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Introduction

This is a "harm reduction" guide for Aboriginal people. The Canadian Aboriginal AIDS Network (CAAN) wrote it to help prevent the further spread of HIV and Hep C. This guide can be used in our communities and reserves, or in cities. We want to encourage the Aboriginal and non-Aboriginal communities to adopt Aboriginal harm reduction policies.

This guide includes:

- suggestions for Aboriginal communities who want to create harm reduction programs;
- suggestions for developing harm reduction policies;
- names and locations of needle exchange and harm reduction programs;
- how to get in touch with Aboriginal AIDS service organizations;
- samples of harm reduction policies; and
- a bibliography of web sites and journal articles.

This guide is being sent to:

- regional health authorities;
- local, regional and national non-Aboriginal AIDS organizations;
- provincial, territorial and federal health departments;
- provincial and federal correctional institutions; and
- municipal, provincial, territorial, and federal governments.

Some Words on Harm Reduction

When CAAN first opened its offices in Ottawa, one of the first projects it undertook was a Needs Assessment to assist in developing Joining The Circle, Phase I. As the Executive Director who oversaw that project in 1997-98, it is interesting to see, how years later, harm reduction is still a priority at CAAN.

What struck me most, as I travelled to various test sites, was that Aboriginal injection drug users, using or not, felt outside the circle. Their dreams were simple - to have the basic necessities of life, and to have access to support, traditional or not, when they needed it. I recall how one person mused how it would be so nice, if she could just go up into the hills with an Elder and get a break from it all.

CAAN supports harm reduction efforts that incorporate cultural and traditional values and meets our people where they are at. With about two-thirds of new HIV infections being attributed to injection drug use, clearly, we must do more.

We can all learn more about the nature of addiction, and build stronger coalitions to collaborate on such important matters. With limited resources, we need to find ways to work together and prevent involvement with injection drug use, address those now injecting, and support those who decide to leave injection drug use behind. Respect is the key.

We hope this manual opens your eyes and fills your minds with how better to approach harm reduction. We thank you in advance for your commitment to this concern.

Kevin Barlow
Executive Director

About "Joining the Circle: Aboriginal Harm Reduction"

Phase I (1996-1998)

In 1996, CAAN put together a funding proposal that was approved by Medical Services Branch and Correctional Services Canada. CAAN hired a research coordinator in 1997 to interview 126 Aboriginal people who use needles to shoot drugs.

They wanted to find out

- the types of programs and services Aboriginal people used; and
- the reasons Aboriginal people did not use programs and services.
- CAAN published a manual about this research in 1998.

The research discovered that there are many reasons why Aboriginal people who shoot drugs are at risk. Aboriginal people who shoot drugs face many issues, including:

- causes and effects of risk taking behaviour;
- abuse and racism that often leads to addictions;
- jail time served for committing petty crimes to feed addictions; and
- not knowing about HIV transmission whether through drugs or sex.

The research discovered that the ma*in reason people do not use harm reduction programs is a poor relationship with the organization offering the program. Most often, people did not use the programs becau*se:

- the organization judged people who shoot drugs, are poor or who had HIV/AIDS; and
- the services did not reflect Aboriginal cultures.

The research found that both on- and off-reserve Aboriginal organizations need:

- to setup more needle exchange programs;
- to start methadone maintenance treatment programs;
- to provide counselling services specific to people with addictions; and
- to make sure both men and women can get condoms.

Since many Aboriginal people move back and forth between the reserves and cities, we need harm reduction services in all of the places people live and travel through.

The research also looked at programs that make people stop taking drugs. These are called abstinence programs. CAAN's research found that abstinence programs do not usually work in the long term for Aboriginal people who shoot drugs. People's addiction to heroine and cocaine is often stronger than their ideals of being drug-free. It is unreasonable to ask them to stay clean before they can go to an abstinence type of program. They probably won't make it to the program. People who do get into the programs often don't succeed. This adds to their feelings of low self-esteem and isolation.

Since abstinence programs aren't working, services need to change. They need to meet people "where they are at." They must not condemn or condone drug use. They must support peoples' right to quality health services and safety measures that help them avoid getting infected and dying.

Phase II (2000 – 2003)

In 2000, CAAN decided to continue the work started in Phase I of "Joining the Circle: Aboriginal Harm Reduction." In 2002, a research coordinator was hired. The researcher formed a national steering committee and worked with an academic advisor from Carleton University.

Phase II looked at what had changed since 1998. The goals of this research were:

- to look at the successful ways that Aboriginal communities use harm reduction;
- to gather together all the information about harm reduction in Aboriginal communities;
- to share this information in a guide;
- to share the guide; and
- to create a Harm Reduction Policy.

To find out about programs for Aboriginal people who shoot drugs, the researcher sent a survey to 242 organizations. This manual is a summary of the 48 surveys that were returned. To learn more about specific programs, the researcher called people who returned the survey. The researcher documented program models so that other communities could use them. These models are very important to setting up programs because starting is the most difficult stage. Once you have a base, however, the rest of the program can be developed according to what the community needs.

This manual gives community members valuable information about starting and running harm reduction programs. Our research shows that communities can succeed in keeping their communities healthy if they persevere and build on other successes.

BACKGROUND INFORMATION

Harm Reduction in contrast to Abstinence

There are many different ideas about how to prevent Aboriginal people from getting HIV or Hepatitis C. Two important ideas behind programs are harm reduction and abstinence.

Harm reduction programs *try to lower the risk of people becoming infected. They teach people how to be safe when they use drugs or have sex.*

Abstinence programs *encourage people to stop doing the things that could put them at risk of being infected. They encourage people to stop injecting drugs or having unprotected sex.*

People don't always agree on which way is best. Both ways reduce harm because they both try to stop the spread of HIV and Hepatitis C. Both hand out condoms, but feel differently about injecting drugs. In this section, we look at both programs.

Abstinence Programs

The easiest way to get infected is to share needles with someone who is living with HIV or Hep C. The disease lives in the blood and blood can end up in the needles. Injecting drugs is dangerous for other reasons. It can cause severe heart, lung and other diseases, and there is always a risk of overdose. Many health and social services agencies are trying to find ways of dealing with addictions. In Aboriginal communities, the elders are also addressing addictions. They have seen how substance abuse breaks down the community. Addictions break down families, cause people to care less about themselves and can lead to an early death. Many Aboriginal people think that abstinence will restore balance and get people back to traditional ways of living.

The goal of an abstinence program is to help the person stop abusing drugs. The person is weaned off substances by going through certain steps. They begin by looking at their past and planning their future. When they have done this, they can take the first steps toward clean and healthy living. They stay off drugs with the support of people who have been on the same journey. They can avoid activities that put them at risk of infections like HIV or Hep C. Staying off drugs also means they are less likely to die because of violence, accidents and overdose.

Abstinence programs have a holistic view of recovery for the individual and their community. These programs believe that addicts can and will stop using drugs if they get the right support and encouragement. *They help people work through a six stage process of overcoming addictions:*

- getting ready to think about change (pre-contemplation);
- thinking about making a change (contemplation);
- preparing to make a change;
- taking action;
- maintaining the new behaviours; and
- ending the old behaviours (termination).

The stages are based on Prochaska's "Readiness to Change Model". This is an important approach to rehabilitation, but it can only succeed if a person wants to stop abusing drugs.

Another abstinence method is 12 step programs. Most of these programs encourage people to think that they have a problem and are powerless.

Another kind of abstinence program helps people accept their past and feel positive about their future. This is called "Substance Abuse Treatment," or SAT, and was developed by Dr. Manjeh Nikakhtar. *The goals of the program are:*

- to stop using all alcohol and drugs (total abstinence);
- to detoxify the body and ease withdrawal symptoms;
- to treat chemical dependency or addiction;
- to ease all symptoms or illness caused by substance abuse and to restore the mind and body to their best condition;
- to treat and ease all mental conditions that cause drug use and result from drug use;
- to get past destructive behaviour and attitudes like suicide, aggression or breaking the law;
- to provide an effective and affordable treatment for chemical dependency and addiction;
- to help stop relapses;
- to tell the public that drug use is a way people medicate themselves, it is not a defect – there are biological, genetic, social, psychiatric, and environmental reasons for drug abuse; and
- to do scientific research, training and consulting in chemical dependency and addiction.

Please note that SAT is a non-Aboriginal program. For information on the Aboriginal approach, see the section on Traditional Healing and Medicines on page 18.

Harm Reduction

Harm reduction programs look at drug abuse from the point of view of the person who is addicted. These programs deal with people "where they are at?" Harm reduction programs try to keep the people who are using safe. They help people to avoid getting HIV or Hep C until they are ready to stop using, if that is their choice. These programs do not discourage or encourage drug abuse. They help people deal with the dangers of drug use. These programs consider the person's health above everything else.

This way of talking about harm reduction was developed by Erickson, Riley, Cheung, and O'Hare in 1997 and the *American Harm Reduction Coalition (AHRC)* in 1993. *The principles of harm reduction are:*

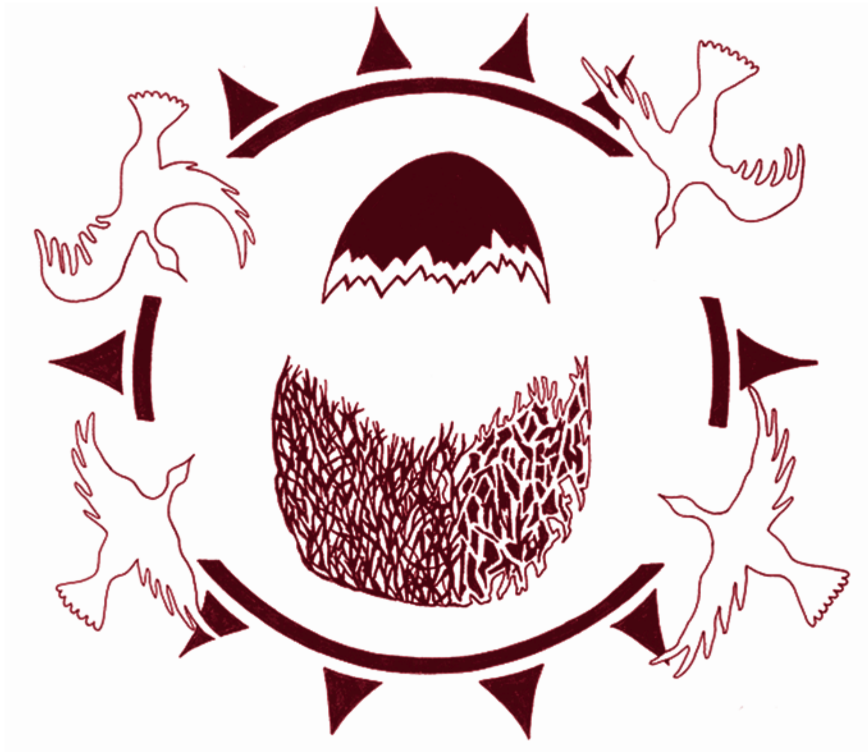
- **No value judgements about using drugs.**
  - ≈ Programs do not make moral, legal or medical judgements about drug use. Drugs are not talked about as good or bad, moral or immoral.
- **No value judgements about the person who uses drugs**
  - ≈ Programs do not judge people for using drugs because drugs are not seen as immoral or irresponsible. Programs respect the dignity and value of all human beings.
- **Focus on the problem**
  - ≈ Programs focus on the dangers of drug use. They focus on preventing people who shoot drugs from getting HIV.
- **Abstinence is not relevant**
  - ≈ Some people may want to quit. Other people will continue to use drugs. The focus of these programs is not on convincing them to quit. Instead, programs concentrate on keeping people from getting infected. Abstinence can be part of the program for people who want to quit, but it is not the focus.

- **Involve the user**
  - ≈ People who are using drugs can make their own decisions. People get information and hear about ways to protect themselves. They are empowered to make choices based on knowledge. These programs believe that people who shoot drugs are able to make their own choices and change behaviours.
- **Involve the Community**
  - ≈ The people and community affected by drug use must be involved in developing and running harm reduction programs. These programs are holistic. They understand the person's whole relationship to drug use and do not treat just the symptoms. The programs are created for the community. They are not "one size fits all" programs for everyone.

Harm Reduction and Abstinence

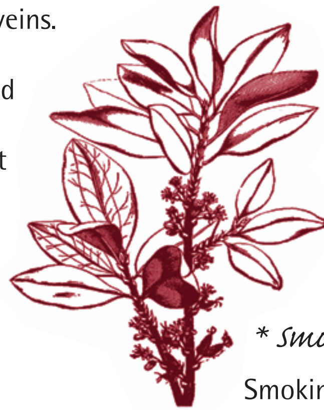
Although harm reduction and abstinence are different, some programs use both methods. They use harm reduction at the beginning to stabilize the client. They expect that eventually the client will quit abusing all drugs. How long it takes to move from harm reduction to abstinence is different for every program.

In this manual, we focus on harm reduction because...



What are the most common Injection Drugs?

In this manual we talk mostly about drugs that people inject into their veins. Of course, all drug addiction needs attention, programs and services. We focus on the drugs people inject because it is so easy for HIV to spread when people share needles. This section describes some of the drugs people use.



Cocaine

Cocaine comes from the leaves of the coca plant, which grows in South America. Pure cocaine looks like a white powder. It is a very powerful stimulant that affects the central nervous system. You can inject, sniff or snort, and smoke cocaine.

It is very easy to become hooked on cocaine. The "high" that comes from injecting cocaine is immediate and intense. Its effect does not last long so the person has to inject many times. Like other stimulants, cocaine does not make people physically dependent, but someone who uses it a lot will need more each time to get the same high. A person can also become psychologically dependent on cocaine. This means they need it to feel "normal." If they don't get cocaine, they might feel very tired, hungry and depressed. All of these are symptoms of withdrawal.

Harm reduction for cocaine users

* Shooting cocaine

Since people who shoot cocaine need to inject many times during the day, the best way to be safe is to have a lot of needles. If they can't get needles, they should be able to get bleach kits.

* Snorting cocaine

Snorting cocaine means inhaling the powder through the nose. When people snort cocaine, it is absorbed into the blood stream. *Remember that Hep C can be passed along by sharing straws to snort cocaine.*

* Smoking cocaine

Smoking cocaine means inhaling cocaine smoke into the lungs. The lungs absorb the drug into the bloodstream as fast as injecting it. This is the safest way to use cocaine. Many harm reduction programs encourage people to snort or smoke cocaine instead of injecting it. There is much less risk in smoking or snorting than in shooting it.

Crack

Crack is the kind of cocaine that people smoke. Cocaine is made into crack by boiling it with water and baking soda. When it is sold it looks like little white rocks. People who use crack heat it in a pipe and inhale the smoke. Crack can also be dissolved into liquid and then injected. People who have taken it said the pleasure they got from it was unlike anything else. It is also very easy to get addicted to crack. Withdrawal pains from crack are the same as from cocaine.

Heroin

Heroin is very addictive. It comes from the seedpod of the Asian poppy plant. Heroin looks like a white or brown powder. Street names for heroin are smack, H, skag and junk. Overdose is very common because

users do not always know how strong the drug is.

A person who injects heroin feels a rush. Sometimes their skin becomes flushed, their mouth gets dry and their arms and legs feel heavy. After that, they nod off and wake up for some time. Their mind becomes cloudy because the drug slows their central nervous system. The effects of a single dose of heroin last for a few hours. Because the drug is so addictive, a user might need another injection shortly after the effects wear off. Withdrawal symptoms are drug cravings, restlessness, muscle and bone pains, insomnia, diarrhoea, vomiting, cold flashes with goose bumps and kicking. Withdrawal symptoms can last about a week. They are the worst between 48 and 72 hours after the last dose.

People who are addicted to heroin need lots of clean needles and bleach kits.

Morphine

Morphine comes from the opium poppy. It is a fine powder that dissolves in water. Common names for it are "M", morph, and Miss Emma. It is a powerful narcotic. Doctors use it for people in a lot of pain. Morphine can be injected, smoked, sniffed, or swallowed.

A person will feel the strongest effects of morphine if they inject it. Morphine makes a person feel very good and relaxed for 4 or 5 hours. It is also easy to become addicted to morphine. A person who uses it regularly can quickly develop a tolerance to its effects. Over a long period of time they need more of the drug to get the high they want. Morphine withdrawal is like heroin withdrawal. People who are addicted to morphine need lots of clean needles and bleach kits.

Dilaudid

Dilaudid is a narcotic painkiller like morphine. It is 8 times more powerful than morphine. A person who uses it starts to feel high within 15 minutes. The high can last more than 5 hours. It is called "drugstore" heroin on the street. It can be taken by injection, as a suppository or swallowed.

People who are addicted to dilaudid need lots of clean needles and bleach kits.

Speed

Methamphetamines and amphetamines are very addictive stimulants. Most people know them as "uppers" or "speed." They can be sold as pills, capsules or powder. They can be inhaled, swallowed or injected.

Methamphetamines are more popular than amphetamines. It is also called meth, crank, crystal or crystal meth. It can be broken down and heated in a liquid for injecting. When it comes in a form that can be smoked it is called ice, glass or

crystal. A person who uses methampheta-mines feels very alert and very "up". They will not want to eat, their pupils will be dilated, their heart and breathing will speed up and they will have a higher temperature.

MDMA or Ecstasy

MDMA (methylenedioxymethamphetamine) is a man-made drug that is both a stimulant and a hallucinogen. It is often called Ecstasy, Adam, XTC, hugs, beans, and love drug. People usually swallow tablets of Ecstasy but it can be snorted, injected or taken as an anal suppository. Users can break up the tablet, mix it with a liquid, heat it and then inject it. They begin feeling high an hour after they take it. They still feel the effects for 4 to 6 hours. People who take Ecstasy feel a little "drunk" and very good.

If a person uses MDMA for a long time, it can cause brain damage. It can also cause jaundice and damage the liver. If the person takes a lot of it at one time, it can cause their body temperature to rise very quickly. This makes their muscles break down and their kidneys and heart will fail. Ecstasy is most popular among teenagers and young adults who go to "raves." It gives them a feeling of confidence and a boost of extra energy.

Downers (tranquilizers, sedatives)

Doctors prescribe tranquillizers to people who are depressed, anxious or cannot sleep. These drugs slow down the central nervous system. Many people have heard of the tranquillizers called Valium, Librium, Ativan, and Normison. They are usually swallowed but they can be injected in the same way as MDMA and speed. It is very easy to abuse these kinds of drugs but no one is likely to overdose on them. They are more harmful when people take them with alcohol and other depressants.
Downers make people feel agitated and rest-less. They also make people feel sleepy, relax the person's muscles and slow their mind. A person who takes downers will feel the effects within 15 to 40 minutes. The effects may last up to 6 hours. People who take them regularly develop a tolerance. They become mentally and physically dependent on them.

Talwin and Ritalin (T & R's)

Talwin is a painkiller that comes in a tablet. Ritalin is a stimulant that also comes as a tablet. On their own they have the usual effects of a painkiller or stimulant. However, they are often injected together. The high is like the one people get from injecting heroin. The drugs are usually sold in a "set" and are sometimes called "poor man's heroin."

Prescription Drugs

Most prescription drugs can be crushed up and dissolved in water or another solution and injected into the vein. The effects will vary depending on the drug used and the users tolerance to it.

Wine

Although not as common, research shows that some people have injected wine. The alcohol would be immediately absorbed into the blood stream causing an instant "drunk" effect. It would be extremely dangerous for those with sugar diabetes.

*The fact is that users can be very creative in their search for a "high" and any number of substances commonly found around the house could be injected. Be prepared.

Drug Combinations: Street Drugs and HIV/AIDS Medications

There has been some concern about prescribing anti-HIV medications to injection drug users because their lifestyles may make it difficult for them to follow the prescribed regimen. Many anti-HIV medications require the client to take them with food as others should be taken on an empty stomach. Others may require the client to drink large quantities of water daily. Most of them require the client to miss as few doses as possible for them to be effective.

It is important thing to remember is that the combination of street drugs with HIV medications may seriously harm the client. The following information provides you with some of the possible dangers.

Cocaine

In the test tube, the HIV virus reproduces twice as fast when there is cocaine in the blood. This means it may speed up how fast you get sick. We do not know exactly what cocaine does to HIV medications in a person's body.

Heroin

The HIV medication Norvir seems to cut heroin levels in half. This means that a person on Norvir who shoots heroin is not likely to overdose. However, people should be cautious.

Heroin and other HIV drugs don't always interact in test tubes like they do in people's bodies. For example, experiments in test tubes seemed to show that HIV medications would increase methadone levels. In real life, the drugs cut the methadone levels.

Synthetic or man-made heroin such as fentanyl or alpha-methyl-fentalyl is powerful in tiny doses. If it is mixed with other drugs, it can kill.

Sedatives (Valium, Halcion)

Sedatives like Valium and Halcion can kill people if they are mixed with some HIV drugs. The most deadly mix is with protease inhibitors like Ritonavir. Taking high doses of Ritonavir and sedatives together can stop a person's breathing. Other sedatives like Ativan and Serax are not as powerful. HIV medications can weaken their effects.

Ecstasy

It is very dangerous to mix protease inhibitors with Ecstasy. In one case in England, a person who was on Ritonavir took Ecstasy and died. Ritonavir keeps the liver from breaking down the Ecstasy. This makes the Ecstasy 5 to 10 times stronger. Other HIV protease inhibitors like nelfinavir, indinavir or saquinavir are also dangerous.

Ritalin

The effects of Ritalin are stronger for people who are taking Ritonavir and similar drugs.

Hepatitis

The various forms of hepatitis range from acute to chronic infections and can prove life-threatening to some people. Acute hepatitis refers to those immediate symptoms that can be cleared up. Chronic hepatitis refers to those symptoms that many people will live with for the rest of their lives. The manual focuses on Hepatitis C because injection drug use is the most common way for the virus to be transmitted from one person to another. However, it is important to include Hepatitis A and B because they can complicate treatment for those already infected with Hep C.

Hepatitis C (HCV)

Hepatitis is a disease that attacks the liver. Hepatitis C, or Hep C, is a hepatitis virus. It can cause cirrhosis and liver cancer. People die from Hep C if they do not get treatment. Before 1992, many people got Hep C when they had a blood transfusion because blood was not screened for the Hep C virus. Nowadays, people get Hep C when they share needles and other injection equipment. This is why people working in harm reduction have become very concerned about Hep C.

Research has shown that more than half of the people who have HIV may also have Hep C. When people have two diseases like this, it is called "co-infection." It is very important to know if a client or patient is co-infected, because treating a person who is co-infected can be complicated.

Symptoms

Signs of Hepatitis C:

- feeling very tired most of the time (fatigue);
- feeling pain or discomfort right below the ribs on the right side;
- feeling nausea;
- not having an appetite; and
- pains in the muscles and/or joints.

Symptoms of cirrhosis or fibrosis of the liver are:

- swollen liver;
- enlarged spleen;
- jaundice (yellowish skin and eyes);
- muscle loss; and
- swollen ankles.

How does Hep C develop?

Many people live for years without any signs that they are infected. Most of them (80%) will become chronically sick because their immune systems can't handle the infection any more. The amount of the virus in their blood will increase, liver function tests increase and they start to show symptoms that the disease has gotten worse. About 20% of people with chronic Hep C will develop cirrhosis (liver damage) and fibrosis (liver scarring) within 10 to 20 years. A smaller number of people develop liver cancer within 20 to 40 years. People with Hep C who are co-infected with HIV are much more likely to have liver failure.

How Hepatitis C is spread

- **Blood products:**
  Before 1992, many people in North America got Hep C through the blood supply.

- **Shooting drugs:**
  The Hep C virus is spread when people share needles and other equipment to shoot drugs. Bleach kills HIV, but it does not kill Hep C.

- **Other needles:**
  Piercing and tattooing can spread Hep C and HIV if the needles are not sterilized.

- **Cocaine straws:**
  When people share straws to snort cocaine, blood droplets from one person's nose can get into another person's bloodstream.

- **Sex:**
  Hep C is rarely spread through sex, because there is not enough Hep C virus in semen or saliva. However, there is enough of the virus in blood, including menstrual blood. This means that the virus can pass to a partner who has open sores on their genitals. The virus can also pass from one partner to another during traumatic sex where one or both partners bleed, or where a person's saliva has some blood in it.

- **Mother to child:**
  Babies whose mothers have Hep C can have the virus in their blood at birth, but they are hardly ever permanently infected. The risk of getting the disease is greater if the mother has a lot of the virus in her blood, especially if she is co-infected with HIV. Breast feeding will not usually transfer the virus from mother to child. Babies born to Hep C positive mothers are immunized at birth.

- **Household items:**
  Hep C can be passed from one person to another on anything that might have blood on it. For example, toothbrushes, razors and nail clippers or scissors often have small amounts of blood on them. Hep C cannot be spread in saliva, semen or urine, so eating utensils and cleaning supplies are safe.

Comparing Hep C and HIV

Hep C and HIV have some things in common:

- They can be passed from one person to another by direct contact with infected blood.
- Both are RNA viruses that convert to DNA once inside a person's body and then back into RNA.
- Both viruses reproduce very quickly.
- Different strains get stronger and resist current medications that are designed to keep them in check.
- Doctors find out if someone has these viruses by testing to see if their body has developed antibodies. If they have antibodies, the person tests "positive" and knows they have the disease.

The differences between Hep C and HIV are:

- The Hep C virus does not need to enter a cell in the same way as HIV does.
- Every adult who tests positive for HIV antibodies is infected with the virus. About 10 to 20% of people who test positive for Hep C may suddenly find there is no more virus in their bodies.
- The illnesses caused by Hep C are just in the liver like cirrhosis or liver cancer. HIV causes many more illnesses that can affect any part of the body, such as pneumonia and different kinds of cancers.
- The Hep C virus mutates at a much slower rate than HIV; and
- The Hep C virus can live outside the body longer than HIV, so it can be passed on through shared razors or toothbrushes.

Co-Infection and Treatment

The biggest problem with co-infection is how to treat both illnesses at the same time. One treatment could be hurting the other. Treating Hep C and HIV at the same time is complicated because Hep C attacks the liver placing a heavy burden on it. When HIV medications are added, they place an even bigger strain on the liver. The way treatments for HIV and Hep C interact with each other may also cause problems.

The liver is responsible for many things in the human body:

- it receives oxygen from the blood;
- it breaks down nutrients so that our bodies can use them;
- it forms proteins which help blood to clot;
- it forms essential carbohydrates and fats; and
- it breaks down toxins, drugs and alcohol so that they can leave the body.

Many medications, including drugs used to treat HIV, pass through the liver. If the liver gets full of toxins from medications, the liver cannot work as well. This could mean that one infection will make the other one worse.

The goals of treating Hep C for someone with HIV are:

- to slow down liver disease and
- to improve tolerance to anti-HIV medications.

Some studies show that the combination can be successful.

Many people who are HIV positive take protease inhibitors. A common drug for Hep C is interferon. Some people think it is a bad idea to take interferon while taking protease inhibitors. Taking both together can make liver function tests rise sharply. (Liver function tests show how hard the liver is working. If the test is high, the liver is working very hard to clear the body of toxins). Often, when someone starts taking drugs to treat HIV, the amount of Hep C in the blood goes up. In some cases, people who have this reaction return to normal after several weeks or months. This tells us that it may be better to treat both diseases at the same time.

What to tell clients who are co-infected

- Talk to your doctor. Find out what treatment strategy is best for you. It may be okay to watch and wait. It may be smarter to start treatment right away.
- If your doctor doesn't know much about Hep C, find one that does.
- If you can, stop drinking. If you can't, try to keep to it one drink a day or less.
- If you can, stop using any other recreational drugs.
- Talk to your doctor before you start taking any new medications. This includes over-the-counter drugs and herbal or traditional treatments.
- Get vaccinated for hepatitis A and B. Hepatitis A is not usually very serious, but if you already have Hep C, it can kill you.
- If you have Hep C, try to avoid giving it to anyone else. Be especially careful not to share needles or other apparatus.
- You are not likely to get Hep C through sex, but a condom is always safest.

Other Issues

You should remember that:

1) Hep C treatments are injected into the client which may cause "triggers" that remind them of their addiction.
2) The biggest side effect from Hep C treatment is depression.
3) Most doctors require the client to be off drugs and alcohol before they begin Hep C treatment.

Hepatitis A (Hep A) Fact Sheets

Hepatitis A is cause by the Hepatitis A virus (HAV).

Signs and Symptoms

There are a number of signs and symptoms of Hepatitis A infection. They are:

- jaundice;
- fatigue;
- abdominal pain;
- loss of appetite;
- nausea;
- diarrhoea; and
- fever.

Long-term effects

Hepatitis A is an acute infection not a chronic one. Therefore, there are no long-term effects. Once you have Hepatitis A you cannot get it again. About 15% of those with Hep A will have relapses over a 6 to 9 month period, but it will go away.

Transmission

The Hep A virus is found in the stool (feces) of those with the virus. It is usually spread when a person puts something in their mouth that has been contaminated with the stool of an infected person.

Risk Groups include:

- those who come in contact with household items of infected persons;
- sex contacts of infected persons;
- men who have sex with men;
- injection and non-injection drug users;
- people travelling to countries with high rates of Hepatitis A; and
- people, particularly children from countries where Hepatitis A rates were high between 1987-97.

Prevention

There are a number of ways to prevent Hep A infection. They are:

- getting the Hepatitis A vaccine;
- receiving Hepatitis A immune globulin within 2 weeks of contact with the virus;
- always washing your hands with soap and water after using the bathroom; and changing a diaper, and eating food.

Hepatitis B (HEP B) Fact Sheets

Hepatitis B is caused by the Hep B virus.

Signs and Symptoms

About 30% of people infected with Hep B have no symptoms. The symptoms are:

- jaundice
- fatigue
- abdominal pain
- loss of appetite
- nausea and/or vomiting; and
- joint pain.

Long-Term or Chronic infection occurs in:

- 90% of infants infected at birth;
- 30% of children infected between 1 and 5 years; and
- 6% of those infected over 5 years of age.

Also, 15 to 25% of those infected will die from chronic liver disease.

Transmission

The virus is spread from person to person by blood or other body fluids. It is spread:

- through unprotected sex (no condom);
- through the sharing of dirty needles or other "works";
- through needle sticks or sharps exposure in the workplace; and
- from mother to child during child birth.

Risk Groups include:

- people who have multiple sex partners;
- men who have sex with men;
- injection drug users;
- household contacts of chronically infected persons;
- infants born to infected mothers;
- foreign immigrants from countries with high rates of Hep B;
- health care and public safety workers; and
- Hemodialysis patients.

Prevention

There are a number of ways to prevent Hepatitis B. They are:

- getting the Hepatitis B vaccine;
- always using condoms when having sex with new sex partners;
- have infants receive hepatitis B immune globulin (HBIG) within 12 hours after being born to a Hep B positive mother;
- never share needles or other "works" to shoot drugs;
- never share personal items that might have blood on them like razors or tooth brushes;
- make sure your body piercer or tattoo artist uses sterilized equipment for every job;
- do not donate blood or body organs if you have had Hep B; and
- get the Hep B vaccine and follow all precautions against needle stick injuries if you are a health care worker.

Traditional Healing and Medicines

Traditional healing and medicines were at the heart of Aboriginal communities for centuries before colonization. Aboriginal people suffered through years of oppression and displacement under the rule of non-Aboriginal society. They were forced to adopt non-traditional ways of doing things. This included western medicine and healing practices. Western practices like pills, syrups, suppositories, surgery, radiation, amputation, psychotherapy or electroshock therapy became the popular way to heal the sick. While some people continued to practice their traditional ways, the majority chose the quick-fix healing methods of non-Aboriginal doctors.

Recently, many people began to see the value of traditional medicine. They saw that it not only restores the body to good health, but mends the mind and spirit as well. This is commonly known as a holistic approach. A holistic approach allows Aboriginal people to reconnect with their culture and traditions. It helps them decide what is best for themselves and their communities. Traditional healing has become very important in recovery from drug and alcohol addiction.

Traditional healers treat addictions like they treat many illnesses. They focus on the four states of the person: physical, mental, emotional, and spiritual. Life is a gift from the Creator and rituals show appreciation for this gift. In this way, healing is directly related to Aboriginal peoples' spirituality or "religion." Some of the most common rituals are traditional smudging, burning sweetgrass, and offering tobacco. Sweetgrass, tobacco, cedar and sage are very important traditional medicines. The sweat lodge is a powerful healing practice. It allows the person to encounter the spiritual world. Through this, the person gets a sense of what they need to do to bring balance back into their life.

In traditional medicine, people usually have to be drug and alcohol free before they begin the path to healing and wellness. This shows a strong commitment and desire to quit using and improve their health. In this sense, traditional healing is like an abstinence program.

Some Aboriginal programs have successfully combined abstinence and harm reduction activities. An example of this is *"All My Relations: Aboriginal IDU Harm Reduction Training Peer Educators Manual"* written by the Manitoba AIDS Task Force. In the program, injection drug users work through all four phases of self-realization. This means they get to look at and address the emotional, physical, mental and spiritual parts of themselves. They are able to set their own goals related to safe using. Total rehabilitation is also possible, if that is their goal.

According to Angeline Dee Letendre in her article "Aboriginal Traditional Medicine: Where Does it Fit?" there are three main differences between western and traditional medicines:

- the philosophical approaches to health;
- the way health care is delivered; and
- the guiding principles of each knowledge system.

Let's look at each area separately:

1. Philosophy

To begin the healing process, traditional medicine looks at the four states of being and treats them all equally. Western medicine usually treats the body and the mind separately. It talks about them as internal medicine and mental health. It does not consider spirituality as part of medicine.

2. Health Care Delivery

There are two main differences in practices: place and power.

Traditional healing often takes place outdoors, where people can feel more strongly connected to nature. The state of enlightenment makes them feel like they are contributing to their own healing. The traditional healer gives credit to the Creator and the spirits called on to heal.

Western medicine usually happens inside a sterile hospital or doctor's office. This often makes the patient feel more passive and at the mercy of the doctor's knowledge. The doctor is referred to as "doctor" while the patient is called by their first name. This tells people the doctor is the expert and the patient is supposed to follow orders. The doctor has a lot of power in this relationship.

3. Guiding Principles

Traditional healing usually involves one caregiver using a number of ways to help make the patient well. This helps to limit side effects from medication. Western medicine may use several doctors to treat all of the patient's symptoms. This can increase the chance of side effects that result from combining medications.

**It should be noted here that Western healing practices have been very successful at curing many people and extending the lives of others. For example, radiation treatment has cured many people of cancer and the new "drug cocktails" are keeping many HIV positive people alive much longer than when HIV was first recognized. There is no doubt that Western medications are working and that they can relieve the patient of his/her illness. This section is simply meant to give people options on their path to wellness. It is also to renew interest in traditional healing for those who feel the need to care for their mind and spirit while their body is on the mend.*

AIDS Phobia

Although many people know about protecting themselves from HIV, they are still afraid. Some people know that having unprotected sex and sharing needles are common ways of getting infected. At the same time, they have negative attitudes toward people who

are infected. They do not see how people living with HIV can still play a useful role in the community. Many people are still afraid of getting the virus from an HIV positive person who handles their food at a restaurant or uses a public toilet.

It is easy to understand people's fears when they don't know about something. But many people refuse to get information and change their views about HIV and AIDS. This can make life very difficult for people who are HIV positive. When fear starts to isolate or endanger people who are HIV positive, we call it AIDS Phobia.

Like all phobias, AIDS Phobia is "an unreasonable fear" of the AIDS virus. This fear can be obvious and hurt people who are HIV positive. It can also harm the person who has this phobia. They may never get tested for HIV because they don't believe they can get infected.

Many people still believe only homosexuals and people who shoot drugs get AIDS. They feel they will never get infected if they don't participate in those activities. They might keep having unsafe sex with casual partners. Their idea of safe sex is heterosexual sex.

Homosexuality and AIDS are not the same thing. AIDS education materials talk about HIV as a virus that does not discriminate by age, race, colour, gender, or sexual orientation. Not all homosexuals, bisexuals, and men-who-have-sex-with-men (MSM's) get HIV/AIDS. Not all people who shoot drugs get HIV/AIDS or Hep C. At the same time, many heterosexual people get infected with one or both of these viruses. It doesn't matter whether a person is gay or straight, they still need to use condoms and clean needles. When people insist HIV or Hep C affects only homosexuals or people who shoot up, we can see that AIDS phobia comes from homophobia or lack of respect for people who are addicted.

AIDS phobia can also give some people an unreasonable fear of sex. Abstinence from sex can be considered a harm reduction activity. At the same time, sex plays an important role in a person's overall health. If someone denies their natural desires for normal human relationships because they have an unusual fear of HIV, they should discuss this with medical professionals. Couples can go to walk-in clinics to be tested together and talk about the results with the doctor or nurse on duty. This is another chance to clear away fears that lead to AIDS phobia.

A report published in 1993 includes some useful information that can help us understand AIDS phobia. The *"Ontario First Nations AIDS and Healthy Lifestyle Survey"* describes five "factors" that affect how people behave towards AIDS. The study does not talk about AIDS phobia exactly, but it helps us understand negative attitudes. *The five factors are:*

- how anxious a person is about AIDS;
- whether people living with AIDS are isolated;
- do people communicate with their sex partners;
- traditional values and AIDS education; and
- are people embarrassed trying to get condoms.

If you would like details of this study, the manual is available from the National AIDS Clearinghouse, 400-1565 Carling Avenue, Ottawa, ON. The authors of *"Ontario First Nations AIDS and Healthy Lifestyle Survey"* are Myers, Calzavara, Cockerill, Marshall and Bullock.

Homophobia

Homophobia is "an irrational fear of physical and emotional love between two people of the same sex." In a broader sense, the term is used to describe the negative attitudes shared by those who cannot accept such relations. It often results in the emotional abuse and physical assault of those men and women who describe themselves as gay and lesbian.

Homophobia has largely contributed to the way Aboriginal gays and lesbians see themselves and their place in the world. As people living outside of the perceived "norm", some gay men and women are driven to seek out other gays and lesbians to provide emotional and spiritual support, and physical contact that fulfils their desires. The journey can be a long and difficult one before they find acceptance and true happiness. Unfortunately, homophobia presents a barrier to those feelings of self-worth as many gays/lesbians are forced to remain "in the closet" or suffer at the hands of the larger heterosexual community. Neither is a healthy way to live. Some "closeted" people never accept themselves out of fear and self-loathing. Others simply continue to act heterosexual as a means of advancing their careers and behaving as society expects them to. Those who do act on their true nature risk the possibility of being shunned by friends and associates and put themselves at risk for threats or acts of physical violence and a lot of mental abuse.

These incidents may cause gays and lesbians to turn to drugs and alcohol as a means of coping with their inability to "fit in." For some of those who experiment with injection drugs, a downward spiral is the only path available as drugs like heroin and cocaine are extremely addictive and can become the only refuge in a persons life. Once heavily addicted, people who would normally obey the law find themselves committing petty or serious crimes to support their habits. Because of illegal activity, they find themselves serving time in jails and prisons where homophobia is even more concentrated. Being openly gay in prison puts people at risk of being beaten, sexually assaulted, and in some cases, murdered. Prison may also pose a threat for some individuals who "shoot" drugs for the first time as a way of becoming accepted or coping with feelings of boredom, depression and anxiety.

Like all people, gays and lesbians experience and deal with negative attitudes in an individual way. Most learn to rise above adversity and lead healthy, productive lives with little or no serious effects from the homophobia they face. However, those with few coping skills are prone to seeking refuge in mind altering substances that can result in serious mental and physical addiction. Aboriginal people already experience marginalization in mainstream society as they struggle for equal access to education, health care, employment and proper housing. When you combine these struggles with feelings of isolation and distress brought on by homophobic attitudes, it is difficult for some gays and lesbians to lead regular lives.

Aboriginal leaders and social service providers have a responsibility to promote acceptance of all community members and foster relationships based on differences. The more they know about gay and lesbian issues including homophobia, the better prepared they are to deal with any negative

results arising from it. This includes the potential for injection drug use. Anti-homophobia training is offered by some human rights groups and could be quite helpful to organizations dealing with injection drug users. This is especially true when we realize that not all homophobic actions have to be violent in nature. Simply ignoring a person in their time of need because of their sexual orientation is enough. It is time for those in positions of authority to extend a welcome to gay and lesbian community members and promote diversity throughout their organizations.

Transgender Issues

Members of the transgender community face very different issues than the rest of society. Even gays and lesbians, 2-spirited people and men who have sex with men do not deal with the same problems. People change their gender either through medical procedure or by simply saying it. Society has a long way to go in understanding this part of human experience.

Over the past 20 years, the gay and lesbian community has grown to become more accepted by society. Governments have passed human rights laws and employment policies protecting gays and lesbians from discrimination. While not perfect, many gays and lesbians are able to live their lives and not worry about losing their jobs or homes because of their sexual orientation. Many communities have thrived in larger cities where cultural diversity includes those who seek same sex partners. This is where they have been most effective in creating change. Unfortunately, the transgender community has not been able to make these kinds of changes in society.

Society believes that men behave or look certain ways that define them as male. The same is true for women as females. In this view, there are no gray areas. People see gender in an either/or way. Either a person is a man or a woman and there is no confusion. This tells us that being like everyone else is good and being different is bad. People who see life from a different point of view are going against what is thought to be "normal" and have much more difficulty being accepted. This is often true of the gay and lesbian community.

The transgender community feels even more different because there is much less acceptance of their experience of life. People can't imagine that any person born male could think they are female or that someone born female would think they are male. Transgender people do not just think they are the opposite sex, they feel that they are. This is the difference between the mind and the spirit. It is much easier to look at the state of the mind than it is to look at the state of the spirit. Some people think that if a person is born one gender but feels like the other inside, they have a psychiatric problem. This makes people afraid of transgender people. It is this fear that brings out prejudice and loathing.

Transgender people face prejudice and discrimination on the street and in many health and social service agencies. If a doctor doesn't know about transgender people, they might not know how to treat a transgendered person in the right way. Social workers who try to help someone find a job or a home might not know the landlord or employer is prejudiced against their client.

Many transgender people leave home early. They often do not complete or continue their education because of prejudice from people in their classes and schools. Because they don't have education, it is difficult for them to get a job. Many turn to prostitution to make a living. They may also be living with past feelings of depression and low self-esteem. Many feel lonely and isolated. They may do desperate things to get someone's acceptance. They might start taking drugs to help them cope with day to day struggles. Once they are hooked they are easy targets for "tricks" and drug dealers. It

also increases their chances of getting HIV or Hep C.

Two-spirited transgender people deal with the same problems as many Aboriginal people. They might also live with the trauma of residential school. The way that Aboriginal people have been pushed aside and forgotten has led to alcoholism and drug abuse, poverty, violence, and isolation. Two-spirited people used to be respected in traditional communities. They were often skilled teachers and healers. Many two-spirited people of the past had a balance of male and female qualities. Their roles were very important to the harmony of the community. As communities moved away from traditional teachings and practices and toward western ways of thinking and acting, the positive attitude toward two-spirited people changed. It became more and more important for people to see themselves as man or woman. The men became more aggressive and provided for the family. The women began to stay at home and be more passive. This is where many lost the understanding that someone could be both male and female. However, Aboriginal people have managed to keep the feeling of community alive. They share common bonds like economic struggles and the way they work hard to preserve their distinct culture within the country. This is true for all community members whether they are male, female or transgender. We need to be more educated about transgender issues. It should be a priority of the social and medical services to help transgender people be more visible and accepted in the community.

Like all communities, the transgender community is made up of many different people and is very complex. One "catch all" phrase won't describe everyone in it. It is important for people who work with transgendered people to use the terms their clients use and prefer. We talked to a member of the Aboriginal transgender community for this project. That person gave us a list of terms to use:

Androgynes

Society and the medical community look at people and see either masculine or feminine qualities. Androgynes are people who don't fall into one category. This can be because of the way they act, look, or dress. They are not usually interested in sex reassignment surgery. They do sometimes try hormone therapy and more minor surgery.

Cross dressers (transvestites)

Society tells men and women what to wear. Cross dressers are men who dress as women and women who dress as men. These people do not usually try to change their bodies. Transvestite is the medical term for cross dressers. People who switch clothes like this prefer to the term cross dresser.

Hermaphrodite (Herm) and Intersexuality

When some babies are born, it is difficult to tell whether they are physically male or female. Intersexed people are born with different degrees of male and female anatomy. Some parents have surgery done on their babies to make them either male or female.

No-op or Non-op

A no-op is a transsexual who has not changed their sex characteristics, like genitals, to match the gender that they live.

This means they have decided not to have sex reassignment surgery.

Post-op

Post-op is short for "post operative transsexual." This means they've had sex reassignment surgery. They are no longer transsexual once they have had the surgery.

Pre-op

Pre-op is short for pre-operative transsexual. The person is planning to have sex reassignment surgery.

Transgender

Transgender people are biologically male or female and partly or completely the other gender. They see themselves as transgender or neutral. They have intimate sexual relationships with heterosexual or same gender partners. Transgender people may or may not choose to have sex reassignment surgery.

Transsexual

Transsexuals are biologically one gender but feel they are a member of the opposite sex. Some transsexuals actively want and complete sex reassignment surgery.

Two-Spirited

This is a person who carries the spirit of both males and females. They can be biologically male or female or biologically intersexed. They identify as Two-Spirited and may have intimate and sexual relationships with heterosexual or same gender partners.

As you can see, people who fall under the common terms of gay, lesbian or transgender live and feel many different ways.

**Transgender Program Suggestion*

One of the programs that responded to our survey said they reserve six beds for male to female transgender youth. We need more agencies like this willing to learn about the special needs of transgender people and adapt their organizations. People need to advocate for more programs and services for transgender people to help prevent deadly infections and early death because of violence, addictions and suicide.

Educating Leaders

One of the biggest obstacles to harm reduction programming is the apparent lack of concern around injection drug use by community leaders. Many leaders feel there are problems that need more urgent attention. They do not believe that people in their communities shoot drugs. This attitude could put people at risk for HIV and Hep C. Both HIV and Hep C are avoidable. If they are not dealt with, infection rates could become epidemic. Communities could be virtually wiped out by one or both of the viruses. This may seem like an extreme statement, but it is a possibility. Our communities are at risk. We should address this issue.

Community leaders need to be supported and educated about injection drug use issues. They must then encourage IDU education and prevention. They should include all community members in community development. This includes people with drug and alcohol addictions. Setting up programs and services for the more marginalized members of a community can happen without taking away support for other programs.

Leaders must acknowledge that people in small rural towns and on reserves no longer live isolated and free from the harms that create "seedy" neighbourhoods in the big cities. Travel, roads, satellite TV and the Internet bring many influences. Cities will always have bigger problems with drugs like cocaine or heroin. But it is still possible to get drugs in more remote areas, and people can still get addicted to them.

Many small communities do not have health centres that can treat AIDS or chronic liver diseases. People from these communities who have HIV or Hep C must leave to get health care. They have to go to a larger town or city away from family and friends.

Aboriginal people in Canada can easily get hooked on drugs because of low education levels, lack of job skills, fewer employment opportunities, poverty and low self-esteem. These problems can also make people who are mentally frail more anxious. Leaders must observe and understand the mental health of people within their communities. They are responsible for providing programs and services to improve the overall state of the community they represent. The sooner leaders take action on health issues, the less likely the issue will become a crisis.

The role of national leaders

The issues that national leaders deem important affects what community leaders choose to focus on. This is because a lot of funding and information is channeled from above to below. Therefore, it is important that community representatives tell national leaders what issues currently affect them.

National political organizations bring the main

concerns of Aboriginal communities and people to the Canadian government and try to get support for programs and services to meet these needs. The Assembly of First Nations (AFN), the Metis National Council (MNC) and the Inuit Tapirisat of Kanatami (ITK) represent their memberships at many National HIV/AIDS meetings and conferences. Although they send messages about HIV prevention and education, they have not written much about injection drug use issues. HIV/AIDS service agencies have always dealt with injection drug users, but their problems have not gotten national attention until recently. Organizations that address HIV/AIDS need to be more informed of injection drug use, not only as it relates to HIV and Hep C infection, but also to poverty, mental health, and crime.

National leaders need be more aware of movements by Aboriginal people. Many travel from rural areas to urban ones and then back again. The leaders also need to be aware of how many people in prison have HIV and Hep C. Recent statistics show that there is almost as much drug use in prison as in some communities. Many prisoners are serving time on drug-related charges and took drugs before they were arrested. They may have been infected with HIV or Hep C before they entered the system. Most jails are supposed to rehabilitate criminals. Rehabilitation should include programs to help people end their dependence on drugs. If they can't get clean, ex-inmates need access to addiction programs and counsellors once they get out.

Reforming Canada's drug laws

National leaders must lobby the government to treat injection drug use as a health issue and not a criminal or moral one. Community leaders must call upon their national representatives to take leadership about changing drug laws and policies within Canada. If these laws were changed, fewer Aboriginal people would end up in the prison system. This could cut down the number of people who get infected in prison.

The legacy of residential schools

Residential schools had a negative impact on many Aboriginal people. Many people took comfort in drinking and drugs to make up for losing their culture, language and homelands. The experience not only affected the residential school survivors, but also created a cycle of drug and alcohol addiction in their children and grandchildren.

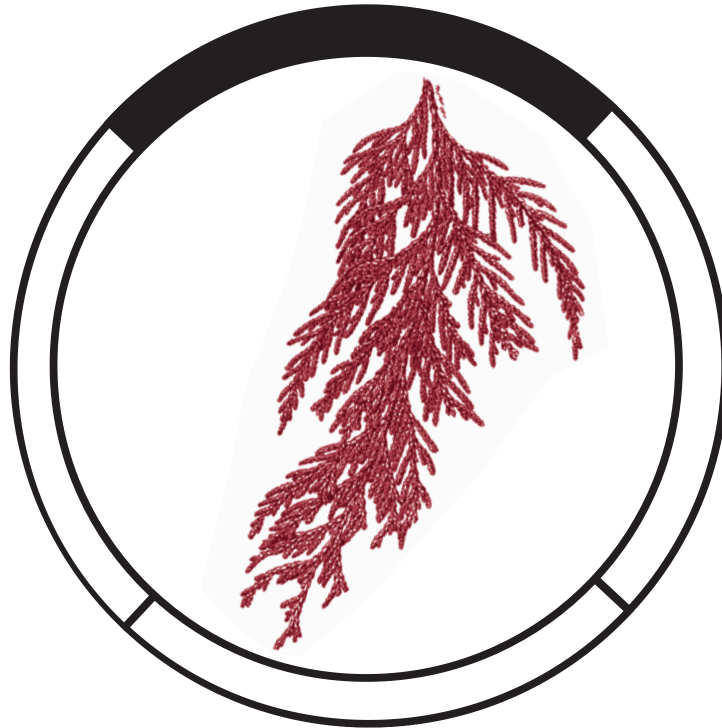
Addictions seriously affect a person's relationships with friends and family members. It makes it difficult for them to parent, and reduces their drive for higher education and employment.

Reasons why people use drugs

Like many marginalized groups, Aboriginal people are less likely to be educated and/or employed. They are likely without adequate housing, proper nutrition, decent wages, and access to quality health care. They may be exposed to crimes caused by poverty. Feeling isolated and deprived may lead some people to use drugs.

People with untreated mental health problems can also end up with addictions.

Any number of social factors can cause drug addiction amongst Aboriginal people. It is up to community leaders to learn what they can about substance abuse and respond to meet the needs of the people they represent.



HOW TO SET UP HARM REDUCTION PROGRAMS

Four Pillars of Harm Reduction

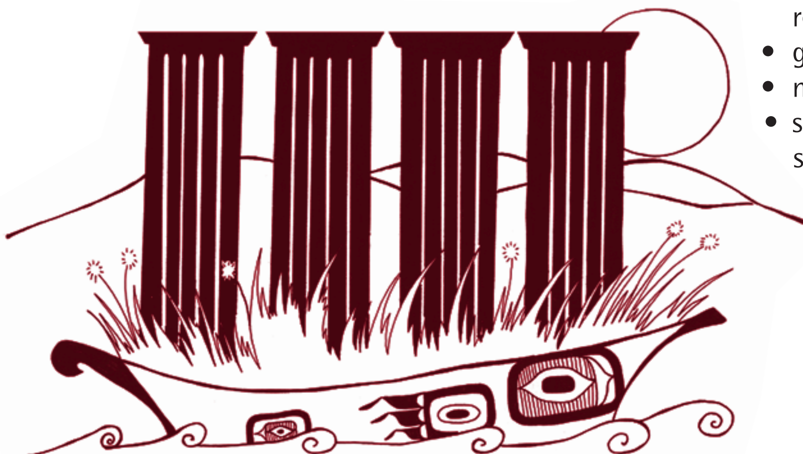
The "four pillars of harm reduction" were identified in 1997 during Phase I of "Joining the Circle: Aboriginal Harm Reduction." The pillars are activities that help to prevent Aboriginal people who shoot drugs from becoming infected with HIV, Hepatitis C or both. *The four pillars are:*

- **needle exchange programs;**
- **methadone maintenance treatment;**
- **condom/dental dam distribution; and**
- **counselling.**

These four pillars are a list of services a community can develop to build a harm reduction program. It will be easier to build a program if support, information and tools for clients, services, and community members are already in place.

Harm reduction programs believe people can make informed decisions if you give them the proper information and tools. They assume that people who use drugs know what they need and will try to keep themselves and their communities safe. *Harm reduction programs must be:*

- culturally appropriate;
- comfortable for the clients; and
- a place where people can talk freely.



Before You Begin

People who shoot drugs are very aware of attitudes and judgments towards them, drug use, HIV and Hep C. Clients must feel that the program is run by people who honestly care and are willing to listen to their concerns.

Getting your community to recognize and support the issues of injection drug use may be one of your biggest challenges. If your program is going to succeed, all programs and services should be acceptable and accessible to the communities they serve. Margaret Ormond has written about what acceptable and accessible means in "Harm Reduction: Considered and Applied." Here is a summary of what she talks about.

Is the program acceptable?

The community:

- decides the program is critical;
- decides how the program will operate; and
- understands that the program is needed for the health of the individual and community.

The program should be:

- supported and influenced by Elders and other influential people;
- part of an existing program that is positive, accountable and has a good reputation with the community;
- grounded in the community's values;
- non-judgmental; and
- seen as one part of a larger system of services that treat substance abuse.

The goals of harm reduction:

- must be like the overall community goals; and
- understood as helpful to the community in meeting its goals.

Is the program accessible?

Programs are accessible when :

- influential community members and other services support new initiatives;
- harm reduction activities and ideas are included in other successful services, like youth groups and women's health groups;
- harm reduction information is included in other programs, like STD screening and testing and HIV testing;
- they use HIV and STD testing as a good time to help prevent illness, not just to give test results;
- clients trust the program because communication is sensitive and respectful;
- clear confidentiality policies are in place, and the program is clear what will happen if people break confidentiality;
- the program design recognizes that people don't always stay in one place, but often move from rural to urban areas then back again;
- practical and emotional support is included as important to health;
- they focus less on changing individuals; and
- they get information out to community members for continued support.

Pillar #1 Needle Exchange Programs

How to set up a Needle Exchange

Needle exchange programs are different from one organization to another. Different regions have different funding, governments and health authorities. All of these will affect the program.

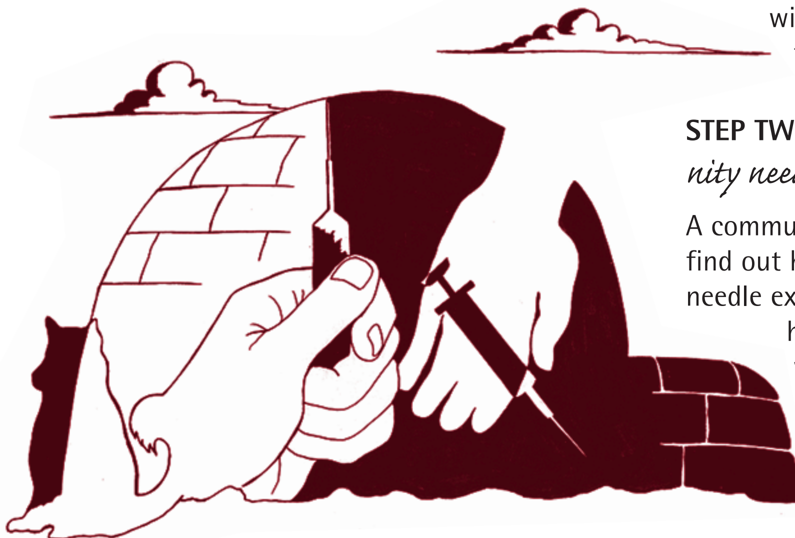
In this section we give you examples of programs that set up successful needle exchanges. You can use this as a starting point and change it to meet you and your community's needs. It is meant to help your community work toward safer injection drug use.

STEP ONE: *Develop your values for harm reduction.*

You need to develop your own set of harm reduction values. They must

- cover the areas you want to work on and
- be accepted by everyone in the organization.

These values are the key to successful programs and services.



Aboriginal and non-Aboriginal organizations have written papers about harm reduction. Read some of these and decide which one is most like your idea of harm reduction. You can download or print many of these documents from the internet. They may also tell you who to contact if you want to order hard copies.

This research will also give you the most up-to-date information on current trends. You must be aware of current harm reduction issues. When you know what the issues are, you can decide which direction you want to move in. Then you need to get your organization to support the idea of starting the harm reduction program.

It is very important that you get support from everyone in the organization. If there are people who resist the project, it may never start. In your presentation to your Board or other leadership, include statistics about Aboriginal people who use drugs. This will support your case for needle exchange services. This is also a good opportunity to share your knowledge and commitment to the project.

If your project is going to succeed, you have to keep up your harm reduction activities. It will not work to give up and change to a focus on abstinence.

STEP TWO: *Find out what the community needs*

A community needs assessment will help you find out how many people will use your needle exchange program. This will also help you decide what your project will look like. For example, will everyone who shoots drugs be able

to get to one place for their needles? Should you try to arrange another office? Should you use a van?

This assessment will also help you figure out your budget. If you have an idea of how many people could use your program, you know how much funding you need for needles and other equipment. It will also tell you how big your office needs to be and how many staff you need to hire. Knowing how much it will cost to run your program will help your chances of getting funding. You can present your needs assessment information to other potential funders. This will help if you need additional funding, a satellite location or moral support in your community.

STEP THREE: *Decide where the needle exchange will be*

Your office is a great place for a needle exchange. If you have been there for some time and are known for the work you do, it will be easier to get other organizations or residents to understand the need for the program.

If your organization does not have room or if a needle exchange would disrupt other services, you might have to find another space. This could be tricky. Remember that people in that area might not want your program near their homes or offices. Often, people focus on what they see as the negative part of the program. A lot of people think harm reduction means agreeing with drug abuse. They might think the exchange will bring drug dealers into the area. Their beliefs about the program aren't based on the facts and it may be frustrating to deal with them. It might be hard to find the right location for your program. Once you have the right location, setting up the rest of the program should be easier.

STEP FOUR: *What you need*

Buying needles for your program will be your biggest expense. You can buy needles from your local health unit or pharmacy. Or you could buy directly from a wholesale syringe company. Some programs get free needles from community health authorities. Since your program is new, you are not likely to get free needles.
Buying syringes wholesale is a good idea because it is cheaper. You also don't have to worry about getting the right amount of needles when you need them. Call around to the local health units, hospitals or pharmacies to find out the name and number of a wholesale syringe company. The company will tell you the minimum number of needles you have to order. They will also tell you how and when they will deliver.

Once you have a supplier you need a secure place to store the needles. It is very important to take inventory. Always match how many you have with how many are going out.

STEP FIVE: *Running your program*

There are two ways to run your needle exchange program. The model you choose depends on your schedule and how many people can work on it.

1) Needle Exchange in Your Office

- A staff person gives out needles from one part of your office.
- Clients meet the staff member, put their needles in a sharps container and take clean needles.

- The staff person keeps track of the number of needles they give out on a log sheet.

This kind of set up may be a great opportunity to work on making good relationships with the people who come for needles. You can invite them in for coffee and talk about other issues like housing or their general health. It's important that the people who come for needles get to know and trust the people that run the program. If you can, give them the counselling they ask for. Be prepared to encourage and support changes they want to make in their life. Post emergency contact numbers in a visible place in case someone is accidentally pricked by a used syringe. You should also post up a list of Universal Precautions.

2) One-for-One Needle Exchange

- Put a one-for-one needle exchange box in your office. It should be easy to get to.
- Leave a log sheet for the person to write down how many needles they take.

Most needle exchanges don't know the names of the people they serve. If you need to know for some reason, remember that your program still needs strict confidentiality to succeed. Give each client a code. Only the staff directly involved with the needle exchange can see the code.

Most programs use the one-for-one needle exchange. There are times when this will not work. The client may have lost or thrown away their syringes, but still need clean needles. Make sure they can get clean needles.

It doesn't matter what kind of program you set up. The most important thing is to give clean needles to people who ask for them. Talk with the people in your organization about which kind of program will work.

An important issue that will need to be discussed by the Board of Directors of your organization is liability for accidents and injuries. Since all organizations are different, you will have to find out what standards your organization has in place.

Universal Precautions with Needles

Before you set up a needle exchange, you should know about how to be safe around needles. The chance of getting HIV at work is very low. The highest risk is when someone is stuck with a needle that has been used by an HIV positive person who has high viral load. A high viral load means a lot of the virus is in the blood.

If you are accidentally scratched or poked with a needle, remember:

- someone stuck by an HIV contaminated needle has less than a 1% chance of getting HIV;
- someone stuck by a needle contaminated with Hepatitis B virus has a 6 to 30% chance of getting Hepatitis B;
- someone stuck by a needle contaminated with Hepatitis C virus has a 4 to 10% chance of getting Hepatitis C.

As part of universal precautions, you should think that all used needles are contaminated. It does not matter if you can see blood in the needle or not. It does not matter if it was used to immunize, take blood, give medicine or get high. If it was used, it is not clean.

To prevent injury:
- never put the cap back on used needles;
- never bend or cut needles;
- never remove the needle from the hub;
- never throw needles in with other garbage;
- put used, uncapped needles into a sharps container – these are red plastic bins you can put things in but can't take out;
- if you don't have a sharps container use something else that the needle won't pierce, like a coffee can with a lid.

If someone has a needle stick injury:
- try to make the injury bleed more;
- wash the injury with warm soapy water for at least 15 seconds;
- if someone's eyes are splashed, wash their eyes with cold water;
- call the person responsible for work place safety to get instructions or first aid;
- review the Integrated Post Exposure Protocol at www.aidslaw.ca/maincontent; and
- write down everything that happened including the time and date.

An organization that runs a needle exchange should also offer these services to staff:
- Hepatitis B vaccination;
- annual flu shots; and
- tuberculosis testing.

*Another important issue is the proper disposal of the used needles you collect in your program. Contact your local waste management centre to arrange pick-up or to discuss the right way of getting rid of contaminated materials.

Part of this information was taken from *"Taking Care of Business"* prepared by Kali Shiva AIDS Services and MAATF.

Pillar #2
Methadone Programs

Methadone has been used to treat opiate addiction since shortly after World War II. It is used to prevent heroine withdrawal symptoms and only has to be taken once a day. It does not give the person a feeling of euphoria. If taken in reasonable doses, it is not toxic to the body. Methadone treatments are swallowed, not injected.

Methadone is addictive, so some people argue that it just replaces one addiction for another and should only be used in extreme cases. Methadone is a good way to reduce harm, because users don't need needles. Once a person is stabilized on methadone, they can be weaned off the drug. In time, they can live drug-free, if that is their goal.

There are two types of methadone programs:

- **methadone maintenance treatment** which lasts for months or years; and
- **withdrawal program** which lasts a few days or weeks.

Studies show that maintenance programs are more successful than withdrawal programs. This is because it includes counseling and support to help people stay away from heroin.

In a maintenance treatment program, a doctor, counselor and pharmacist work as a team. The doctor often acts as counselor for many clients. *The basic program runs like this:*

- The doctor conducts a standard assessment: they take the client's medical history and runs blood and urine tests.
- Once the assessment is finished, the doctor can prescribe methadone.

The client gets the methadone from the local pharmacist every day.

If the client has moderate or severe psychiatric disorders, they should always combine methadone with counseling.

When someone starts taking methadone, it can take up to two weeks for their body to get used to it. After that, there shouldn't be any side effects. It is important that the client see their doctor several times during the first few weeks. This is to make sure they are getting the right amount of methadone. Too much of the drug is dangerous. If they get too little, they will feel withdrawal symptoms.

The purpose of methadone maintenance treatment is to rehabilitate people with opiate addictions. *The four main goals of methadone maintenance treatment are:*

1) Help the client more actively take part in society. Look at employment, schooling, vocational training, or homemaker activities.
2) Help the client feel free of heroin "hunger." You can tell how this is working by seeing several urine samples that test negative.
3) Help the client stop antisocial behaviour. You can tell how well this is working when you compare their arrests or jail time with their previous experience.
4) Help the client to accept that they need help for their drug abuse or other psychiatric problems.

Sticking with Methadone

If someone is thinking about entering a maintenance program, they need to keep several things in mind.

- They need to commit to coming every day to get their prescription.
- They will have to make plans to get methadone when they travel and on holidays.
- They should know that methadone does not give any "high" feelings.
- They might feel side effects like constipation, sweating, insomnia, drowsiness, aching joints and muscles, lowered sex drive, irregular menstruation, and changes in appetite.
- Methadone is a strong drug and it is dangerous to use it incorrectly.

Sticking to the program often depends on knowing and dealing with these issues. The key to staying committed to the methadone program is getting extensive counseling.

Addiction is a health issue. Health does not only include the body. It also includes a person's psychological, social, spiritual and emotional needs. A client who meets regularly with a counselor has a chance to talk about their problems, recent developments in their life and maybe plans to quit drugs altogether. They have a greater chance of succeeding.

Some clients in the program may relapse or "fall off the wagon." Make sure they know that mixing methadone and drugs can cause overdose and death. Drugs to avoid are: alcohol; tranquillizers; barbiturates; analgesics (like Digesic); heroin, and any mixture of these.

Getting Off Methadone

If the client wants to quit drugs completely, remember that getting off methadone can be as difficult as getting off heroin. Symptoms of withdrawal from methadone are nausea, loss of appetite, diarrhoea, cramps, muscle tension, irritability and disturbed sleep. Support and encouragement will help the client feel stable and able to succeed.

In spite of the difficulties, methadone maintenance treatment is still a way to help people end their drug addiction.

How to Set Up a Methadone Maintenance Treatment (MMT) Program

This is what you need to set up a methadone maintenance treatment program:

STEP 1: *Learn More*

Before you talk to anyone, do some research about methadone treatment. A good contact is the Addictions Research Foundation (ARF). You'll learn a lot about methadone treatment. This will help you to develop a realistic and workable program. Contact the Addictions Research Foundation at (416) 535-8501.

You might not need to set up a special clinic for a methadone maintenance treatment program. It could be set up as part of an existing community or mental health program.

STEP 2: *Find a doctor*

Find a doctor in your community who can prescribe methadone. Since you are developing this service, meet with the physician to talk about working with your program.

The doctor will need a week to get ready before they offer the service. First, they take a one-day course with the ARF or similar organization. They will learn the protocol of prescribing methadone and possible negative or positive side effects. After that, they spend 4 days observing how a licensed clinic runs the program.

Regular tests will tell the doctor how well the program is keeping the client off drugs. It will also help the doctor check up on the client's overall health. This means the doctor can also offer support around diet, exercise, and rest.

If your program is working with an individual doctor, they will have to send clients to the local lab to run blood and urine tests. If the doctor practices with a nurse, the nurse can do the tests. The program might have to buy some medical equipment for these tests.

*If you are from an isolated community where a doctor may only visit once a month, have the doctor write your client a prescription for one month to avoid disrupting treatment.

STEP 3: *Find a pharmacy*

You need to find a local pharmacy that is willing to give out the methadone. Clients must be able to get their methadone without problems or interruptions. The pharmacist can also help support the client by giving information about drug interactions and practical advice. This will also help the client's commitment to stick with the program.

If you find a pharmacist who you are comfortable with, they will probably need training.

STEP 4: *Find a counsellor*

Clients in the program do better with therapy. Therapy provides case management and support. The therapist will counsel the client to deal with their mental and emotional needs. They give support and guidance to people who want to work toward a drug free life. They can help them work toward developing their skills or find a job. They can also offer support to the client's children or partner.

STEP 5: *Set up supports*

If your treatment program is in the local hospital, you won't need to find too many supports. The doctors, nurses, therapists, and medical supplies are all right there. If you set up the program in a community centre, you will have to arrange all of these resources before your program begins.

Possible issues

Here are some comments from the Addictions Research Foundation about problems you might face.

The biggest difficulty in starting a methadone maintenance treatment program is finding a doctor who is willing to prescribe methadone. This is especially true in smaller communities. Community members might see methadone users as dangerous or "low lifes." People might not want to go to

a doctor's office with "those" kind of people hanging around. If the doctor thinks this might be the case, they are not going to treat methadone clients. It is very important to educate local doctors and community members about the program if it is going to be successful.

Another problem can be the cost of travel. Some clients have to go to a larger city to see a doctor who prescribes methadone. The doctor may not be considered a specialist but rather as someone who provides a service that the community doctor does not. If this is the case, the client's travel costs won't be covered. This makes it difficult for clients who can't afford travel.

Services offered by the Addictions Research Foundation

The ARF might be the first place a client goes who wants to start methadone treatment. Once the client is stable, the ARF will talk to the doctor in the client's community. A doctor might be more willing to take on a methadone client with the support and guidance of a larger organization like the ARF.

The ARF also supports clients who are considered difficult in their own communities. The Foundation has a Web provider where doctors and pharmacists can talk about issues related to the treatment. They can also watch the progress of different programs.

Pillar # 3 Condoms and Harm Reduction

Condoms have been a very important part of harm reduction activities since the beginning of the AIDS epidemic. They can prevent the spread of sexually transmitted diseases like HIV. Condoms for women are just as effective for birth control and for safe sex. People who are not sure of their partner's sexual and medical history should always use condoms. The latex can break during sex but this is very rare.

There are two main ways that STDs can pass from one person to another:

- Some diseases are passed from infected semen or vaginal fluids to the male urethra and the vagina or cervix. These are called "discharge" diseases. They include HIV, gonorrhoea, chlamydia, and trichmoniasis.
- Some diseases are passed by touching infected skin or mucous tissues. These are called "genital ulcer" diseases. They include syphilis, genital herpes, chancroid and genital warts.

Condoms work best to prevent the spread of discharge diseases. This is because condoms prevent the exchange of bodily fluids between partners. Condoms aren't as effective against genital ulcer diseases. This is because condoms don't cover all of the infected areas.

Studies on couples where only one partner was HIV positive have shown that when the couples always and properly used latex condoms, the virus was not passed sexually.

Condoms are an inexpensive way to prevent the spread of disease because STDs cannot pass through latex. They should be easily available.

Who Should Give Out Condoms

Condoms can be given to the community through:

- community health clinics;
- outreach workers;
- local HIV/AIDS organizations;
- offices of community services; and
- information fairs held in the community.

Condoms in the office must be clearly available. They should also be in a private place.

How to Set Up a Program to Give Out Condoms (Condom Distribution)

- Find a company who can supply you with lots of high quality condoms.
- Get in touch with local, provincial and national HIV/AIDS organizations to get pamphlets about safer sex.
- Choose a private area in the clinic or office where people can take condoms without being seen. Perhaps leave a basket of condoms near your information display. Privacy is very important.

- If your office has no private area, the counselor could give out condoms.
- Arrange to give out condoms at community events, like dances or sports.
- Give out condoms during health care or safer sex talks in schools and at community workshops.
- If you have a needle exchange program, give condoms out with clean needles.

Condoms and Needle Exchanges

Giving out condoms at your needle exchange might be a good time to talk about how important it is to use them and how to use them properly. If it doesn't feel right at that time, just give a few condoms out with their needles. This is still a good way of promoting your program and getting the safer sex message out. The more information the client has, the better their chances of not getting infected.

Getting Condoms for Your Program

In some countries, condoms have not been available and HIV has devastated their people. In Canada it is much easier to get and use condoms. It should be fairly easy to get and give out condoms in your community. Make sure you have enough high quality condoms for your program.

If your organization can afford it, buy condoms from wholesale companies. You could also buy them from local pharmacies. *If you can't afford to buy them, you can get condoms free from:*

- Innu and Inuit Health Commission;
- Provincial Aboriginal Health Divisions; and
- Regional HIV/AIDS service organizations

It is also important to have safer sex pamphlets that help people to use condoms properly. Condoms can only help people avoid STDs if they are used correctly. You can get pamphlets from Regional Health Units.

Condoms in Prisons

Giving out condoms in prisons has a separate set of principles and problems. We talk more about this in the section called "Harm Reduction in Prisons."

Pillar #4 Counselling

Counselling is a very important part of treatment for injection drug users. It provides the client with an opportunity to discuss their addictions and any daily hardships they face. Support and guidance are especially important for those who wish to quit using drugs. The following section provides an overview of the many issues a counsellor will have to help the user deal with. It also provides suggestions for those who are counseling clients on methadone.

Counselling Injection Drug Users (General)

Counselling is extremely important for injection drug users as it offers them some support and gives structure to a chaotic lifestyle. Counsellors can help users with a number of daily activities or concerns that need attention. These may include health, hygiene, nutrition, and the law. Below is a list of matters the counsellor may assist the users with. Many are similar to those found in the methadone maintenance treatment counselling section that follows. However, a more detailed list will better address the active user.

- **DEMOGRAPHICS**
  Take the clients name, address, and contact information;

- **DRUG HISTORY**
  Ask how long they have been using; what are their drug(s) of choice; how often do they inject throughout the day; are they binge users who do not inject for weeks or months; where on their body do they normally inject (injection sites); what other substances do they ingest other than injection drugs (ie. alcohol, marijuana);

- **GENERAL HEALTH**
  Ask how their overall health is. Do they experience common symptoms like headaches, colds or allergies? Do they take medication for diabetes, heart disease, blood pressure, and other conditions? Do they have a drug plan? How do they cover payment for prescriptions?

- **HIV/AIDS**
  Ask about their HIV status. Are they HIV positive or have they ever been tested? If they are positive, are they currently taking medications to suppress their HIV. If so, do they experience many side effects from the medication? Do they have difficulty remembering to take their medications when they are using dope?

- **CO-INFECTION**
  Ask if they are co-infected with Hepatitis C. If so, how is their liver functioning? Are they on medication to suppress the hepatitis? Any side effects?

- **HOUSING**
  Find out how their housing situation is. Do they have a home or an apartment? Are they staying with friends or at a shelter? Is the place they are staying secure and properly equipped with lights, heat, cooking facilities and a proper bathroom? If not, you may want to refer them to a housing

agency that can help them find a better place at a reasonable price.

- **NUTRITION**
  Find out if they are eating properly. Do they get enough food? Do they access community food banks? Give them contacts if they need to access one. Also give them nutritional information so that they are getting the right nutrients their body needs. If possible, provide lunches in your office for your clients. Even one good meal a day will help.

- **EMPLOYMENT**
  Find out if they are working. If they are not, would they like to? Do they feel they are able to work? Provide them with contacts at a local employment agency if that is something they wish to do.

- **FAMILY**
  Find out if they have dependant children living with them. Who cares for their children when they are using? Find out if Social Services has taken their children and if they have contact with them.

- **RELATIONSHIPS**
  Find out if they are sexually active, particularly when they are using. Do they have one steady partner or multiple casual partners? Advise them to practice safe sex for the benefit of themselves and their partners. Give them information on Sexually Transmitted Diseases as well as condoms/dental dams and lubricant.

- **THE LAW**
  Find out if they have served time in prison for felonies or in local jails for misdemeanours. Are they on probation or have been ordered to do community service? Encourage them to keep regular appointments with probation officers as instructed by the courts.

- **OPTIONS**
  Find out if they want to quit using drugs. Let them know of the options (ie. Methadone Maintenance Treatment, intense counselling). Provide referrals to discussion groups for support, networking discussion of HIV or Hep C status.

- **OTHER REFERRALS**
  Refer clients to shelters, food banks, hospitals, STD clinics, dentists, and training centres.

Methadone Maintenance Treatment Counselling

Counselling and support are essential to the client on methadone. Any number of reasons may cause a client to interrupt his/her treatment. It is important that clients have someone to discuss these issues with. Clients need to have someone who will understand that their first few tries on methadone may not have been successful because they were not ready. They need someone who will support and encourage them to try again when they feel they are better able to make the commitment that methadone maintenance treatment requires. The following information provides tips and considerations for those who counsel methadone clients.

Operational Considerations

- Mandatory/Voluntary- most methadone programs are mandatory which requires the clients to show up for regular urine tests. However, others are voluntary giving the clients the option to show up;
- some organizations (like AIDS service organizations) require the client to be HIV positive, but in special cases may take clients who are Hep C positive;

- they provide good spaces for straight (heterosexual) men with HIV to discuss their issues;
- they may also require the client to be street involved (living on the street, involved in sex trade etc.) and not just on methadone;
- some clients may show up Ahigh@. You must plan to deal with this. Will you allow them to attend or ask them to come back when they are not high? It is your choice;
- it is important to check clients arms, not to see if they were using, but to make sure they do not have abscesses that require medical attention. If they do, you will need antibiotics for infection, antiseptic to clean the wounds, and bandages to protect the cleaned area;

The User

- Trauma- evidence suggests a connection between childhood trauma and injection drug use. Some injection drug users may have experienced physical, emotional or sexual abuse or neglect. Some medical professionals see the act of injection as a form of self-mutilation similar to cutting or slashing the body. It is important for the counsellor to help the client deal with these childhood issues;
- it appears that a person's emotional growth stops when they become addicts as they take more and more drugs to escape facing past and present problems. Drugs provide "relief" from the clients reality so they do not have to feel pain;
- users know how to deal with each other on the streets. It is a very cut and dry approach. However, they do

not deal with everyday events the same way as non-users who expect life to have ups and downs. They simply want a constant state of feeling "good" without having to solve a number of problems;

- to get "clean", most users must leave their world behind. It means leaving their friends (support network) and changing locations (neighbourhoods) to stay on the path to recovery. This is difficult for them;

The Counsellor

- create an environment that does not judge. Be prepared for what might happen. Also make the environment Aboriginal appropriate with posters, art, books and information;
- demand confidentiality. Without trust the client will withhold information or lie;
- if a client relapses and starts using again, it is important to help them understand that "now" may not have been the right time for them to stop using. Counsellors should assure clients that they can try again later when they are better prepared. Always focus on the positive side of things;
- let them know that any time spent "clean" is valuable and that if they did it once, they can do it again;
- dosage- it should be remembered that methadone maintenance treatment comes with many side effects for the clients. Finding the right dosage is important. Too much methadone will make them drowsy or depressed as too little will not stabilize them enough;
- methadone is an addictive substance. The client will eventually need additional support from the physician/ counsellor when they "white knuckle it" to get off the methadone and be completely substance free;
- abuse- many heterosexual men have difficulty discussing childhood sexual abuse. The counsellor should refer them to support groups for men who survived abuse (eg. The Men's Project in Ottawa);
- create bridges between your service organization and others nearby;
- discuss mortality issues with those who are HIV positive. Many will feel death is upon them and that quitting drugs will be pointless since they are "doomed" to die of AIDS related illnesses;
- discuss HIV/AIDS Anti-reteroviral Therapy (HAART) in its relation to methadone. There are various interactions between methadone and drugs used to suppress HIV. There are also interactions with other drugs (eg. high doses of vitamin C might make the methadone client feel high and then agitated);
- discuss holistic healing as the path to wellness (mind, body, spirit);

Pharmacy

- a good pharmacy is absolutely necessary for treatment to be successful. You must find one that sees itself as an extension of the doctor who prescribes the methadone. They should be willing to provide counselling to the client whenever needed. It would be best to have one that is willing to deliver methadone to the client should

he/she be temporarily incarcerated. Each dose is essential to the client's well-being;

Meetings

- some groups see food and drink as a distraction. But many use food and drink as "bait" to get clients into their offices and meeting spaces. It can be done inexpensively and may make a difference for even one person;
- two hours is a maximum time to have clients sit and talk. Have a cigarette break after one hour, but be sure to let them know it is a one-smoke break as some might want to linger in the smoking area;
- conferences like "Opening Doors" in Ganonoque may provide an opportunity for ex-users to meet and build a support network;

Other Issues

- *Condoms*- users should be asked if they are sexually active while using. If so, they need to be prepared by having condoms available to them at all times;
- *Relationships* need to be discussed. Who will the injection drug users hang out with once they get clean? Suggest support groups similar to Alcoholics Anonymous where they feel fellowship and begin creating new support networks;
- *Coping skills* need to be addressed. Most women injection drug users have worked in the sex trade as have many gay or transgender IDU. Some men who identify as heterosexual have also done sex trade work for drugs, though most steal, deal drugs or "muscle" others for a fix.
- *Risks* - many IDU put themselves at greater risk for infections or violence (eg. no condoms, rougher sex) when the money offered for sex is higher.
- *Life skills* - need to be taught to help ex-users make a "plan of action" after they are stabilized.
- *Family issues* - many will have to deal with social service agencies and the courts to get their children back.
- *The Law* - many will have to deal with legal charges once they are stabilized.
- *Volunteering* - encourage ex-users to volunteer at local agencies where they can be helpful to other users and keep in touch with those experiencing similar things.

Harm Reduction in Prisons

The information contained in this section of the manual reflects the efforts of Correctional Services Canada (CSC) to deal with the issue of injection drug use in the Federal Prison system, only. CSC has created a number of programs and services to reduce the transmission of viral infections by drug injection that defines and supports their Harm Reduction philosophy. In contrast, information provided by the Prisoner's HIV/AIDS Support Action Network (PASAN) suggests that current programs and services are not operating as best they could since inmates are still getting infected through the sharing of injection equipment and unsafe sexual practices. The following information talks about the programs and services now in operation as well as those that have yet to be created in Canada's Federal prisons.

People who are sent to jail lose many of their rights. They are still entitled to basic human rights under the Canadian Charter of Rights and Freedoms. Offenders deserve to serve their time in a place that is free from harm. This is not always the case. HIV/AIDS organizations must remind the Government and Prison officials that prisoners have rights and should be given access to all programs that reduce the transmission of deadly viruses.

The phrase "Silence = Death" was very powerful and important to the early community-based AIDS movement. It was a call to action. Unfortunately this phrase is still needed, especially in prisons. *There have always been two cornerstones of the AIDS movement:*

- giving voice to people living with HIV/AIDS; and
- fighting for recognition of human rights and health care needs.

These ideas must include the rights of people living with HIV/AIDS in prison. We need to create services that respond to their needs and institutions that respect prisoner rights. In the past, unless the community-based AIDS movement takes the lead the kind of change we need does not happen. (adapted from *Pros and Cons: A Guide to Creating Successful Community-Based HIV/AIDS Programs for Prisoners*, Rick Lines, 2002, page 13).

Shooting drugs is and will continue to be a problem in the prison system. Even though they are not allowed, drugs that people can shoot find their way into prisons. Even though prison staff try to enforce the rules, many inmates shoot up for the first time while in prison. *There are many reasons for this, for example:*

- Drugs like cocaine and heroin leave the body much faster than marijuana. This means offenders are less likely to test positive in routine urine tests.
- Stimulants and opiates give a quicker, deeper high than marijuana. This kind of high appeals to people who need a "fix".
- Prisons are close quarters where people need to fit in with the inmates who "rule." Many inmates are forced to take part in things they wouldn't usually do. Shooting drugs is one of them.

The reasons for providing harm reduction services in prison are obvious. More and more inmates are getting infected with HIV and Hep C from sharing needles. The prison system does not want to provide needle

exchange programs. They see needles as possible weapons for offenders.

The following is taken from *Pros and Cons: A Guide to Creating Successful Community-Based HIV/AIDS Programs for Prisoners*, by Rick Lines, 2002, page 67.

> "While there is easy access to drugs of all varieties in Canadian prisons, there is no access to clean needles in Canadian prisons. Despite advocacy efforts by prominent community-based organizations and respected medical professionals, no jurisdiction in Canada currently provides sterile syringes for IDU's in custody.
>
> "This creates a scenario where imprisoned IDU's across Canada regularly share injection equipment (commonly referred to as "rigs", "fits", or works") by necessity. It is not uncommon for an institution of five hundred prisoners to have only three or four syringes in circulation. This means that all the IDU's in that institution use those same three or four needles. Given their scarcity, prisoners must use and re-use syringes over and over again for months."

This clearly tells us that we need to work harder to get the prison system to develop needle exchange programs. Until that happens, bleach kits may help reduce the spread of HIV and Hep C. *Other issues that need to be addressed are:*

- methadone maintenance treatment in prisons;
- sexual activity among inmates; and
- community support upon release.

All of these issues are covered in the following sections:

Bleach

A new needle is the best way to avoid HIV and Hep C. Cleaning used needles with bleach is not as good. There is no proof that HIV or the Hep C virus is completely destroyed by bleach. But cleaning needles is still an effective harm reduction activity and may help stop the spread of the viruses. This may be especially true in prisons where a lot of prisoners use only a few needles.

In 1996, the government approved a bleach kit program for all federal penitentiaries. Some people do not support this program because they are afraid bleach may be used as a weapon against prison guards and other prisoners. This means that even though it has been approved, some penitentiaries make it hard to get bleach or refuse to give it out. What people need to remember is that when there isn't a needle exchange program, bleach kits may be the only way we have to keep the virus from spreading.

Some prisons give out watered-down bleach. *In Pros and Cons*, Rick Lines says that "[f]or bleach to be effective, however, the bleach must be full strength, and access to bleach must be consistent and discreet." It also says that this is why some "leading community-based organizations are demanding the provision of 100% full strength bleach (as well as distilled water for rinsing the syringe) in all federal and provincial institutions." The prisons that do give out bleach give it out in small containers throughout the institution. The containers are monitored by staff.

Remember that bleach kits help stop the spread of HIV and Hep C but are not 100% effective. This makes needle exchange programs much more important and valuable.

Condoms

Sex between offenders is much more common than some people believe. Offenders who wouldn't call themselves homosexuals have homosexual sex while inside. This could be because they are isolated in prison and still need human contact. Whatever the reason, people have sex inside and need help to protect themselves from infection.

In many prisons, sex between consenting offenders is against the rules. This makes it much more difficult to run programs that give out condoms, lubricants and dental dams. Offenders without these services are at risk for HIV. Some prisons hand out condoms but they do not do it privately. This keeps many people from using the service. Offenders may be more comfortable taking condoms from prison medical staff than from guards but homophobia in the system often stops them.

Offenders must be able to get condoms from a program that respects privacy. Some people suggest the prison leave condoms in a broom closet, cleaning station or in the private family visiting area. Offenders could pick them up from these places without being seen. Peer counselors who are trusted by other prisoners could also give them out. There are many creative ways to get condoms to prisoners if the right people get together to think about how.

Tattooing

Tattooing is very popular among offenders. A tattoo may show that they belong with a certain group of inmates. It may also be a way to show how they are different from everyone else. Whatever the reason, many offenders get tattoos. The offenders who do the tattooing have honed their craft on their peers.

> "Unlike injection drug use, tattooing is a fully legal activity in Canada. It is an art form that is safe for both artist and customer, provided there is access to proper training and sterile equipment. Despite its legality and broad societal acceptance, tattooing remains a prohibited activity in prisons." (*Pros and Cons: A Guide to Creating Successful Community-Based HIV/AIDS Programs for Prisoners*, Rick Lines, 2002, page 70).

The rules against tattooing have driven the activity "underground." Tattoo artists must work very quickly to get one done. They often re-use the scarce inks and needles to finish the job. This is a problem because it can spread HIV and Hep C from person to person. Tattooing causes a lot of bleeding and unless there is a way to sterilize equipment, many prisoners may be exposed to infected blood. Some community based organizations say that "[a]ll prisons should provide safe tattoo programs, whereby prison tattoo artists may practice their skill in clean environments, with access to professional equipment, and access to proper sterilization and waste disposal facilities." *(Pros and Cons: A Guide to Creating Successful Community-Based HIV/AIDS Programs for Prisoners*, Rick Lines, 2002,

page 71). This is a simple answer to a problem that should not really be a problem.

Methadone Maintenance Treatment (MMT)

Methadone is a successful treatment for heroine and morphine users and it lowers the risk of getting HIV or Hep C. It used to be that someone had to be in a methadone program before going to prison to qualify to get it while inside. This decision was overturned in spring of 2002. Offenders now have the choice to go on methadone as a way to kick their addiction. A drug that prisoners can swallow like methadone is very important because it cuts the risk of infection that comes with shooting drugs. Methadone will help satisfy the offenders' physical and mental need for drugs without the high. It can stabilize them and they are less likely to act out.

Here is an example of how to set up an MMT program.

STEP ONE: *Assessment*

The Corrections methadone program also uses a team approach. The team includes the offender, their parole officer, a doctor and other medical staff in the institution. If an offender wants to get into the methadone treatment program, they have to talk to their parole officer about it first. The parole officer works out the details with the doctor and other medical staff in the prison who will help with treatment.

STEP TWO: *Administration*

Once the offenders' request is approved, they meet with the nurse every day. The nurse gives out the methadone the same as any other medication. The offender also meets with the doctor once a week to make sure the program is working for them. The offender must also have access to programs, education and support while inside. Once they are released, the prison arranges for a local doctor to continue treatment. They also need the programs and support services set up to help them stay on track.

STEP THREE: *Support*

Support is a very important part of the treatment program. People in the program need a supportive network of other people who are on methadone as well as medical staff who care about injection drug use. This will help them stick with the program and maybe help them quit drugs altogether, if that is their goal.

Counselling and Support Outside Prison

Counselling and support services are very important when offenders get out and rejoin mainstream society. A number of programs and services can help make this transition easier. Offenders who are addicted to injection drugs have extra issues and needs. They must know where to go for clean needles, condoms, dental dams, methadone treatment, detoxification programs, and support programs.

Although CAAN supports harm reduction programs, we still promote programs and services that use the abstinence approach. *These programs include:*

- assessment and referral agencies;
- short-term residential facilities;
- long-term residential facilities;
- outpatient programs;
- recovery homes;
- self-help groups; and

- spiritual or religious healing.

There are many differences between people who inject drugs. Each person must be respected "where they are at". Some may not want to, or feel they cannot quit using. Others might be ready to try withdrawal and sobriety. We need a variety of programs and ex-cons need to know where they are.

One important program is peer support. Many ex-offenders are not comfortable in a support group with addicts who have not done time. They feel that their prison history might affect how others look at them. It is very important for them to talk openly about their concerns as a drug user and as someone who is trying to readjust to life outside. This may be even more important to people living with HIV or Hep C who were encouraged not to talk about it while inside. People with HIV have specific issues they need to deal with. They need a group that won't judge them so they can talk about their own mortality and how their addictions may affect their health.

Other

The following is a list of harm reduction initiatives operating in Federal prisons:

- Reception Awareness Program (infectious diseases education/prevention offered to inmates at reception;
- Choosing Health in Prisons (health promotion education, including components on infectious diseases);
- Peer Education and Counselling programs
- National HIV/AIDS Peer Education and Counselling Program
- National HIV/AIDS Peer Education and Counselling Program- Women's Components
- Circle of Knowledge Keepers (Aboriginal Peer Education and Counselling Program);
- Educational materials and brochures on infectious disease transmission and prevention;
- Funding through Canadian Strategy on HIV/AIDS for inmates to organize /develop educational activities/projects which focus on HIV/AIDS;
- Infectious disease information sessions by community organizations; and
- Screening for HIV/AIDS and HCV at admission and throughout an inmate's sentence- testing is often incorporated into special health fairs and health promotion sessions organized by institutions.

FUNDING FOR HARM REDUCTION PROGRAMS

Funding for Harm Reduction work

To prepare this guide, the researcher looked for information about possible funding sources for harm reduction programs. *We found information:*

- through a list serve on the web;
- a catalogue of federal and provincial funders at the local library; and
- the Guide to Canadian Health/Medical Grants 2002/2003.

Most of the funders tell people:

- guidelines to follow as you write your proposal;
- deadlines for applying; and
- contact information.

Some funders will give organizations money to start up a project, and the organization has to look for other funders to continue the program.

List of funding sources:

Edmonton Community Foundation
601 Royal Bank Bldg., 10117 Jasper Ave.,
Edmonton, AB T5J 1W8
(403) 426-0015
Attn.: Mr. Doug McNally, Executive Director

Edwards Family Charitable Foundation
PO Box 29093, Halifax Shopping Centre,
Halifax NS B3L 4T8
(902) 468-8176
Attn.: Ms. Helena D'Entremont, Administrator

Fraser Elliott Foundation
Commerce Court West, Suite 5300,
Toronto ON M5L 1B9
Attn.: Mr. Roy Fraser Elliott, President

Exton Charitable Foundation
Guardian of Canada Tower, Suite 816, 181 University Ave.,
Toronto ON M5M 2X7
(416) 862-8565
Attn.: Mr. Eric Exton, President

George Linsell Foster Foundation
c/o Sanders and Cline, PO Box 70, 14 Southwick St.,
St. Thomas, ON N5P 3T5
(519) 633-0800
Attn.: Mr. E. Frank Sanders, Q.C., President

Gelmont Foundation
1 Place Ville-Marie, Bureau 1901,
Montreal QC H3B 2C3
(514) 487-1353
Attn.: Mr. Nahum Gelber, President

Thomas And Beatrice Gilroy Trust For Charitable Fund
National Trust Company, 666 Burrard St.,
Park Place Tower,
Vancouver BC V6C 2Z9
(204) 947-0281

Good Foundation Inc.
R.R. #2, Breslau ON N0B 1M0
(519) 648-2823
Attn.: Mr. James M. Good, Secretary

Abraham And Malka Green Charitable Foundation
20 Eglinton Ave. West, Suite 1600,
Toronto ON M4R 2H1
(416) 487-3883
Attn.: Mr. Abraham J. Green, President

Health Canada
4th Floor, Jeanne Mance Building, Tunney's Pasture,
Ottawa ON K1A 1B4
Address Locater: 1904A3
Tel: (613) 954-8549; Fax: (613) 954-7363;
Email: nhrdpinfo@ISDTCP3.hwc.ca

Martha Lou Henley Charitable Foundation
PO Box 49390, 1055 Dunsmuir St.,
Vancouver BC V7X 1P3
Attn.: Ms. Mary Lou Henley, President

The Foster Hewitt Foundation
c/o Dixon Management Services, PO Box 1090, 34 Weatherstone Court,
Niagara-on-the-Lake ON L0S IJ0
(905) 468-5858
Attn.: Mr. F.W.A. Hewitt, President

The Hope Charitable Foundation
c/o National Trust Co., One Financial Place, 1 Adelaide St. East,
Toronto ON M5C 2W8
(416) 361-4096
Attn.: Mr. David R. Windeyer, Treasurer

Donald F. Hunter Charitable Foundation
Aldermines Corp., 130 Adelaide St. W., Suite 2060,
Toronto ON M5H 3P5
Attn.: Mr. Donald H. Hunter

Nelson Arthur Hyland Foundation
45 St. Clair Ave. West, Suite 601,
Toronto ON M4V 1K9
(416) 920-6010
Attn.: Mr. Gerald F. Hayden, Jr., President

Imperial Oil Charitable Foundation
111 St. Clair Ave. W.,
Toronto ON M5W 1K3
1-800-668-3776
Attn.: Mr. John Zych, Secretary

Norman And Margaret Jewison Charitable Foundation
20 Queen Street West, Suite 2700, Box 27,
Toronto, ON M5H 3S1
(416) 923-8580
Attn.: Ms. Elizabeth Broden, Assistant

Lorne And Evelyn Johnson Foundation
2400-13th Ave.,
Regina SK S4P 0V9
(306) 586-0944
Attn.: Mr. Douglas Edward A. Lee, Executive Director

The Kahanoff Foundation
4206-400 3rd Ave. SW,
Calgary AB T2P 4H2
Attn.: Mr. James B. Hume, President

Stuart Ross And Lillian Marie Kelly Foundation
88 Nelson St., Brantford, ON N3T 2N1
Attn.: Dr. Robert Farley, Secretary

The Manuel And Eva Kimel Foundation
76 Miranda Ave., Toronto, ON M6E 5A1
(416) 785-1400
Attn.: Mr. Manuel Kimel

Justin And Elisabeth Lang Foundation
PO Box 518, Port Hope, ON L1A 3Z4
(416) 504-8922
Attn.: Mr. Robert Lang, President

The Moe Levin Family Foundation
15 Windsor St., Westmount, QC H3Y 2L7
(514) 486-0264
Attn.: Mr. Moe Levin, President

Samuel And Rose Levy Charitable Foundation
91 Scollard Street, Toronto, ON M5R 1G4
Attn.: Mr. Gary Bluestein, President

Kathleen Meek Foundation
RR#5, S-12, C-35, Gibsons, BC V0N 1V0
(604) 922-0442
Attn.: Ms. K.N. Meek

T. Donald Miller Foundation
45 St. Clair Ave. West, Suite 801,
Toronto ON M4V 1K9
(416) 920-6010
Attn.: Mr. Gerald F. Hayden, Q.C., President

The Minerva Foundation
PO Box 47079, 62 Edmonton Centre,
Edmonton, AB T5J 4N1
(403) 420-6666
Attn.: Mr. Douglas O. Goss, President

The Minnedosa Foundation
PO Box 1289, Minnedosa, MB R0J 1E0
(204) 867-3728
Attn.: Ms. Gwen Hoffman, Secretary-Treasurer

Austin S. Nelson Foundation
310-4209-99th St., Edmonton, AB T6E 5V7
Attn.: Mrs. Dorothea Nelson, President

Nickle Family Foundation
Office #401, Highstreet House,
933-17th Ave. SW,
Calgary, AB T2T 5R6
(403) 244-4237
Attn.: Mr. Samuel Wm. Aylesworth, CEO

The Senator Norman M. Paterson Foundation
PO Box 664, Thunder Bay, ON P7C 4W6
Attn.: Mr. Donald C. Paterson, President and Secretary-Treasurer

The Carol And Morton Rapp Foundation
10 Guildwood Parkway, Suite 229B,
Scarborough, ON M1E 5B5
Attn.: Mr. Morton Rapp, President

RBC Dominion Securities Foundation
P.O. Box 50 Royal Bank Plaza,
Toronto, ON M5J 2W7
(416) 864-4367 Attn.: Michael Sharpe

The Arcangelo Rea Family Foundation
20 Cadeau Terrace, Unit 23,
London, ON N6K 4G2
Attn.: Ms. Juliann Good, Director

Royal Bank Of Canada Charitable Foundation
200 Bay Street, 9th Floor,
Toronto, ON M5J 2J2
(514) 874-2362
Attn.: Mr. David Grier, Executive Director

Royal Lepage Charitable Foundation
39 Wynford Drive, Suite 400,
Toronto, ON M5E 1S9
(416) 510-5882
Attn.: Mr. George J. Cormack, President

The Saint John Foundation
PO Box 6549, Station A,
Saint John, NB E2L 4R9
Attn.: Mr. John F. McCrossin, Treasurer

The John A. Sanderson and Family Trust
c/o Canada Trust, 20 Eglinton Ave. West,
Toronto, ON M4R 2E2
(519) 758-2631
Attn.: Mr. Paul Read

The Saskatoon Foundation
308 4th Ave N, Suite 102,
Saskatoon, SK S7K 2L7
(306) 665-1766
Attn.: Ms. Darlene Bessey, Executive Director

The Lewis and Ruth Sherman Charitable Foundation
865 Danforth Place,
Burlington, ON L7T 1S2
(905) 522-9082
Attn.: Mr. Lewis Sherman, President

The Victor And Rhoda Shields Charitable Foundation
114 Dunvegan Rd., PH #1,
Toronto, ON M4V 2R1
(416) 486-9876
Attn.: Mr. Victor Shields, President and Secretary

Carolyn Sifton Foundation Inc.
c/o McCarthy Tetrault, PO Box 48, TD Tower,
Toronto, ON M5K 1E6
(416) 601-7579
Attn.: Mr. G.P.H. Vernon, Q.C., Vice President

Denise et Guy St-Germain Fondation
48 rue Robert,
Outremont, QC H3S 2P2
Attn.: Mr. Guy St.-Germain, Trustee

Thunder Bay Foundation
PO Box 824, Station F,
Thunder Bay, ON P7C 4X7
(807) 683-3609
Attn.: Mr. Ed Gravelle, Executive Secretary

Winberg Foundation
44 Eglinton Ave. West, Suite 400,
Toronto, ON M4R 1A1
(416) 483-3400
Attn.: Mr. Milton Winberg, President

301-161 Portage Avenue E.,
Winnipeg, MB R3B 0Y4
(204) 944-9474
Attn.: Mr. Dan H. Kraayeveld, C.A., Executive Director

HARM REDUCTION POLICY DEVELOPMENT

Harm Reduction Policy Development

Develop policy for your harm reduction programs that reflect the interests and methods of all programs within your organization. Once you have drafted policy around all aspects of your new program, send copies to your Board of Directors and appropriate staff members to review and comment on. Revise according to the suggestions and have it approved by the Board. Inform all staff members who will be directly working in the program that they must read and abide by the set policy. Update as necessary based on changing needs of the environment (ie. Safe injection sites).

Following, are two examples of harm reduction policy. You may review and adapt to your own program. Please note that these are simply templates to help you get a start on what items you will need to address for policy development. You may also find other samples of harm reduction policy on the web. Simply type "harm reduction" policy and enter. Many examples will come up for your information.

SAMPLE ONE

Alberta Alcohol and Drug Abuse Commission

POLICY ON HARM REDUCTION
December 2001

POLICY STATEMENT

The Alberta Alcohol and Drug Abuse Commission (AADAC) recognizes the value of harm reduction as one approach along a continuum of interventions that address the prevention and treatment of substance abuse and problem gambling. Consistent with the Commission's mandate, AADAC will provide programs and services that reduce the risks and consequences of addiction or harmful involvement with alcohol, other drugs and gambling.

CONTEXT

1. AADAC accepts the following definition of harm reduction: A policy or program directed toward reducing or containing the adverse health, social and economic consequences of alcohol, other drug use and gambling without necessarily requiring a reduction in consumption or abstinence from substance use or gambling.[1]

2. The idea of reducing the harms associated with alcohol, other drug use and gambling is neither a new concept nor an alternative approach. Instead, it has emerged as an extension of existing and accepted public health practices (i.e., secondary prevention with high-risk groups).

3. A harm reduction approach accepts that, within society, a continuing level of substance use (i.e., alcohol, other mood-altering drugs, tobacco) and gambling is inevitable. Therefore, harm reduction strategies focus on reducing or containing the negative consequences of substance use and gambling. The harm addressed can be related to health, social, economic or other factors that adversely affect the individual, community, and society as a whole. Negative consequences can be the direct result of use or may arise as an indirect consequence of efforts to deter alcohol, other drug use, and gambling through the enforcement of laws and regulation of behaviour.

4. The first priority of harm reduction is to actively engage individuals, target groups, and communities to address their most pressing health and safety needs. From this perspective, persons with alcohol, other drug, or gambling problems are treated respectfully as legitimate members of the community who need help, and who share in the responsibility to find solutions to the problems associated with substance use and gambling.

5. Harm reduction is complementary to the abstinence model of addiction treatment. While harm reduction emphasizes a change to safer practices or patterns of use, it does not rule out a longer-term goal of abstinence—should the individual decide to pursue it.

[1] *AADAC EXC Position on Harm Reduction* (May 1999). Adapted from: *Canadian Centre on Substance Abuse* (CCSA), National Working Group on Policy (1997). *Harm reduction: Concepts and practice* (p. 2), Ottawa: CCSA.

6. Although many of its proponents advocate some type of drug policy reform, harm reduction is not the same as legalization or decriminalization.

PRINCIPLES FOR ACTION

Harm reduction is part of a multidimensional response to substance abuse and problem gambling that includes addiction prevention and treatment, supportive public health and social policies, research and evaluation. Harm reduction does not offer a simple solution to the complex problems that can arise for individuals and communities because of substance use or gambling. AADAC delivers prevention, treatment and information services for alcohol and other drug abuse and problem gambling. Harm reduction strategies within these service areas are consistent with AADAC's mandate and responsibility to support population health.

Prevention

AADAC will deliver quality prevention and education programs that (1) prevent the development of alcohol, other drug and gambling problems, and (2) increase protective factors and reduce risk factors clearly associated with addiction.

The Commission will support community harm reduction activities or undertake targeted intervention strategies aimed at reducing the immediate health and safety risks associated with substance use and gambling. AADAC believes that harm reduction initiatives play an important role in offering substance users and gamblers support and access to other health, social, and community services, including addiction treatment.

Treatment

AADAC will deliver treatment programs and services that promote health recovery among those persons affected by problems related to substance use or gambling. In the context of addiction treatment, AADAC promotes abstinence as the most appropriate goal for dependent clients, and the Commission views harm reduction as complementary in initiating action toward this objective.[2] AADAC takes a client-centered approach to treatment. Recognizing that not all dependent clients will choose abstinence as a treatment goal, the Commission will provide comprehensive assessment and match individual clients to appropriate program options.

Information

AADAC will provide the public, the media, and clients with current and accurate information about harm reduction, especially when working to address the needs of particular groups such as youth, injection drug users, or prison populations.

Joint Initiatives

The Commission works with individuals and communities to develop and provide addiction prevention, treatment and information services that minimize the negative consequences of substance use and gambling. AADAC believes collaborative strategies must reflect the characteristics and needs of target groups, and should engage the genuine support of all those with a stake in the issue; individuals who gamble or use alcohol and other drugs, community groups, policy makers, health professionals, social service providers, law enforcement agencies, and the judicial system.

[2] *AADAC EXC Position on Abstinence* (May 1999).

Research
Harm reduction initiatives, like other AADAC programs and services, will be based on sound research and current best practices in the addiction field. AADAC will support the systematic monitoring and evaluation of harm reduction strategies and the dissemination of research results in order to advance professional knowledge and improve service delivery.

Adopted: January 23, 1998 (Position on Harm Reduction)
Adopted: February 11, 2000
Amended: December 7, 2001
Review: 2004

SAMPLE TWO

ACT's Harm Reduction Policy

The AIDS Committee of Toronto (ACT) affirms a policy of harm reduction in the delivery of education, support and advocacy programs and services.

In adopting harm reduction, ACT is committed to service provision for drug users that is pragmatic, respectful, collaborative, non-judgmental and affirmative of choice. ACT affirms that its services are not conditional upon drug and alcohol abstinence. However, we recognize that drug or alcohol may, at times, be a barrier to an individual benefiting fully from a service. ACT staff and volunteers will engage individuals in these situations as much as possible given any limitations.

Harm reduction is both a philosophy and a set of strategies to reduce health risks associated with drug use. Its underlying rationale is that the risk of HIV transmission and infection is a greater harm to a person's health than drug use. Its priority is to minimize the negative consequences related to drug use rather than reduce the prevalence of drug use.

Harm reduction:

- acknowledges that there is a continuum of risk involved in injection drug use, such as:
  - ≈ sharing used needles,
  - ≈ cleaning needles and works between use,
  - ≈ switching from injection drug use to non-injection drug use, and
  - ≈ abstaining from drug use.
- promotes any movement on the continuum of risk that reduces risk, therefore, abstaining from drug use is not the only acceptable goal.
- supports drug users to reduce their risk of HIV as much as possible.
- recognizes and accepts that not every drug user will choose to or be able to abstain entirely from drug use.
- supports the drug user to make informed decisions about what harms associated with drug use he or she is willing to address and how.
- supports a variety of strategies for decreasing the harms associated with drug use, such as:
  - ≈ needle exchanges/clean needles distribution;
  - ≈ cleaning supplies to decrease the risk of HIV transmission;
  - ≈ using methadone to replace heroin; and
  - ≈ adequate treatment programs (both reduction and abstinence based) available for drug users who seek this as an option.
- addresses larger social issues which have an impact on drug use and services for drug users:
  - ≈ confronting the stigma associated with drug use through community education, particularly to social service providers and the police and through advocacy.
  - ≈ advocacy for social change - that drug use be viewed as a health issue, not a criminal issue.

Other Web Sites

1) www.harmreduction.org/issues/policy
2) www.dph.sf.ca.us/harmreduction/HarmReducPolProc.htm
3) www.ccsa.ca/docs/wgharm.htm

LISTING OF NEEDLE EXCHANGE AND HARM REDUCTION PROGRAMS

Listing of Needle Exchange and Harm Reduction Programs

Mainline Needle Exchange
2158 Gottingen Street
Halifax, NS, B3K 2B0
(902) 423-9991

Exchange Works
Halton Region Health Department
Burlington, ON
(905) 330-3305
E-mail: Cecil McDougall:
mcdougallc@region.halton.on.ca

Eastern Ontario Health Unit
Needle Exchange Program
Cornwall, ON
(613) 930-3125

Wellington Dufferin Guelph Health Unit
Harm Reduction Outreach Worker
Guelph, ON
(519) 821-2370

Counterpoint Needle Exchange& Methadone Clinic
AIDS Committee of London
Suite 120, 388 Dundas St
London, ON N6B 1V7
(519) 434-1601
www.aidslondon.com

Four Counties Needle Exchange Coalition
Peterborough, ON
(705) 749-9110

Lambton Health Unit, Needle Exchange Program
Point Edward, ON
(519) 383-8331 ext. 450
lambhlth@ebtech.net

Superior Points Harm Reduction Program
Thunder Bay, ON
(807) 624-2005

The Works
Toronto Public Health
277 Victoria St MN FL
Toronto, ON M5B 1W1
(416) 392-0520

Harm Reduction Program
Lawrence Heights CHC
Toronto, ON
(416) 787-1661

Street Health
AIDS Awareness and Harm Reduction
Outreach Program
Toronto, ON
(416) 964-2459

Queen West Community Health Centre
Harm Reduction Programs
Toronto, ON
(416) 703-8482, ext 120

Street Connections
886 Main Street
Winnipeg, MB R2W 3N8
(204) 582-2311

All Nations Hope AIDS Network
Scotia Bank Building, 1504B Albert Street
Regina, SK S4P 2S4
(306) 924-8427

HIV/STD Health Nurse
Tillicum Haus Native Friendship Centre
927 Haliburton St.
Nanaimo, BC V9R 6N4
(250) 753-6578
tillicum_hivstd@home.com

PHA Contact (Needle exchange)
ANKORS, West Kootenay Boundary
AIDS Network, Outreach and Support
Society
101 Baker Street
Nelson, BC V1L 4H1
(250) 505-5506
1 (800) 421-AIDS
info@ankors.bc.ca
www.ankors.bc.ca

Aboriginal AIDS Service Organizations

NOVA SCOTIA

AIDS Coalition of Nova Scotia
Suite 321, 1657 Barrington Street, The Roy Building
Halifax, NS B3J 2A1
(902) 429-7922
1 (800) 566-2437
acns@acns.ns.ca
www.acns.ns.ca

Healing Our Nations
45 Alderney Drive, Suite 607
Dartmouth, NS
(902) 492-4255
1 (800) 565-4255
Fax: 902 492-0500

NEW BRUNSWICK

AIDS New Brunswick
65 Brunswick St.
Fredericton, NB E3B 1G5
(506) 459-7518
1 (800) 561-4009
sidaids@nbnet.nb.ca
www.aidsnb.com

AIDS St. John
Medical Arts Bldg.
115 Hazen Street
St. John, NB E2L 3L3
(506) 652-2437
www.sjfn.nb.ca/community_hall/A/aidssj.html

HIV Clinic, Moncton Hospital
135 MacBeath Ave.
Moncton, NB E1C 6Z8
(506) 857-5596

Sexual Health Center
860 Main Street, 3rd Fl.,Suite 303
Moncton, NB
(506) 869-6954
maria.richard@gov.nb.ca

PRINCE EDWARD ISLAND

AIDS PEI
85 Water Street,
Charlottetown, PEI. C1A 1A5
www.aidspei.com

AIDS PEI Community Support Group
199 Grafton St.
Charlottetown, PEI C1A 1L2
(902) 566-2437

QUEBEC

Bureau regional d'action sida
109, rue Wright, Suite 03
Hull, PQ J8X 2G7

Coordonnatrice clinique
Dopamine
55 Des Pins
LaPrairie, PQ
(514) 251-8872
guylene.desjardins@videotron.ca

Fondation Menard Parisien
267, avenue Quintal
Lavel, PQ H7N 4W4

Sida Vie Laval
90, boul. Levesque est
Laval, PQ H7G 1B9

AIDS Community Care Montreal/Sida benevoles Montreal
2075, rue Plessis, Niveau sous_sol
Montreal, PQ H2L 2Y4
(514) 527-0928
www.accmontreal.org

AIDS Intervention Centre - CLSC Metro
1801 de Maisonneuve West, 4th Floor
Montreal, PQ H3H 1J9

CAP Sida Monteregie
462, boul. Sainte_Foy
Longueuil, PQ J4J 1Y2

Agent D'Information
Comite des personnes atteintes du VIH du Quebec (CPAVIH)
2075, rue Plessis
Bureau 310
Montreal, PQ H2L 2Y4
1 (800) 927-2844
cpavih.general@arobas.net
www.cpavih.qc.ca

Fondation d'aide directe sida Montreal
1442, rue Panet
Montreal, PQ H2L 2Z1

Chez Ma Cousine Evelyn
3702 Ste. Famille
Montreal, PQ   H2X 2L4
(514) 288-7244

COCQ-SIDA
1 Sherbrooke est
Montreal, PQ H2X3V8
(514) 844-2477 Ext 28
hendricks.cocqsida@websos.org
Project Coordonator

Dopamine
4560 Adam
Montréal, PQ H1V 1V2 (514) 251_8872
beaulieu_maryse@hotmail.com

Centre des ROSES Abitibi_Temiscamingue
380, rue Richard Bureau 220
Rouyn_Noranda, PQ J9X 4L3
(819) 764-9111
1-(800) 783-9002
centre-r.o.s.e.s@cablevision.qc.ca
www.cablevision.qc.ca/centredesroses

SIPE Lanaudiere
80, rue Wilfrid_Ranger
St_Charles Borromee, PQ J6E 8M
(514) 752-4004
sipe@sympatico.ca

Sidaction Trois_Rivieres Inc.
CP 1142
Trois_Rivieres, PQ G9A 5K8
(819) 374-5740

ONTARIO

Sexual Health & Communicable Disease, Region of Peel
Health Department
Brampton, ON
(905) 791-7800

AIDS Education Services
Cornwall, ON
(315) 769-5691
gyaid@gisco.net

Wesley Urban Ministries and Social and Public Health Services
Hamilton, ON
(905) 546-3597

HIV/AIDS Regional Services
Kingston, ON
(613) 545-3698
hars@kingston.net
www.1.kingston.net/~hars/

ACCKWA- Kitchener Waterloo and area AIDS Committee of Cambridge
Kitchener, ON
(519) 570-3687 or 1-(888) 689-2178
www.acckwa.com

Peel HIV/AIDS Network
77 Queensway, West, suite 101
Mississauga, ON
(905) 896-8700
peelworks@phan.ca

AIDS Committee of North Bay and Area (ACNBA)
240 Algonquin Avenue, Suite 202
North Bay, ON, P1B 4V9
Phone (705) 497-3560
Fax (705) 497-7850
www.aidsnorthbay.com

AIDS Committee of Durham
Oshawa, ON
(905) 576-1445
www.aidsdurham.com

Canadian HIV/AIDS Clearing House, Canadian Public Health Association (CPHA)
Ottawa, ON
(613) 725-3434
aidssida@cpha.ca
www.clearinghouse.cpha.ca

National Distributor of HIV/AIDS information; loaning library with 18,000 titles. Reference and referral services and development of HIV prevention information.

University of Ottawa Health Services
Ottawa, ON
(613) 564-3950

AIDS Committee of Ottawa
Ottawa, ON
(613) 238-5014
aco@netrover.com
www.theaco.on.ca

Bruce House
312 Parkdale Ave.
Ottawa, ON
(613) 729-0911

Centre for Addiction & Mental Health
Sault Ste. Marie, ON
(705) 256-2226

AIDS Niagara / Outreach Co-ordinator
St. Catherines, ON
(905) 984-8684

AIDS Committee Of Regional Niagara (ACORN)
St. Catherines, ON
(905) 984-8684

AIDS Committee of Sudbury
Sudbury, ON
(705) 688-0500
1 (800) 465-2437

AIDS Committee of Thunder Bay
Mail : P.O. Box 24025,
Thunder Bay, ON P7A 8A9
In Thunder Bay: 345-1516
Toll free: 1-800-488-5840 (Within 807 area code)
Fax: (807) 345-2505
Street Address :
217 South Algoma Street (Algoma and Cornwall)

Thunder Bay, ON P7B 3C3
actb@tbaytel.net
www.tbaytel.net/actb/

Sister Margaret Smith Centre
Thunder Bay, ON
(807) 343-2400

AIDS Committee of Toronto (ACT)
Toronto, ON
(416) 340-2437
ask@actoronto.org
www.actoronto.org

Ontario HIV Treatment Network
Toronto, ON
(416) 642-6486
(877) 743-6486
info@ohtn.on.ca
www.ohtn.on.ca

Casey House Hospice
Toronto, ON
(416) 962-7600, ext. 225

Progress Place, Double Recovery
Toronto, ON
(416) 323-0223

Toronto Public Health, East Region
HIV/AIDS Prevention Program
Scarborough, ON
(416) 396-5275

Toronto Western Hospital Addiction Program
892 Dundas St. W.
Toronto, ON M6J 1W1
(416) 603-5800, ext. 2796

Hostel Outreach Program
Toronto, ON
(416) 482-4003, ext. 240

Prisoners With HIV/AIDS Support Action Network (PASAN)
Toronto, ON
(416) 920-9567

Ontario Aboriginal HIV/AIDS Strategy
14 College Street, 4th Floor
Toronto, ON M5G 1K2
(416) 944-9481
1-800-743-8851
Fax: 416-944-0501

Canadian Harm Reduction Coalition
23 Hillsview Ave.
Toronto, ON M6P 1J4
(416) 604-1752
www.ihra.org.uk

Central Neighbourhood House
Street Survivors Programme
Toronto, ON
(416) 891-4171

519 Church Street Community Centre
Toronto, On
(416) 392-6878

COPA Community Outreach Program In Addictions
Toronto, On
(416) 516-2982, ext. 222

MANITOBA

Addictions Foundation of Manitoba
1031 Portage Ave.
Winnipeg, MB R3G 0R8
(204) 944-6243

Nine Circles Community Health Centre
705 Broadway Avenue
Winnipeg, MB R3G 0X2
(204) 940-6000
http://www.ninecircles.ca

SASKATCHEWAN

File Hills Qu'Appelle Tribal Council
Health Educator
3rd Floor, Fort Qu'Appelle Indian Hospital
Box 985
Fort Qu'Appelle, SK
(306) 332-8295

AIDS Programs South Saskatchewan
Scotiabank Building, 1504 B Albert Street
Regina, SK S4P 2S4
(306) 924-8420, ext. 8425

Provincial Strategy Team on HIV/BBP and IDU
Saskatchewan Health
3475 Albert St.
Regina, SK S4S 6X6
(306) 787-6333

All Nations Hope AIDS Network
Scotia Bank Building, 1504B Albert Street
Regina, SK S4P 2S4
(306) 924-8427

AIDS Saskatoon
Box 4062
Saskatoon, SK S7K 4E3
(306) 242-5005
(800) 667-6876
aids.saskatoon@home.com
http://members.home.net/aids.saskatoon

ALBERTA

Aventa Addiction Treatment for Women
2005 10th Avenue Southwest
Calgary, Alberta T3C 0K4
Phone (403) 245-9050
Fax (403) 245-9485
www.aventa.org

Society Housing AIDS Restricted Persons
#530, 23012 17th Avenue SE
Calgary, AB T2A 0P9
(403) 272-2912
sharp@canuck.com
thesharpfoundation.com

AIDS Calgary
200, 1509 Centre Street South
Calgary, AB
(403) 508-2500

Aboriginal Youth Network
Box 34007 Kingsway PO
Edmonton AB T5G 3G4
Phone: (780) 459-1058 or 1-866-459-1058
Fax: (780) 419-7266
siteadmin@ayn.ca
http://www.ayn.ca

Hobbema Indian Health Services
(403) 585-3830
Fax: 403-585-2203
Alberta Alcohol and Drug Abuse Commission
803 10909 Jasper Avenue
Edmonton, AB T5J 3L7
(780) 427-6526

Edmonton Persons Living with HIV Society:Living Positive
#703, 10242- 105 Street
Edmonton, AB   T5J 3L5
(780) 488-5768
(877) 975-9448
livepos@telusplanet.ca
www.connect.ab.ca/~livepos/"

Aboriginal Support Services
HIV Edmonton
#600, 10242, 105 Street
Edmonton, AB   T5K 3L5
(780) 488-5742
Fax: 780-488-3735
www.hivedmonton.com

Alberta Drug Harm Reduction Society
PO Box 82012, RPO Yellowbird
Edmonton, AB
peebles@powersurfr.com

Visions Centre for Innovation
Box 34007 Kingsway Mall PO
Edmonton, AB   T5G 3G4
Phone: (780) 459-1884
Fax: (780) 458-1883
http://www.visions.ab.ca/

AIDS Jasper
P.O. Box 2427
Jasper, AB T0E 1E0
(780) 852-5274
aidsjasp@incentre.net

Lethbridge HIV Connection
1206 6th Ave South
Lethbridge, AB   T1J 1A4
(403) 328-8186
lethhiv@telusplanet.net

HIV/AIDS Network of Southeastern Alberta Association
550C Allowance Avenue SE
Medicine Hat, AB T1A 3E3
Tel: (403) 527-7099
Fax: (403) 527-7307
hivnetwork@hivnetwork.ca
www.memlane.com/nonprofit/aidsmh

Central Alberta AIDS Network Society
#203, 5000 50th Avenue
Red Deer, AB
1-877-346-8858 (in Alberta)
(403) 346-8858
(403) 391-8140
caans@telusplanet.net

CAANS/ACCH
#203, 5000 50th Avenue
Red Deer, AB T4N 6C2
(403) 346-8858

BRITISH COLUMBIA

Regional HIV/AIDS Awareness Coordinator
P.O. Box 713
Dawson Creek, BC
(250) 782-9174
lorieabdai@hotmail.com

AIDS Society of Kamloops
PO Box 1064
Kamloops, BC V2C 6H2
(250) 374-7192
email: ask@telus.net
website: www.aidskamloops.bc.ca

New Westminster Needle Exchange, New Westminster Public
Health Unit
537 Carnarvon St.
New Westminster, BC V3L 1C2
604-777-6740
heatherwinnichuk@sfhr.hnet.bc.ca

AIDS Prince George
#1, 1563 2nd Avenue
Prince George, BC V2L 3B8
(250) 562-1172
aidspg1@pgweb.com

Social Worker, Gilwest Clinic
Richmond Health Services
7000 Westminster Highway
Richmond, BC V6X 1A2
(604) 278-9711, ext. 4193
alzwiers@rhss.bc.ca

Needle Exchange Coordinator
ANKORS
Box 83
Robson, BC
(250) 505-5506
alexander@ankors.bc.ca

Community Development Manager
Metis Family Services
10615 King George Hwy
Surrey, BC V3T 2X6
(604) 584-6621
michel@metisfamilyservices.com

BC Women's Hospital
Vancouver, BC V6H 1N9
cherylparsons@hotmail.com

AIDS Vancouver
1107 Seymour Street
Vancouver, BC V6B 5S8
(604) 681-2122
av@parc.org
www.aidsvancouver.bc.ca

Environmental Youth Alliance
PO Box 34097, Station D
Vancouver, BC V6J 4M1
(604) 689-4446
noxmadima@yahoo.com

DEYAS Downtown Eastside Youth Activities Society
32 East Hastings
Vancouver, BC V6A 1P7
(604) 251-7615

BC Persons with AIDS Society
1107 Seymour Street
Vancouver, BC V6B 5S8
(604) 681-2122
bcpwa@parc.org
www.bcpwa.org

Peter AIDS Foundation, University of Victoria
2665 Carolina Street
Vancouver, BC V5T 359
(604) 619-2312
tkerr@intergate.bc.ca

HIV+ Chairperson, DTES HIV/IDU Consumers' Board
105, 177 East Hastings Street
Vancouver, BC V6A 1N5
(604) 688-6241
cnsbd@direct.ca

AIDS Vancouver Island
304, 733 Johnson Street
Victoria, BC V8W 3C7
(250) 384-1345
info@avi.org

John Howard Society of BC
#7, 475 Head Street
Victoria, BC
(250) 361-1551
wbjhsbc@islandnet.com

Victoria AIDS Respite Care Society
2002 Fernwood Road
Victoria, BC V8T 2Y9
(250) 388-6220
varcs@islandnet.com
www.varcs.org

YUKON

Blood Ties Four Directions Centre
4203F 4th Ave.
Whitehorse, YK Y1A 1K1
(867) 633-2437
Fax: 867-633-2447

NORTH WEST TERRITORIES

Consultant, Reproductive Health,
Health Promotion Unit, Population Health
Division
Health and Social Services, NWT
Box 1320 CST 7
Yellowknife, NT X1A 2L9
(867) 876-7051
lonahegeman@gov.nt.ca

How we put together this manual

Phase II is guided by a national steering committee. *Members of the committee include:*

- Aboriginal people living with HIV/AIDS;
- people who teach and do research in universities; and
- work in AIDS service organizations.
- An Aboriginal researcher is responsible for this project.

To find out about harm reduction used in Aboriginal communities, the researcher developed a survey. The survey asked people about the challenges and successes of harm reduction programs. It also tried to find out where Aboriginal people go to find programs and services that use harm reduction.

The researcher analyzed the information gathered from the survey. *The researcher also looked at:*

- current literature on harm reduction;
- studies on harm reduction; and
- policies of regional harm reduction activities.

The researcher used this information to write a draft guide to Aboriginal Community Based Harm Reduction.

Research Methodology

The first step in gathering information about harm reduction activities was developing the survey. The researcher, the academic advisor and national steering committee members all contributed to this process. Harm reduction is a fairly new idea. Finding the right questions to ask was a complicated process because different people have different ideas about what harm reduction means. The survey had to allow for information coming from organizations that have been developing harm reduction programs for some time and ones that are just starting this work. The survey was finalized after many discussions and revisions.

Survey

The purpose of the survey was to:

- identify harm reduction programs and services for Aboriginal injection drug users throughout Canada;
- give the researcher a way to develop a list of activities to talk more about in telephone interviews;
- find out what the barriers are to successfully starting and running harm reduction programs and services; and
- help meet the objectives of Phase II.

The survey was 6 pages long. It covered 8 different areas:

- what groups of people the organization serves;
- the organization's vision for their harm reduction programs and services;
- what the organization knew about harm reduction;
- what harm reduction activities the organization used;
- how their programs were designed and run;
- advocacy;
- traditional teaching and healing; and
- who their funders were.

Each section asked people to talk about their knowledge or experience and any barriers they came across.

Respondents

The people who responded to the survey were from many different organizations:

- HIV/AIDS Service Organizations;

- Aboriginal Social Service Organizations;
- Needle Exchange Programs;
- Public Health Units;
- Health Canada;
- Native Alcohol and Drug Abuse Programs;
- Provincial Addictions Foundations;
- Native Reserve Communities; and
- Correctional Services Canada.

Returns and Data Analysis

We think that 242 of the 264 surveys we sent out got to the right person. Forty-eight (48) were returned to the CAAN office. The small number of returned surveys tells us that there are not enough programs and we need to educate Aboriginal service providers about drug use issues.

The information we got from the returned surveys was enough to meet the objectives of our project. We found out about a number of programs and services. The responses helped us begin to gather information on how to set up harm reduction programs.

Follow up Calls

The researcher was able to find out which organizations could provide more information about their programs. We contacted three needle exchange programs.

It was harder to get information about methadone maintenance treatment programs. No community we contacted has methadone treatment as part of their programs and services. Instead, they refer people to methadone programs in other places. We contacted one of the responding prisons to discuss their methadone program. The researcher talked to the Addictions Research Foundation in Toronto about setting up methadone programs in urban and rural communities.

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The Red Road: Pathways to Wholeness, An Aboriginal Strategy for HIV and AIDS in BC, prepared by the B.C. Aboriginal HIV/AIDS Task Force.

Harm Reduction: Concepts and Practice, A Policy Discussion Paper, Canadian Centre on Substance Abuse, 1996.

Harm Reduction: Defining Our Approach, Healing Our Nations: Atlantic First Nations AIDS Network, May 2001.

The Harm Reduction Model, Diane Riley, Harm Reduction Network Printing, 1996.

Hepatitis C, Your Personal Health Series, HIV, AIDS and Injection Drug Use: A National Action Plan, sponsored by the National AIDS Strategy in collaboration with Canada's Drug Strategy, Health Canada, May 1997.

Injection Drug Use and HIV/AIDS: Legal and Ethical Issues. Montreal: The Network, 1999.

The Legality of Syringe exchanges in Ontario: Comments to the Toronto Board of Health, October 4, 1990, Diane Riley.

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Prince Albert Seroprevalence and Risk Behaviour Survey: Seroprevalence of HIV, Hepatitis B, Hepatitis C and High Risk Behaviours Among Injection Drug Users and their Sexual Partners, prepared by Prince Albert Health District and Saskatchewan Health, 1998.

Profile of Injection Drug Use in Atlantic Canada, prepared by Caroline Ploem for PPHB Atlantic Regional Office, October 12, 2000.

Pros and Cons: A Guide to Creating Successful Community-Based HIV/AIDS Programs for Prisoners, Rick Lines for the Prisoner's HIV/AIDS Support Action Network (PASAN), 2002.

Recommendations Concerning AIDS and Drug Use in Prisons: A Harm Reduction Approach, Diane Riley, Canadian Public Health Association, (presentation to Toronto Board of Health, January 27, 1994).

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Safe Injection Facilities, Proposal for a Vancouver Pilot Project, prepared by Thomas Kerr for the Harm Reduction Action Society, November 2000.

Taking Care of Business, A Peer Training & Resource Manual for HIV+ Injection Drug Users, Kali Shiva AIDS Services in collaboration with the Manitoba Aboriginal AIDS Task Force, Winnipeg, MB, November 1999.

Under the Influence: Making the connection between HIV/AIDS and Substance Use, Canadian AIDS Society, October 1997. CD Rom

Guide to Canadian Health/Medical Grants 2002/2003, Canada Grants Service, Toronto, ON, 2003 Edition.

Glossary of Terms

This glossary lists some words you will hear a lot about when talking about people who use needles. You might hear them from different programs, services or government agencies.

AASO is an AIDS Service Organization that deals specifically with Aboriginal clients.

Abstinence means to refrain from using drugs or alcohol.

Acute refers to an illness that is sudden and severe, but not chronic.

APHA is a an Aboriginal person living with HIV.

ASO is an AIDS Service Organization.

Bleach Kit is a harm reduction measure where small bottles of bleach and distilled water are used to clean drug injecting equipment.

Chronic refers to an illness that is present over a long time period.

Community Based refers to those things that are created and controlled by and for a community.

CSC means Correctional Services Canada.

Culturally Appropriate Services refers to services aimed specifically at Aboriginal people with components that promote and respect Aboriginal traditions and practices.

Dental Dams are small sheets of rubber used by dentists to keep an area dry and clean. They may also be used during oral-vaginal or oral-anal sex by stretching one over the particular area.

Gender refers to the sex that a person is born as or identifies as.

HAV means Hepatitis A virus.

HBV means Hepatitis B virus.

HCV means Hepatitis C virus.

Harm Reduction is a pragmatic, non-judgmental approach to drug use with a focus on reducing the harms caused by drugs. These could include viral infections like HIV and Hepatitis C, overdose, and skin infections and abscesses occurring at the injection site.

Hepatitis C (Hep C) is a viral infection resulting in chronic liver disease.

HIV stands for Human Immunodeficiancy Virus which attacks the body's immune system leaving it open to opportunistic infections.

IDU stands for Injection Drug User or Users.

MMT means Methadone Maintenance Treatment (or Therapy).

NEP means Needle Exchange Program.

Offender is a more agreeable term when referring to a prisoner or inmate.

PASAN means the Prisoner's HIV/AIDS Support Action Network.

Prisoner is the term for someone incarcerated in prison.

Rig is a slang term for syringe.

Sharps Container refers to a place where one can dispose of used syringes.

Triggers refer to needles, drugs, and other things that remind users or ex-users of their addictions.

Works is a slang term for injecting equipment.

Notes

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