Complementary Paths

Complementary/Alternative Therapies - The Role of Community

Presenter:
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ABSTRACT

Issues:

Although there have been tremendous advances in western conventional medicine, the integration of alternative/complementary therapies with allopathic medicine is increasing. This is happening despite a lack of reliable research and clinical outcome studies. In addition to very little information, there is also a lack of accountability on the part of product manufacturers and therapists resulting in no guaranteed quality control and often fraudulent claims. PWA's look ahead to the possibility of continuing multiple-drug therapy for many years. It is crucial that studies be initiated to ensure quality of life for those involved and to minimize the physiological damage resulting from long-term drug therapy. The benefits, risks and possible interactions of alternative/complementary therapies when used in conjunction with conventional medicine need to be clearly demonstrated.

Challenges:

In order for research in these areas to occur, the motivating factors for such investigations must be based upon long-term cost-saving benefits and patient well-being rather than short-term profits. Botanical and other supplement information is confusing, sometimes conflicting and rarely gives adequate instruction regarding dosing requirements. Many PWA's do not have the financial resources to access a professional for advice in these areas and proceed haphazardly.

Conclusion:

As the desire by the patient population to play an active role in their health care increases, so will their needs for information about and access to their choices. Consumer-based community organizations have the ability to provide unbiased responses to these needs by providing an information exchange, referrals to accredited products and/or therapist and in the development of community research initiatives in areas not being investigated by the scientific community.

Biography:

Tom Mountford is currently project head of the BCPWA Treatment Information Program, an Information Officer and newsletter editor with the program as well as an editor of the BCPWA News for the last five years. He is a past board member of the BCPWA Society, the British Columbia Coalition of People with Disabilities and the Wings Housing Society. He is both a consumer of and an educator in the area of alternative/complementary therapies.

T:PM7 Empowerment and Enablement: Alternative Roads, Complementary Paths

Balancing Scientific and Policital Perspective in Complementary Research

Presenter:

Allan Best

• Notes •

The Lived Experience

Presenter:

Francisco Ibañez-Carrasco

• Notes •