Complex and unique HIV/AIDS epidemic among Aboriginal Canadians

Opportunistic infections that were the hallmark of the early days of the AIDS epidemic in Canada — PCP, MAC, CMV and meningitis — are conditions that nurse Doreen Littlejohn sees regularly at the Vancouver Native Health Society.

These infections — *Pneumocystis carinii* pneumonia, *Mycobacterium avium* complex and cytomegalovirus — are rarely seen now among, for example, male homosexuals who still make up the majority of Canadians living with HIV, observes Mark Tyndall, an HIV/AIDS researcher at the British Columbia Centre of Excellence in HIV/AIDS.

But among the population served by Littlejohn, people are routinely diagnosed late, when their CD4 counts are low and their viral load high. "We try to stabilize them as much as possible," with primary health care and other services, says Littlejohn who runs the society's Positive Outlook Program, which sees up to 200 people a day, 7 days a week. "Then we talk to them about starting a treatment regimen."

The unique and complex nature of the HIV/AIDS epidemic among Aboriginal Canadians is reflected in statistics that show the population has a far higher proportion of new HIV infections caused by injection drug use (53%, compared to 14% among non-Aboriginals) and among women (about 45% compared to 20%).

Meanwhile, researchers are warning that there is potential for explosive outbreaks of HIV among young, injection drug using Aboriginals. A study of drug-using Aboriginal youth in Vancouver and Prince George has found high rates of hepatitis C infection (57% and 62%, respectively), which is also passed through needle sharing. About half the youth, whose average age is 23, are injection drug users, and the HIV prevalence among the entire group is now 8%.

Around the world there have been situations among illicit injection drug users where HIV "suddenly goes from low to high prevalence — to 30% to 40% — in a year or 2" as happened in Vancouver's Downtown Eastside in 1996 and 1997, says Dr. Martin Schechter, an epidemiologist and co-investigator of the Cedar Project.

All the ingredients for such an outbreak exist in Prince George, where the risks include more cocaine injection, which involves more frequent needle use than heroin, and less access to care than in Vancouver, warns principal investigator Patricia Spittal. About 50% of the youth in the study group are female, and many are involved in the sex trade, she said.

"This is more than a big city issue ... and man, this thing is moving," notes Spittal. Proven harm reduction strategies — such as very accessible needle exchanges and mobile health care vans to help sex workers — need to be introduced in smaller centres, she argues.

Treating HIV among people with addiction problems and who may be homeless or living in marginalized conditions is challenging. Littlejohn's program offers what it calls "maximally assisted therapy" (MAT), in which HIV medications are kept on site and dispensed to clients at the centre. "We have to work with their comfort level; MAT can be viewed as paternalistic. We try to address all the determinants of health."

Spittal also sees some hope in the growing acceptance of community-based research, where researchers work with the community, as has been spearheaded by the Institute for Aboriginal Peoples' Health. "The innovations are going to come at the community level, that is how you are going to get better designed programs." — Ann Silversides, Toronto

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Canapress

Lou Desmerais' Vancouver Native Health Society tries to cope with the many patients suffering from HIV/AIDS.

HIV prophylaxis expensive and sometimes difficult to obtain

Canadians seeking help after being accidentally exposed to HIV through a sexual encounter can meet with a range of unhelpful responses and no clear policies.

Yet, if a month-long course of anti-HIV medication is initiated within 72 hours of exposure, evidence from a key study of occupational exposure among health workers indicates that infection can be prevented in most cases (*MMWR* 1995;44). It can also cost up to $1500.

But when used appropriately, the cost effectiveness of post-exposure prophylaxis (PEP) for HIV is "a no brainer," says Toronto HIV physician Gordon Arbess. However, the lack of clear policy in this area is an "ongoing problem," he said.

Although Canadian provinces and territories have guidelines for dealing with exposures during the course of work and at least 2 provinces (British Columbia and Ontario) have developed guidelines for dealing with sexual assault exposure, the delivery of PEP for accidental sexual exposure has received the least policy attention.

The whole area of PEP for HIV is "a relatively new field, just the last 10 years, and there has, as yet, been no real consensus in the area," says Dr. Michelle Roland, the leading expert on non-occupational exposure to HIV and a physician with the Positive Health Program at the San Francisco General Hospital.

She is confident that recommendations from a forthcoming report from the WHO and the International Labour Organization will soon provide policy and service delivery guidance for both the developed and developing world in PEP for all types of HIV exposure.

While the US Centers for Disease Control and Prevention has issued guidelines in this area, the UK is arguably the leader in its guidelines for non-occupational exposure. As well, Britain's chief medical officer of health recently asked every primary care trust to ensure that PEP is one tool in their HIV prevention approaches.

about accidental sexual exposure.

In Britain, if a physician concludes treatment is necessary, the cost of the 28-day course of 2 or 3 anti-HIV drugs is covered by the National Health Service. For Canadians whose drug costs are not covered by a public or private drug plan, the $1000 to $1500 price tag can be a major deterrent to treatment.

Dr. Matthew Schurter, a second-year family practice resident, says he recently saw 2 patients at an Ottawa emergency ward who inquired about PEP for HIV: a cleaner who had experienced a needle-stick injury while cleaning an outdoor area and a young gay man who was "extremely worried" because of a broken condom during sex with a man he said had HIV. "The [drug] cost would have been covered if I had a needle-stick [injury]... it didn't seem fair that they would have to pay. This seems to me to be an anomaly in the health care system."

Roland agrees it is unfair that some have to pay, while others do not, but notes "you have to remember that this is not a unique equity issue within [Canadian] health care."

It's easier for the system to respond to accidental HIV exposure among health care workers, for example, from accidental needle-stick injury, because the worker is usually available for HIV testing, Roland noted. Moreover, at sexual assault clinics, medical attention is accompanied by extensive counselling.

But the "real challenge" for other types of non-occupational exposures is service delivery and feasibility. Offering

> The lack of clear policy on prophylaxis for HIV is an "ongoing problem," says Toronto HIV physician Gordon Arbess.

"Previously PEP was available, but there was a prescribing lottery — you had to go to the right clinic and know the right things to say," explained Will Nutland of the Terrence Higgins Trust, which offers an online risk self-assessment tool for those worried

services to people who have been exposed to HIV through sex or some other non-occupational route "has a place, but it is very individual," says Dr. Alastair McLeod, chair of the Committee on Accidental HIV Exposures at the BC Centre for Excellence in HIV/AIDS. "A doctor can provide this if he knows the person and the circumstances," but emergency departments are not well suited to appropriate service delivery.

Like McLeod, Roland says the best setting to deal with these situations is at STD clinics, where there is the opportunity to provide risk reduction counselling at a time when patients, concerned about possible HIV exposure, are vulnerable and receptive. The Terrence Higgins Trust endorses this service delivery route and has written to every sexual health clinic in Britain seeking their policies and hours of operation.

Both Nutland and Roland say that primarily, HIV prevention remains essential and that demand for PEP for HIV is not very high. "This is not some big panacea, but we should make it available and link it to prevention," says Roland. — Ann Silversides, Toronto

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Fight to free the world of WMD heats up

The Democratic People's Republic of Korea's decision to test a nuclear bomb on Oct. 9 has renewed fears of an arms race in which the currency of power will be nuclear weapons.

North Korea's breach of a global moratoroium on nuclear explosive testing has also spurred a raft of new calls for disarmament, including ones from Physicians for Global Survival (Canada) and the chair of the independent Weapons of Mass Destruction Commission (WMDC).

Physicians for Global Survival President Dr. Dale Dewar urged in a letter to Prime Minister Stephen Harper that the federal government take leadership in a renewed international effort to uphold and implement the Nuclear Non-Proliferation Treaty. Dewar also urged Canada to oppose sanctions against the North Korean people. "This is already a threatened people. Sanctions must target the leadership, not the populace."

WMDC chair Hans Blix, meanwhile, decried the test as a call to other states