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Consultation Results

"Priorities for Action In Managing the Epidemics"

Prepared by: ANKORS Staff, volunteers and consumers
And ASK, OAAS, ARC and the Boys and Girls Club of Williams Lake

Executive Summary

In all we think that this document is a good beginning for discussion. We hope that there will be a final document that will set key strategies to address the multiple issues of HIV and AIDS. We are however, extremely dismayed and concerned several issues.

We strongly recommend that this approach be defined within a broad harm reduction lens. The work being done to reduce infection, increase health for those living with HIV and AIDS and the support, outreach and education with individuals who are most at risk is all based on reducing harm. The broad tenants of harm reduction must guide this work and be the cornerstone of this work – locally, regionally and provincially.

Issues:

- Much of the background of this proposal is centered on the visible and easy to document issues faced in the urban, lower mainland settings.

  While we all appreciate the specialties and multiple contributions of St. Paul's and the Centre for Excellence and we acknowledge the special issues faced in the downtown eastside and the number of epidemics faced in Vancouver - *it must be acknowledged that individuals who move to Vancouver from rural British Columbia feed these epidemics.*

  There are many complicated social, economic and health reasons that drive people to the more urban communities. The lack of options available for young gay men, individuals living with HIV and AIDS, for people who use injection drugs and for the aboriginal communities has created a culture of migration for safety, services and community. Life in rural BC is complicated by a lack of confidentiality, of service availability, specialists, shame, poverty and limited supportive community. Moving can, for some, be the only viable option.

- There is a lack of community input, expertise and voice in this document or in the plans to address HIV, AIDS and Hepatitis C in British Columbia.

  While there is some mention of the "community" there is no apparent role or value given to the depth and breadth of experience and talent in the AIDS community.

  There is no method to hear, consult or understand what is happening on the ground, in the community of those at risk and those living with HIV, AIDS and Hep C.

- There is a lack of strategies for action or any implementation plans. There is little or no mention of accountability, no measurements tools outside of epidemiological information and no communication plan.

  There is general discussion about the need for action and work in prevention however, there are no key strategies for women; for gay youth; for gay men; for aboriginal men and women; for individuals who use injection drugs.

- There is no acknowledgement of *rural British Columbia.* There are immense challenges for those who live in and for those who provide service for individuals

and communities in rural BC. The lack of specialist service availability - lack of testing, support and counseling services, the lack of needle exchange, methadone providers, health care providers, etc. impacts people's lives on a daily basis.

Rural communities have the same issues, needs and concerns faced in larger urban centers however these look very different, require a specialized and flexible approach and often involve extensive travel, community partnership and specialized service delivery models.

- Reliance on epidemiological information to define the work done. Epidemiological information can tell where the virus was, where the infections occurred however community outreach, prevention, harm reduction and support services often can tell where the virus is. Rather than wait for the virus to tell us where it was, we must structure our response to address where it is.

- *Page 2, Section 1.1, paragraph 3*
  "This document primarily examines functions that fall within the domain of the province's health sector. It does not address the broader range of action that would enable the Province of British Columbian to address the root causes of HIV vulnerability and infections, such as efforts to prevent discrimination, to protect children from sexual and emotional abuse and to alleviate family poverty. These more comprehensive efforts are long-term in nature and require the involvement of many different sectors."

  HIV is directly transmitted as a result of poverty, living at risk, discrimination, addictions, being sexual without power, discrimination and the impacts it has on individuals – the social determinants of health.

  Any action for managing the epidemic must take into account and address these many infection factors.

  "On the surface, HIV may look like a health issue. Thus, you might conclude that the solutions to this epidemic lie within the health sphere. We have learned that nothing could be further from the truth. HIV is a socio-economic issue, a human rights issue, a social justice issue, a gender bias issue, and a racial and religious issue. It is influenced by the determinants of health, including poverty, homelessness, education, employment and race. Unless the decision makers in these areas are engaged, we will never solve the root causes that allow the spread of this disease. In Canada, we have recognized this but have done very little to address it."
  Louise Binder, Chair of the Canadian Treatment Action Council, Co-Chair of the Ministerial Council on HIV/AIDS, chair of Voices for Positive Women at the International Gender Institute meeting in Halifax, January 2003.

This is what drives the epidemic.

Executive Summary
Responding to HIV/AIDS in BC

There are issues throughout this document where the %, the language and the populaqtions who are vulnerable are not consistent – there will need to be an editing to ensure that the language is non-judgemental or blaming, where the vulnerable populations are identified the same throughout the document and to present the percentages of change, reduction, infected, etc. are the same.

Prevention:

- language is blaming and judgemental when defining those who "put themselves at risk".
- How will you measure the reductions in HIV positive transmission? What will be the baseline?

Care, Treatment and Support:

- Linking individuals to appropriate services will be contingent on whether there are services to link them too. There are fewer services, they are harder to access and limited to the number of positive individuals they can/will provide services too.

  There are no addiction treatment services in the whole of East, West Kootenay and Boundary, in Williams Lake, 100 Mile House. Access to detox, treatment and aftercare support services will usually involve travel and transportation. There are no city to city bus lines, most individuals will rely on hitch-hiking or greyhound.

  Physicians who are educated on HIV/AIDS are few and those who are treating positive individuals, are often reluctant to become the local "HIV" expert as this may impact the rest of their general practice.

- Transportation is always an issue. If people cannot reach the services then the services must reach them.

  Individual's specialists are often in Vancouver or in Calgary. Travel is complicated by weather, lack of public transportation, social service travel allocation, poverty and illness.

- Tailoring services to populations being served is a solid strategy. Services must be relevant and culturally appropriate.
- What is an 'appropriate' service? Who is going to define it? How and when will consumers identify their needs and wants?

Capacity:

- To strengthen the capacity of this strategy there will need to be additional funding, supportive work negotiated and backed with policy development, within the mandates and mission of government Ministries.
- The Intergovernmental Committee on HIV/AIDS needs to be visible, vital and effective. Partnership and collaboration on the ground must be matched by action at the bureaucratic level.

- Communication from all levels must be shared on a more frequent and inclusive manner. If the IGC does not know what the needs are – and who has been asked – then how can they address or respond to emerging issues?
- Increasing and improving capacity on multiple levels will enhance the whole of the province to respond to a multitude of issues, including the reduction of HIV transmission.
- Ensure that there is a method to "scan the environment" to adjust planning, programs and strategies that may not be planned for.
- Building capacity should be included within the rest of this document. Implemented within each of the goals, objectives and key strategies.
- Will this also address the need for groups and organizations to deal with their equipment issues?
- Concerns that this may only be used as a downloading of responsibilities in this strategy.

Cooperation and Coordination:

- Again, this must be visible in the provinces commitment to social health. For example:
  - It is proven that those children who are taught about sexual health, how to make choices, have strong self-esteems become sexual later in their adolescence. Implementation of sexual health education, discrimination, anti-bullying programs will impact youth who may be most at risk as they develop into adolescents and young adults.
- Individuals may present with complex mental health issues involving drugs, street involvement, homelessness and are living with HIV/HCV.
- How do agencies, ministries plan strategies to address these complex lives?
- How does an AIDS serving organization negotiate case management?
- How does an individual access advocacy?
- How does an organization with no outreach strategies or funding engage with those that do?

1. Introduction

Pg. 1

- Must take into consideration the number of individuals who move to the coast when they test positive. This is true for men who have sex with men and for people who use injection drugs.
  The reasons for this are multi-fold: there are few tailored medical services for pws's; anonymity and confidentiality cannot be assured in small communities whereas they can more so in larger communities; social stigma and community ostracization can force an individual to move elsewhere to find support and community.
- Many individuals test in larger centers. There are few testing sites in our region, none anonymous.
- People with HIV are as mobile as the virus. There are few ways to track individuals who leave urban or rural communities outside of HAART and not all of those living with HIV/AIDS have reached the treatment stage while some have never considered this as an option for an array of reasons.

1.1 Purpose and Organization

- *Page 2, Section 1.1, paragraph 3*

"This document primarily examines functions that fall within the domain of the province's health sector. It does not address the broader range of action that would enable the Province of British Columbian to address the root causes of HIV vulnerability and infections, such as efforts to prevent discrimination, to protect children from sexual and emotional abuse and to alleviate family poverty. These more comprehensive efforts are long-term in nature and require the involvement of many different sectors."

HIV is directly transmitted as a result of poverty, living at risk, discrimination, addictions, being sexual without power, discrimination and the impacts it has on individuals – the social determinants of health.

Any action for managing the epidemic must take into account and address these many infection factors.

"On the surface, HIV may look like a health issue. Thus, you might conclude that the solutions to this epidemic lie within the health sphere. We have learned that nothing could be further from the truth. HIV is a socio-economic issue, a human rights issue, a social justice issue, a gender bias issue, and a racial and religious issue. It is influenced by the determinants of health, including poverty, homelessness, education, employment and race. Unless the decision makers in these areas are engaged, we will never solve the root causes that allow the spread of this disease. In Canada, we have recognized this but have done very little to address it."
Louise Binder, Chair of the Canadian Treatment Action Council, Co-Chair of the Ministerial Council on HIV/AIDS, chair of Voices for Positive Women at the International Gender Institute meeting in Halifax, January 2003.

This is what drives the epidemic.

1.2 Document at a Glance

Prevention:

- There should be identified key strategies for all populations – women, aboriginal communities (on and off reserve), people who use injection drugs, gay youth, gay men, men who have sex with men and rural BC.
- The lack or reduced service availability for hidden populations (gay men, gay youth, people who inject drugs in particular) makes rural work challenging and innovative. The good work that is done in our communities could work well in urban communities with some 'urbanizing'. Ensuring that there are ways to share programs, staff and local strategies will increase everyone's toolbox.
- Increase the existence of rural needle exchange and methadone programs. There is no funding to provide mobile or fixed needle exchange programs in the East Kootenay's as well as the south Okanogan.

  Options for additional needle exchange sites:
  - All health units could be distributing needles and providing disposal for injection drug users.
  - Hospital emergency rooms could be providing needle exchange services

With either of these options there would be an expectation of extensive training for staff with respect to addictions, marginalization, harm reduction and prevention goals. There are issues throughout the province and our region that people who use injection drugs presently face when trying to access needles from health units, pharmacies and other non-needle exchange sites.

As there is some resistance with physicians as well as a lack of trained and available doctors – use of street nursing is paramount for rural work. Attach an outreach position to rural ASO's – nurses could accompany mobile needle exchange, provide opportunities for consumers to test for HIV, HCV, etc., have regular vein, health checks, receive vaccination, etc.

- Low threshold (safe consumption sites) may not be effective or responsive in rural BC. There is a possibility that public health offices could be useful for safe consumption sites. This acknowledges the need to educate and mandate harm reduction, non-judgmental service provision by front line staff, nurses, management, etc.

Care, Treatment and Support:

- There should be identified key strategies for all populations – women, aboriginal communities (on and off reserve), people who use injection drugs, gay youth, gay men, men who have sex with men and rural BC.
- Transportation issues must be a consideration in the ensuring that care effectively attracts and retains…………
  In rural communities consumers and staff must travel to access and provide services in home communities.
- Lack of access to care, treatment and support ghettoizes those living in rural BC. How will the services be spread out in a respectful, anonymous way or how do we assure that individuals can access care in the urban areas?
- There are issues around trained, accessible, available and committed service providers.
- Lack of addiction services in the East, West Kootenay and Boundary impacts the "whole" families recovery and ongoing sobriety. Few if any options for aftercare or for supported recovery.
- Lack of methadone providers. No methadone clinic in the WK, one in Cranbrook. Options: nursing support on an outreach basis for those on methadone. Caribou Health ran a successful pilot project that provided support, outreach and services to several communities in the North (now part is in the Interior Health region).
- Issues for physicians being known as the HIV doctor in small communities.
- Issues for those in recovery and having to go to the lower mainland. Many who have left the downtown Eastside cannot go back to Vancouver for treatment, as their recovery is so fragile.

Capacity:

- Objective 1: concerns that this may mean mandatory testing for vulnerable populations.
- Objective 2: what is the working definition for cbo's?
- There should be identified key strategies for all populations – women, aboriginal communities (on and off reserve), people who use injection drugs, gay youth, gay men, men who have sex with men and rural BC.
- Key Strategy 1 – acknowledge the rural regions of BC. Ensure that there is research dedicated within the rural communities.

- Would be interesting to track how many individuals leave their home communities to access treatment in urban centers. How long do they stay? When do they return home?
- Anecdotal evidence shows individuals leaving rural communities for testing (anonymous), care (Vancouver, Kelowna, Calgary), drug treatment (Kamloops, Kelowna, lower mainland)
- These strategies seem to move beyond the paper prepared on testing by Dr. Perry Kendall.
- What is a sentinel system?
- How will names be recorded?
- Is there any plans to do a mapping system with names of partners who are identified?
- What are the guidelines and boundaries that will be put into place to protect confidentiality and individuals who access services?
- Again editing issues – language around anonymous partner/follow up with partners of newly diagnosed individuals.

Coordination and Cooperation:
- There should be identified key strategies for all populations – women, aboriginal communities (on and off reserve), people who use injection drugs, gay youth, gay men, men who have sex with men and rural BC.
- Ensure that we share our models here at home as well as internationally.
- There is good work going on in rural and urban BC – necessity is the mother of invention.
- Who are the stakeholders?
- PAN – RRAN should be key players here as well as any connection between the health authorities, physicians, nurses, etc.
- Define surveillance.
- Hep C keeps coming in and dropping away. The document must either drop it or include it throughout.

2. Business Case for Action

Paragraph 3 & 4
- Speaks to huge gaps in prevention programming, addictions, supportive treatment, etc.
- Social determinants of health – people who are hungry are not going to worry about risk/harm reduction.
- Individuals who are using direct observed therapies are very being very successful in managing their treatment protocol – expanding this will be expensive but may assist the reduction in health issues, transmission and illness.

Pg. 8
Paragraph 3 & 4
This entire document should be developed on the principals of population health and be reflective of how the social determinants of health impact people's lives.

Please note the statement on page 28 – the last paragraph reads – " Coordinated efforts across government departments to address the public health determinants that contribute to HIV vulnerability are essential to a strategic and effective response to HIV/AIDS throughout the province.

- Increase the support to those who are on HAART – difficult regime to follow especially for the most marginalized.
  Better support and living conditions prior to HAART will also reduce the needs and costs.
- Lack of access to specialist's care and support outside the lower mainland complicates and impacts individual's long-term health.
- Increase access to non-traditional health care providers and methods of improving health have a direct impact and correlation on the ongoing health of persons living with HIV/AIDS.
  For example: vitamins, stress/anxiety/depression/exercise/massage/naturopathy etc.
- Ensure that there are palliative care beds available throughout the whole of BC. Many individuals come to their home communities to die.

3. The HIV/AIDS Epidemic in British Columbia

Paragraph 1

- "Engaging in unprotected sex" - remember to acknowledge the lack of power that women often have around condom use and choice of sexual activity.

Pg. 10

<u>Bullet 1</u>

- Note new Prince George stats. Decline of HIV transmission in the injection drug using population is only in the lower mainland.

3.2 Living with HIV/AIDS

- "...primarily because these individuals died of causes not attributable..."
  How/What do they attribute these deaths too?

Pg. 11

Paragraph 2

- Individuals often test outside of their rural communities for confidentiality, anonymity and in particular when they feel they may be positive.

Paragraph 3

- Most hospitals do not have palliative care wards. Most deaths are supported in hospitals or at home with hospice and partner/family support. Individuals in rural communities should have the option of dying at home or in the hospital. Note: Kamloops Palliative Care Program.

<u>3.3 Gender</u>

Graph 2

- 270% increase – WOW
  Is there a correlation here with the men who have sex with men stats? If the gay men numbers were factored out, is there a direct correlation with those who are having sex with men and living as heterosexuals?
- Another spot that needs to address the issues of power and choice.

<u>General Comment</u> – there is no mention of transgendered individuals in this document at all – the HIV positive statistics for m/to/f individuals are very high. Several years ago almost 100% of the individuals who identified in the lower mainland were positive.

This statistic should be brought out – it is probably hidden in injection drug use or sexual transmission – is it recorded as men who have sex with men or heterosexual transmission?

- *Gender and gender dysphoria has a huge impact on HIV vulnerability.*

"These risk factors include............engaging in the sex trade"

- There has been no study done (that we could find) that factored out injection drug use and sex trade risk. There are several sex work activists who argue that sex work is not as high a risk as we are being led to believe. We are not talking about those who are engaged in the sex trade on the street particularly, the number of those men and women who work on the street is much lower than those who work from homes, in businesses and other venues. The majority of these women/men are scrupulous about using protection.
- I wonder if there were a study done if the risk factors have more to do with the marginalization and accompanying risks (abusive boyfriends, partners who use drugs, rape, etc.) than the trade of sex for money. Money does not transmit HIV.
- If sex workers do contract HIV from sex work (tricks) is it listed as heterosexual contact or sex work?
- If it is homosexual sex work is it listed as homosexual contact or sex work?
- Review of how these statistics are kept may prevent the epidemiologists from re-marginalizing sex workers and their work.

3.4 Age

Paragraph 2

- Changing definition of vulnerable population again.
- Older individuals 40 – 49 What are the factors – aboriginal, women, injection drug users, gay men, people in general?

3.5 Risk Factors

- These numbers do not include men who have sex with men.
- Power in relationship
- Graphs do not reflect the information in the bullets.
- 25% other/unknown – this is a huge number, ¼ of the total. Why is this number so large? Does it correlate to the increase in anonymous testing?

Page 14

Paragraph 2

- Tease out the stats that reflect gay men from men who have sex with men

Paragraph 3

- In the mid 80's prevention and education was moved out into the general population. The degaying of HIV began then.

Page 15

Paragraph 1

- Reduction in HIV+ test results may be true in the lower mainland, not recently in Prince George.

Paragraph 2

- This section is speaking about young gay men, it should be clearer.

Page 16

- Will this strategy/priorities be used to direct the priorities for the Aboriginal Plans? Will it impact the owrkplans within health authorities?

Page 17
Last paragraph

- Why is this even mentioned in this document? Remove it.

4. Managing the Epidemics

4.1 **Building on our Strengths:**

Paragraph 2

- Needle Exchange numbers are low. ANKORS provides fixed and mobile services to over 13 communities in the West Kootenay and Boundary area alone. We are a regional ASO – each community should be counted as it stands.
- There is no needle exchange programming within the East Kootenay or the South Okanogan regions outside of public health.
  While this may work for some individuals, most of those who do not access mandated services, whose lives are disorganized and in flux cannot access public health between the hours of 8:30 to 4:30. There are many issues with public health. These offices are often located in other buildings with other tenants – Williams Lake, Kimberley public health are located in/near courthouses and police. The other issues that must be addressed are: mandates, atmosphere, staff training, judgmental attitudes, expectations from consumers and those who provide the services.
  As well, there are the issues of lack of transportation to and from the public health office, WCB rules, education for front line staff on harm reduction and injection drug use, etc.
  Combining fixed and mobile needle exchange that engages in relationship, provides education and support is absolutely necessary to increase the self-care and reduce risk for those in the injection drug community. By having flexible hours, combining fixed and mobile needle exchange, engaging in relationship and developing trust the health and social impacts within this population is dramatic.

Page 19
Paragraph 4

- Expand research dollars and expertise into rural BC. The whole of the interior does not have a university, which makes it difficult to access the federal research dollars.

Paragraph 6 & 7

- This is really the first mention (other than paragraph 2 above) of community based AIDS service organizations and persons living with HIV/AIDS organizations. Whatever the role is to be, this whole section needs to be expanded and the work being done must be given more detail, acknowledgement and value.
- Information on the Inter-ministerial structure and their work needs to be communicated within the community and to the other stakeholders in the province – addictions, mental health, health care providers, etc.

'attract and retain consumers" This will be dependant on a number of things – health care support, housing, treatment, travel support, confidentiality, anonymity, etc.
What does attract and retain mean? How will this be measured?

- Bullet 2
  Many of the strategies must be structured for urban needs and for rural needs. Alternatives that work for rural BC must be identified and used.
  Must be concurrent with retaining physicians as well as providing training for their education around harm reduction and treatment for those who are addicted.
  How can we ensure that rural physicians are willing to provide these services? There must be some brainstorming around confidentiality for consumers who use these services.
- Bullet 3
  Expand, increase and provide non-traditional testing opportunities in rural BC.
- Bullet 4
  Support, testing, education must be available in sub-stations – lock-up – and transfer stations in rural communities. Issues at times re: medications.
  Additional training for city and RCM police on HIV, harm reduction and addictions.
- Bullet 5
  Roundtable – Give them real jobs to do and the power to do them. Must have actual planning and implementation abilities. Must have consumer representation and voice, community representation and community agency.

<u>Care, Treatment and Support:</u>

Objective 2 – again a change in the defining of vulnerable populations
Objective 3 – HIV+ women all access treatment at a lower rate than men. Increasing aboriginal women's access to this level is not a great goal. Broaden it to increase for all women and the more vulnerable groups.

Key Strategy:

- Bullet 1
  Creating services that are safe re: confidentiality and anonymity
  It will look significantly different than services in larger, urban centers.
  Must deal with, acknowledge and address the reality of the lack of supportive services in rural, isolated communities.
  ANKORS continues to provide education, support and outreach services through telephone contact only, through a friend of a friend, etc. While these individuals have complicated lives and needs their privacy and confidentially within their home communities remains a larger concern than their health.
- Bullet 2
  ...ensure that care, treatment and support are readily available....
  Contingent upon creating a means of accessing these services
- Bullet 3
  Voluntary partner notification?
- Bullet 5
  No services at this point in provincial prisions, must be initiated and then continued.

<u>Capacity:</u>

- Strategy 1

Ensure that rural research is funded and supported.

Page 24

- Bullet 3
  There are issues with respect to safety. Is there a plan to discuss or provide information on how public health will be dealing with safety in relationship and safety in the community issues?

Coordination and Cooperation:

- Strategy 3
  Share the information within the province. Develop a communication, skills and methodology sharing process. Develop a provincial clearing house and ensure there is funding to create pamphlets, videos, etc that can be distributed throughout the province.
- Strategy 4
  Best practices: Ensure that you have consumer and aso representation at these tables. Those who receive and provide have clear ideas of what best practice is and have been trying to develop these for years.

Resource Implications:

Paragraph 2

- Will the money that is anticipated in being saved be made available to increase the programming, staffing and outreach for prevention, support and education?
- I have great concern about the earlier statement that money may need to be moved from other programs into prevention. While this is a nice idea, most ASO's operate on very tight budgets. The funding for HIV/AIDS has not been increased since 1997 while the number of individuals who are living with HIV has continued to increase.
- There has been mention of HCV in this document. There are some organizations who have received Health Canada funding for short-term projects that are being completed at March end. A limited number will begin for a one-year period. None of the funding from Health Canada that is going directly to the Ministry of Health has been committed to support community-based responses to HCV in this province.
  While many of our organizations who work with people who are living with Hep C do so because being at risk for Hep C also means you are at risk for HIV, there are no dollars to support his work.
  The epidemics are broadening and the dollars have remained stagnant. There needs to be an increase, federally as well as provincially to address the multiple issues of prevention, care, support, outreach and education.

Devolved Funding:

- Devolution may have worked from a fiscal point of view but it has impacted the way groups/programs and services are connected. There must be a commitment to develop and implement a communications strategy that ensures that all levels of those working with HIV and AIDS are aware of the multiple actions taking place. There is no one place to call any longer, agendas are built according to local needs and priorities, which is fine, however there must be some sort of action to ensure that the response is connected, communicated and coordinated throughout the province.

- The Addictions Services are being addressed differently throughout the province, at times differently within the same regions. There were recommendations years ago that addictions should have a stand-alone authority to guide and supervised the work done and planned. The carving up of these services will impact a coordinated response to the multiple issues of addiction in this province.
- As well, there has been a shift in the monies allocated to ASO's depending on the health authority. ANKORS has (all Interior Health HIV/AIDS contracts) [and thank you very much the powers that be] received a 4.4% increase for salary and benefits this fiscal year. Not all health authorities have given their contractors that adjustment.
- The funding that was devolved was based on the 1997 numbers. The cost of programming, outreach and service has increased dramatically since that time. As we are on a fixed budget the slash occurs in hours of work, not in programs. Distance demands that staff travel and the cost of our travel budget has increased over 20% in the past 5 years while the dollars feeding that increase have not changed.
  Rents, office supplies, equipment continue to increase.
  Our office needs 5 new computers due to their age. There is no funding for this.

Centralized Funding:

- Bullet 2
  Methadone is not widely accessible. There are issues with physicians available to prescribe. In the WK/B region there is only one physician. Anyone who uses methadone uses this physician there is no sense of confidentiality or anonymity. It is will known that this doctor is a methadone doctor and assumptions are made with respect to his patients.
- Funding for street outreach nursing that would support methadone prescribers may offset some of the issues around access, confidentiality and anonymity. As well this type of support may reduce the number of individuals who "chip" to maintain some semblance of recovery. This position could be attached to and provide support within many AIDS Service Organizations and would enhance services, expand the abilities of programs and increase the services to those at risk or living with HIV.
- There are alternatives to methadone. Many people are terrified of becoming addicted to methadone and a large number of people addicted to opiates turn to cocaine when they go on methadone in order to continue getting high. It may be cost-effective, but there are other alternatives. Morphine or a heroin maintenance program must be instituted as well. There must also be other supports – addiction is not simply a chemical issue.

Implications for the Future:

- Bullet 1.
  It seems like this strategy and action plans are going to be implemented with no new money. Organizations and support networks have expanded the work we have done for years without any additional dollars. Services have been reviewed, adjusted and shifted as the virus has. To say that a shift toward prevention may take allocated dollars from some other place to ensure this work can be done is quite frankly ludicrous and shows the lack of understanding of the actual work being done in this province on shoestring budgets.

What do you really think we have been doing?

- Bullet 2
  We absolutely support the increase and a provincial strategy on testing. However, again this will impact service providers who are working with those who have just received their test results, those who are living with HIV and AIDS and those who are enrolled in the HAART program. The impact of moving money from one sector to prevention will impact support services in a major way. Would this be where we are to shift "extra" money?
  If there will be an increase to the Centre then that increase must be paralleled into the community and the service providers throughout the province.

- Bullet 3
  There are alternatives to methadone. Many people are terrified of becoming addicted to methadone and a large number of people addicted to opiates turn to cocaine when they go on methadone in order to continue getting high. It may be cost-effective, but there are other alternatives. Morphine or a heroin maintenance program must be instituted as well. There must also be other supports – addiction is not simply a chemical issue.

5. Roles and Responsibilities

5.1 BC Ministries of Health Planning and Health Services:

Paragraph 1 & 2

- With health authorities, aids service organizations and consumer groups. Collaboration and partnership must be active at all levels – must be real and relevant.

- First sentence, paragraph 3
  These concepts and roles need to be defined and practices stemming from them need to be determined with AIDS service organizations, consumer groups and consumers.

- Last paragraph
  While the Centre for Excellence and the BC Centre for Disease Control have some experience, those who are doing prevention here in the province are experts and deserve to be a part of this group in a real and relevant way.

5.2 Health Authorities

- Consumers must be included at all levels of planning, programming and implementation strategies. They are, ultimately, who we answer to and they are the reason we are here.

5.3 Community

- Bravo for including the Pacific AIDS Network. To act as the clearing house for the province would be a role that PAN could play with adequate funding and the creation of an infrastructure.

Page 28
Paragraph 2 and 4

- This is a very small and vague description of what service organizations and consumer groups do for, about and with HIV and AIDS in this province. This whole section on community needs to be expanded, defined and the relebvancy of our work needs to be expanded. ASO's and consumer groups are the reason that HIV has a voice and a presence in BC. The prevention, support, advocacy, outreach and harm reduction work in this province is some of the best in the world. There are innovative programs and services that flex at the moment that the virus shifts and that must be recognized and given real value.

5.4 Government of British Columbia

Paragraph 1

- Oh my.

  I absolutely agree that this is the role that the provincial government must play to effectively combat and reduce the number of HIV and Hep C transmission.

  That they must lead in the areas of human rights, social health contracts and in the development of social support networks that care for our most fragile and discriminated against populations.

- They must as our elected leaders ensure that we who live in comfort, ease and relative security assist, support and care for those who are most damaged, most at risk and most fragmented, by ensuring that the society we live in is one that cares for all.

  However, none of this has happened since this government was elected and came to power. The impact that the provincial government has had on the social determinants of health is enormous.

  The reductions in income assistance, changes to disability legislations, devolution of provincial responsibility to health and social authorities, reduction of hospitals, reduction of service providers in the youth sector, there has been a reduction of funding for almost every piece of society that support the poor, the disenfranchised and those most at risk for HIV.

  The provincial government has increased and contributed to the opportunities for HIV transmission.

  The service and support reductions have increased the risk that individuals live in and with; have placed youth (14-19) at huge risk due to the lack of support offered; decreased the options for individuals who live at the margins of our society to access real, relevant and supportive care.

6. Monitoring the Framework

I am hoping that there is community involved somewhere in feeding data, doing the work and implementing the strategy. Not only does this monitoring only use urban measurement data, it does not speak to the work that will be done in regions, by partners, through collaboration or by community.

There seems to be several important data sources that have been forgotten:

- Consumers
- Community and consumer groups
- Regional health authorities

As individuals will now have their progression through services tracked by their "numbers" how might you support this on the ground in AIDS organizations or Consumer groups? There is not the infrastructure in place that would allow for this at this point and there is not a data base on those who tested prior to the May date.

How will community groups share their information and how will that impact the planning and implementation process?

General Notes:

1. Hepatitis C was mentioned early in this document and then it was dropped from the planning, discussion and implementation. While many who live with Hep C were infected by the blood system (as it was early in the HIV/AIDS epidemic) many more individuals are living with HCV due to their marginalized and fragmented lives. There must be a parallel plan to address the transmission, prevention and support, care, treatment and life issues faced by those living with Hep C.

   I am quite sure that the costs for living with Hepatitis parallel those for HIV. As well, BC has one of the highest rates of people living with Hepatitis in Canada. This is a health issue that must be acknowledged and addressed.

2. Vulnerable population definitions changes throughout the document. They all need to read consistently in the whole of this document.

3. % and numbers are different throughout the document. Goal numbers change throughout and needs to be consistent.

4. Discrepancy in HIV, AIDS and HCV in the document. Either place HCV in this strategic planning or delete it and create a document that will address it's issues.