



Pacific AIDS Network (PAN) Fall Conference Notes Day 1

Tuesday, Oct 30th 2018 8 – 12:30pm

Location: Grand Okanagan Hotel, 1310 Water Street, Kelowna

9:00-10:30am Women's Lived Experience Panel

Presenters: Wendy, Charlotte, Erica, Patience

Moderator: R.

- **Janet:** All women WLE of HIV and HCV have shared experiences: impacts, stigma, differences in diagnoses as well. This panel represents layered experiences of HIV, HCV, or both. These women are leaders in their own right and have moved through diagnosis, care, treatment.
- **R.:** Former chair of PWN, survivor of sexual abuse, drug addiction, HIV, HCV for over 2 decades. This session emphasizes the impacts of HIV and HCV on relationships, families, experiences of support. Hoping the panel helps attendees to think about how the community can provide support for women.
- **Charlotte:** My name is Charlotte and I am from the Shuswap Band. Currently living in Kamloops for the last 12 years, diagnosed 12 years ago HIV in the Surrey Correctional Facility, with only a nurse providing a phone number to Positive Living Society, which supported in pre and post release supports. Lucky to have those resources in the correctional facility. Diagnosis led to depression and addiction due to a lack of care, and stigma on the reserve, where Charlotte was on bail. Stigma was so bad Charlotte moved to Kamloops where there were more supports and services than you will ever find on reserves. One of the things addressing today: services that have been there for women and that work for the community. The number one thing that has helped Charlotte is IH: the King Street Centre in Kamloops, whose model is "every person matters". Here, we have a large team that consists of a wide range specialists, such as public nurses, case management, adult community support services, counselling services, and primary care and mental health. Most importantly, urgent response and mental health and substance use emergency services. Another resource that is very helpful and important in communities is the Kamloops Food Bank, or any food bank. Kamloops Food Bank is where Charlotte volunteers once a week. Being on income assistance is not a lot of money, even being on PWD and living with HIV. Only having so much to work with, you can't really make ends meet. So being able to get services such as hampers, vegetables, meat, produce and bread, we are able to get the services we need to tide us over until the next cheque. We live from cheque to cheque because of the price of living. The price of living is so high these days, it's frustrating for people living with multiple barriers and a chronic illness. Another place that is very important in community is the mental health and substance use centre through IH. I have been in recovery for 8 months. At Mental Health and Substance Use, they have incredible resources. Prior to

recovery, I was in a program called STELLAR, which is a 6 month program run through the Phoenix Centre. There, I found counselling and programs such as Working Through Anxiety and Relapse Prevention. Finally, we have the ASK Wellness Society, who have been with me every step of the way since diagnosis. After my diagnosis, I went straight to the street after leaving the reservation where I was stigmatized and battered by the community overall. I was immediately entrenched in addiction, the sex trade, etc. etc. ASK took me despite her being banned from many services in community. They provided me with a shower, a meal, bus tickets, and hope. I volunteer as a peer to give back to the community that has helped me. Two of the things I feel are important to address for women LHIV or people with chronic illnesses across the board – with all that is in Kamloops, women living with HIV or hep C have a lack of housing overall, especially for families. With the rise in rent and the price of living, it is next to impossible to find a place to rent, especially if you are on your own. That is the reality. Without housing, you cannot help someone in addiction; you cannot even help them off the street. For example, I am with BC Housing – of the list of 5 housing resources, 3 are for seniors. There is a 2 year wait list to get into that. There is automatic stigma when you are seen around the King Street Centre or any IH centre that provide services they need. At King Street, I pick up meds, have doctor appointments – what helps is to have staff on hand to help immediately, and at the same time give a safe space to stay on the path to wellness. Stigma is worse on the reservations. I have experience with incarceration, sex work, homelessness, poverty, problematic substance use – and my most important focal point is housing and stigma. All of these parts that have impacted me do not define me!

- **Erica:** My name is Erica, my role is to give you a little bit of an inside – a quick snapshot of my story as a woman who proudly identifies as LE. What I mean by that is a woman who is very skilled at navigating structural violence, things outside of her control, policies that have impacted her life as a woman, as a mother, as a PWUD. I thought I would let you in to be part of the journey and listen to the message and the ask at the end of this. I was diagnosed in a treatment facility – it's interesting to find out that many of us, sadly, are diagnosed in a medicalized or criminalized model, instead of our own autonomy and agency to seek help as anyone would. I was diagnosed in 2010. I had my daughter with me in one of the only places that I know of in BC that support women with children in a treatment setting. This was what I needed, this was not my first rodeo. When I left, I knew there was something inside me – my identity had been smashed. I don't know where to put the blame. I was a woman who felt I could not mother, and was told I could not mother because I used drugs. I did my best and jumped through the hoops because I wanted to be a good mum. I do not suggest this is the best way for women to come to a place for how we should access or be invited into treatment – it is a 50/50 Russian roulette when you apprehend children from mothers. When I recognize this in myself, and in my community, in every opportunity I have I want to bring in the collective experience of women I meet – wherever I have been, women who supported me, including my heroin dealer, who is a strong woman and helped me in many ways, including help me looking after my newborn when I was sick. I found it oddly incongruent that I was deemed an unfit mother on heroin, but I was able to parent on methadone. My experience on that is that I was more boxed on methadone than on heroin. This just didn't seem right. I was also not a criminal – but my substance use, and the drug policy that impacted me, was therefore why I was criminalized. I'm not a criminal, I've been criminalized by drug policy. One thing I learned from all the years of navigating the streets is that this is inherently wrong. This is not safe! Women who use drugs and inject drugs, and women who live with HCV – we know we are more likely to be second off the needle, we are more likely to share works with our

sexual partners, we are more likely to be dependent to get help to inject than men. 27% of people who use drugs need help with injections. The majority are women. We find ourselves in different power structures. In the last month, I had two women who had been injected in the jugular, and kicked out of resources because no-one would speak to this because they were youth. Why am I speaking to this? My experience has been when I came to a place and met a woman who trusted me, saw something in me, and pulled me in, that was true inclusion. She put me in places that trusted me and built my skills and experience – she was not a person with LE, but she believed in me. I ask of services, as we are lacking services, and we know the predictor is the diagnosis of HCV, we also know how it plays into the criminality, which plays into the stigma, which plays into the overdose and our communities dying. It's hard to speak about HCV and treatment and recovery when we are dead and we are dying. We see the shift of money moving around. Those of us with LE do this for free and we will continue to do this and speak truth. For those of you who are showing up as allies, and there have been many partnerships of people who have come in – reflect on yourself and reflect on your agency or body that if you are going to do this work, that ally-ship is very different than ownership. I cannot tell you how it feels to be working in some places, when I'm working with people who do not understand and who do not care, but dictate or make decisions on my behalf, it's like being a gay person working with a homophobe. It is not safe. It is not okay. When I speak to inclusion, I don't mean just this. I mean involving us from start to finish. Only then will we have liberation.

- **Patience:** My name is Patience, originally from Zimbabwe. I was a refugee in South Africa for more than 6 years. I never thought of coming overseas. It just happened that I found myself in Canada. I was diagnosed in 2007, but I think I had had HIV since 2000. I knew something was not right, but to take the step – I thought I was doing to die, because it was not easy for me to intercept the truth. Through the immigration process, I was told my HIV diagnosis. When I was diagnosed, it was the shock of my life – I tested more than 10 times. After 2 months, I came to Canada. With the abuse, and coming to Canada without family. Everything happens for a reason. For the terminology in Canada – when my doctor told me HIV was criminalized, I interpreted this my own way – I thought having HIV was a crime. PWN was my home. Now all of us women are homeless. It was something difficult for all of us to accept that PWN was gone. It is on all of us as a community to fight the good fight. My pain is your pain – what happens to you happens to me. That was the time we were supposed to come together to fight. Women facing so many challenges and one of the biggest challenges is the support, especially for newcomers. PWN was our home. PWN was our family. PWN empowered me to engage in the community and also I participated in the PLDI training and that opened my eyes. After that we came together as people from Africa and we founded ACP Net and it was our home. We used to support each other in an appropriate cultural way. We come together, we cry, we share our stories. When it comes to the ACB community, it is a struggle to share because of taboos and because of stigma. When it comes to stigma, I feel like we haven't done enough. Ask yourself, where is the stigma coming from? Stigma comes from people who are ignorant about how HIV is transmitted. Who are those people? Let's target all those people where stigma is coming from. HIV is manageable right now, but still people are dying. Why is it so? People are dying because of ignorance, of misinformation, and this is a problem in the African community. Since 2015, we have lost 5 beautiful women in the African community. People come in as newcomers with challenges, like PTSD from their country of origin. We all know the definition of refugee – people who have fled due to persecution. They have PTSD, they come to Canada, and they are diagnosed with HIV – and there is trauma. I am not talking

of Africans only, I am talking of all people with new diagnoses. Most of them have been negated by their families. What do we do? In the end, we judge them – but it's not our role to judge them. People are afraid to engage in programs because of that judgement. Let's not judge, let's help since people who are negated by their families end up in the streets. If we come together as a community, we need to find out where we can support people. It pains me to be in the DTES and when I listen to stories in the DTES – I feel that we don't love one another. We hear stories of people being negated by their families. HIV is not our identity. Drug use is not our identity. We need to see each as brothers and sisters and love and support each other. We have all these policies crafted – we are the experts when it comes to HIV. We need to engage! Nothing About Us Without Us. We need to engage in policy and decision making. Look at criminalization. They just draft these policies that are going to harm people. We have to stand up and fight and mobilize the agencies that are not working with HIV. One time I was told that I could not sit next to someone because HIV is contagious. We have a lot to do in our community, and as we are here together, let's start by how we are going to fight the stigma. Because stigma is an epidemic. Let's do something together.

- **Wendy:** I am a peer navigator with PLBC. I am also a recovering addict and former sex trade worker. Similar stories to my beautiful sisters here – I have been living with HIV for 12 years, since 2006. When I was diagnosed, I was given 0 support. I knew nothing. All I knew is that I was going to die, and that I was going to die a really terrible death. I got my diagnosis in the process of transitioning out of sex work and getting off of drugs. I went to my methadone clinic, and I went into the doctor's office, and he was in a hurry, he didn't have a lot of time. He was looking at my blood work, and he said "you know that you have HIV, right?" And I said, no, I have HCV, and he pointed at a piece of paper and said that means you have HIV. I think they gave me a glass of water and sent me on my way. I had a choice to get on a bus back to where I was doing well, or I could get a bus back to the DTES – I was going for a day, but that day was about a decade later. Nothing was said – I just assumed you get diagnosed and get more money in disability. I didn't know that services or ASOs existed – all I knew was that I was going to die. Being a good addict and being in denial, I decided to ignore it and it would go away. So I continued on my merry way in addiction and sex trade. I worked on the street as much as I could to get as many drugs as I could. A few times over the years, I came into contact with doctors who tried to talk to me about treatment and HIV medication, but I knew I was going to die, and I also knew that if I started HIV drugs, I would get lipodystrophy and obviously that wasn't going to work for me, so I would just wait until I wasted away and disappeared. No-one talked to me about opportunistic infections, or criminalization. Looking back, the possibility of being a registered sex offender might have led me into treatment. I was given a lot of antiquated and wrong information because someone knew someone with HIV once who died. Fast forward – I have been working as a peer navigator with PLBC since 2012. I started as a part-time contractor working 5 or 10 hours and in 2016, I was promoted to full time peer navigator. I remember being out there on the street and thinking if I can ever get out of here and use my lived experience and help people not go down this road or down this road for so long, all my time out there was not for nothing. I am blessed – now part of my role as a PN is educating health professionals on marginalization and addiction. To me, it's very important doing these presentations – something I always start my presentations with is that I am an "ask me anything person". You can ask me those icky weird questions to help understand and empathize better, and I am a safe person to ask those questions to. Fast forward again – I am going to talk about a combination of barriers and reasons why women have barriers and

issues getting HIV treatment. Some of these are my own lived experience – some of them are what I know working with my clients, all women with HIV but also sex trade workers, lived through abuse, trauma. When we have a client or patient who is resisting treatment and care, I jump to the bigger things – and forget the logistical, tangible things “do you need coffee? Do you need lunch?” Often it is the more immediate, stigma-based reactions – realistically, where do they go for their care? If they are struggling with addiction, is there care not in a safe space for them? What time of day for treatment is a huge issue – I have many clients who need afternoon appointments or drop in. Does she have transportation? Does she have support and a peer navigator and someone who can help her get there? Can she get all her things in one place? Do they have an understanding of ARVs? Are they ARV ready? If someone is resistant, I make sure – even if they don’t want to go on meds, I want them to understand about opportunistic infections. All of the things with a compromised immune system that we are vulnerable to. I also talk about criminalization, which sometimes a bit of a shock – that this could be a consequence of not being on meds and still in the sex trade. Bad experiences with health care – what happened, how can we fix it? Sometimes people don’t want to go into a HIV clinic. Making sure people have the resources on hand. One more thing – if you do have a patient or a client who is resistant and doesn’t want to go on meds, talk to them, talk to a peer navigator – often times, it’s something that can be worked out really easily.

- **R.:** I see some reoccurring themes. One of the things is about stigma – stigma on the reserve, stigma in accessing care, stigma from your friends and family. Safe places for women – women have different vulnerabilities because they are women. Identifying barriers – getting good directions, following it. Supporting families. Engaging in community. I had many years where I couldn’t engage in community because I was so sick. Education – focus it where it needs to be. Paid work for poz women. Mental illness, depression, PTSD – how can we get better services for women? Quicker access for newcomers, better access, better referrals for newcomers. We are the experts! We are stronger together. We need to have more inclusivity in all aspects of health directly affecting us and our families.

Q&A

- Neil: Thank you! Thank you to PAN for putting this together, all these amazing women. It’s great to see that PAN stepped up and did this. I want to put in a plug for the Empowerment session that just happened for women. We need to step up in our community to make sure our women are represented. I am really thankful for this panel this morning. Thank you, all of you, you were all very brave.
- Q: We have a number of sexual and reproductive health clinics across the space. How can we create safer space for women or folks who identify as women. What are the 3 things that would make it feel safer and invite you in?
- A, Erica: I want to make this clear -I think first and foremost is do the internal work first, how we show up as allies. Many of us have skills to smell bullshit right away. I want to caution, with funding and money, I feel like I have a dollar sign on my back. Many of us have been harmed by the services that are now going to promote, educate – so there needs to be a bit of reconciliation. It takes the internal work to reflect on this and to heal – this is across the board. If you get money to do something, it’s because you show up as an ally. Another is – ask the women! Ask the women to create the safe space, ask the women what they need. But are we working with people who really are allies? Do the work to show that, and if there has been harm, do the work to reconcile. I’ve been in rooms where I’ve been pushed as a woman who uses

drugs, or has HCV by people who were supposed to be my allies. I'm about self-reflection, healing that, and moving forward.

- A: Wendy: At PLBC, we have a women's lounge on the third floor. It's part of my job to supervise volunteers and the work there. We can't get women in there, why? A big part of the reason that I was so happy to be invited to this conference – how do we get women in PLBC? There seems to be a disconnect. November 29th 4 – 7 PM, we're organizing an event called Glitz and Glam at PLBC for WLHIV, a few of things we will have is makeovers from MAC, tarot cards, food, cheesecake, onsite childcare. I'm hoping to get a lot of HIV positive women and their allies coming to this event and saying "omg, PLBC is so great and I want to access services here!" if you are a WLHIV, please come to this event.
- Tom: It's a little bittersweet. I was chair and vice chair of BCPWA. I'm disappointed that we are hearing this conversation today. I would have thought that we would be a lot further ahead. These issues have been going on a long time. I want to express my support for the women on the panel, and put a call out to this room that what was really successful 25 years ago were siloes of identity met in the security of their own meetings. But eventually we came together – after, we did come together and try to work as a community as a whole. Women are not the only ones affected by the issues. As an older gay man, I identify more with women than with younger gay men.
- Q, Daryl: I ask and am curious about the source of the stigma. What I've discovered within the HCV community and I've seen it evident in the HIV community – much of what you were talking about, the separation of groups. We stigmatize each other! We need to come together and work together. It's my hope – HCV has been bundled up as part of STBBIs by the feds. HCV organizations are not so thrilled about that – it's reduced funding for HIV organizations, but ASOs have been tasked with doing HCV work. We're asking everyone to support our work as the ugly stepsister, and as a box that has been ticked.
- Q: Erica, I would love to see this group go talk to MCFD and educate MCFD about addiction, and HCV, and all these things. Sometimes I think they need to be at these conferences – you made a comment, it's a 50/50 when you take away a woman's children. There's tons of stigma.
- A, Erica: Here's the thing that I have come to see – I self-blamed a lot. That internal dialogue, the stigma, how people held me in society, which was not very kind when I used drugs. My worthiness only came when I stopped. I need your help right now – not when I'm in recovery, right now. When we call it structural violence, MCFD, absolutely we want our children safe, there are other ways! A lot of this is because of the laws and the criminalization – I was deemed a good mum when I was taken out of criminality. Instead of punishing women – women who can get segged in prison, can be forced into internal cavity searches for drugs. This IS SEX ASSAULT. How do we heal from trauma when you are still participating in harm like that?
- Comment: First, I wanted to thank PAN as well. I want to applaud all of you amazing goddesses on this platform in sharing your stories. Honestly, for the rest of us in this room, we can hear stats and research – but we're humans, and that's what ties us together. I can really relate to the humanity and human experience that you have shared in this room. I'm stepping into an arena that may be controversial. I feel that we all have a lot of work to do. It pained my heart when PWN closed their doors. We need their doors open. When I hear the questions of why is there this disconnect, very few women are showing up at PLBC. We know that there is a need. We as a society need to wake up, and recognize that we as a society all come from female. Females need to respect themselves in that. I understand the trauma-informed buzzfeed and we get trained in it, below those layers – we have succumbed to generational patriarchy.

And if we can eradicate that somehow, we are moving in the right direction. We need to be doing that in tandem with all of these surface efforts of creating safe space. It all needs to happen in tandem. We as males need to recognize that we come from female. When females can start to recognize themselves as valuable.

- A, R.: I was diagnosed when I was 17, and seroconverted at 16. I was invisible as a woman, and as a youth. I feel that we are invisible today, almost as invisible as I was then. If you know the right people, the right number, you can get the right care. There's not enough outreach. We have a lot of work to do. We're still in the same place around stigma, around ignorance. It makes me angry, frustrated, it makes me want to cry. I wanted to share that with you. We need to get out and be more open. We have so many barriers. We're all very talented, beautiful, talented women, we know what's going on. But we don't have the money, means, to do it. If we were there, things could change. (Erica: Leadership! Not just consultation! What happens is the little bits and pieces). And then we could work in tandem.
- A, Wendy: As I said, I'm a PN, and having a job, having a career in my life that I get to have because I'm HIV positive, and being a recovering addict, being on the street, having been in jail, every so often I remember that I am incredibly privileged to be an HIV positive woman in Canada. There's a lot of people who have it a lot worse. There's something incredibly powerful when a group of women get together in a room and talk about what we need, but also what's working. What's working for your organization? What challenges are you having? I am incredibly privileged to work in HIV and be open and empower other women. I wish any woman who wants to do this kind of work - that you get to.
- Q, Jenny: I was also diagnosed in 2000 at the Surrey Pre-Trial Correctional building. I had the quick test and then was sent off to my cell. When I was released, they drive you back to wherever you were when you got arrested, which was basically back to the streets, back to my addiction. I went through the removal of children. I was using, but I was a very good mom. When they came and removed my child, that was it. The father ended up getting custody, and a few months before this, I had just gotten sole custody. MCFD took my child with his father, I went deeper into my addiction, I couldn't stand the pain in my chest. I had to use, I was a basket case, I couldn't live. About 10 years later, I ran into my ex in the streets, and he had abandoned my son, and my son was raised in foster care after that. If someone had told me I could have gotten custody back, I would have! The majority of my female clients have lost their children with no hope of ever getting them back. I can't believe that that is the step - they're removed, and you're supposed to jump through these hoops when you don't have hope. I hated myself. I felt worthless. I stopped trying, I stopped showing up to my visits because I couldn't leave them every time. Especially with First Nation women, even though there are willing family members would take them. The idea of having a talk with MCFD - I'm going to try and have a sit down with them and my clients, and maybe come to some sort of agreement with advocacy that they do these things, and maybe housing is provided at the same time for them to get their children back.
- A, R.: Communication is a huge barrier to these things happening. I have a daughter who is 24. She was taken away from me when she was 5. I have a lot of the same feelings of guilt and shame. I understand greatly and it touches my heart.
- A, Erica: It's shocking with First Care, with Dr. Abram, that we don't have more of that available in other communities. You have to explain to people that these resources exist - people are blown away. We don't speak to the good work that has been done for so very very long. First Square has been amazing for women. Women, no matter where they are on the substance use journey, are supported. MCFD breaks

the attachment and then forces people to do attachment training that they contributed to, when the research shows that that's not okay!

- A, Wendy: Thanks for sharing that, that's a really common story. Wouldn't that – women who have had their children apprehended, wouldn't it be amazing to have a peer support group for that?
- Comment, Shannon: I have been living with HIV for 16 years. It is so important for women to share their stories. We really need to continue these sort of engagements with the community. I also want to hammer home to ASOs that when you are providing services for women, you need to look at the net benefit for women. These orgs are chasing funding and looking to keep people employed, but we need to look at the net benefit for the individual woman. There really needs to be more HIV positive women working in paid positions. There's a huge disconnect in women to be paid for the work they do. What Patience said – Nothing About Us Without Us. You have to include women in these decisions. Including women into those discussions and in those leadership roles and hearing and implementing what they have to say, and not just as a token on your board. One other thing – many organizations are struggling with getting women into spaces. There are many barriers that are unique to women and we need to be innovative. Women are entrenched in being mothers and wives and working minimum wage jobs and not always having the access to education and the time to get into these spaces. What worked for the men isn't working for the women.
- A, Charlotte: I just wanted to make a point on things that I heard on the floor. Obviously, as an HIV positive woman, when there's a safe space, one the reasons it isn't being used is because of the stigma, the location, depending on your title, and you're like "I ain't going in there! That's Positive Living, and everyone knows that Positive Living is! Like hell I'm going in there!" Number 2: someone in addiction, it's not about their time, it's about how much dope they're going to get, between their addiction, their vulnerability, if they're homeless. It's kinda hard to put them in a space if they don't have a shower, a meal, proper rest. In Kamloops, we presently don't have a space for women support groups, or a space just to lounge and chill. Having seen what I heard on the floor – that just makes my ideas of how to get people in the room better.
- A, Patience: I would love to see policymakers in these conferences. All that we are saying right now will go in vain. Policymakers, all the people behind the stigma, we need them in the room.
- Q, Chad Dickie: It's wonderful to see you women up there. Thank you so much for your powerful stories and the fact that you are showing for me that you are leaders and are living positively as women with HIV. One of the things that is missing, as I sit on a number of committees – no-one with HIV is there. One of the things with the primary care networks – these things are coming about, and a lot of these things are coming about because of what happens in oncology and acute HIV care. When I went back to my reserve, I was by myself. I am trying to encourage PLHIV and PLHCV to get involved and find out more about patient-oriented research. We design the questions! If we're there at the beginning, that gives us a voice. I really encourage your voices – not staying a silo, we need to expand and give our voices to these other realms.

10:30-11:00am Women's Empowerment Forum (ViVa) - Shannon Olsen

We got to attend the HIV Empowerment Forum on October 25 – 28, presented by ViVa. It was on Kwantlen territories, 24 women attended, and it was supported by PLBC and Shafiyah and Adam, and the Elder on site, Sheila Nyman. Also the event funding came from PHSA.

What is Viva Women? A grassroots community of diverse, HIV-positive women from across BC, empowering each other through leadership, mentorship and support. It is a standing committee of PLBC.

Who attended? WLHIV from each of the HAs.

Purpose? Skills building, reducing isolation, community building, exploring/documenting needs of women living with HIV in BC, addressing needs and issues facing WLHIV. Feasibility and development, and implementation of resources for women.

Process? Reviewed data from CHIWOS and WATCH. (CBR, important it gets back in the hands of women who can use this). We looked at what empowerment means to positive women. The Quescussion – brainstorm priority topics which are important to women (discussion posed as questions so that action can be taken). Event was jam-packed. Hopefully developing a webinar to go into further detail.

Identified 3 most important topics, and broke into 3 conversation cafes

95 words were identified as correlated to empowerment for WLHIV. Words included: knowledge, skills building, MIPA/GIPA, not accepting stigma, job placement, Nothing For Us Without Us, leadership roles, lifting each other up, standing up for change, knowing when to let others leads, share your journey, education, community.

3 pieces of focus: connecting and supporting women, especially in rural areas; addressing stigma; Women's Lounge at PLBC. This pertains to how do we get women in spaces and is this the most effective way to engage.

1. **Connecting and supporting women:** sharing our stories and events to learn from each other. Sharing stories online – for women living in rural events, perhaps sending tablets with information pre-loaded into communities that don't have access to Internet. Most of us live in areas that have Wi-Fi, but we have to acknowledge that so much of our province does not have access to Wi-Fi. Having virtual and online support groups (Skype, Webex, Zoom) may help to address additional barriers. Replicating communities like Native Health and focusing on connecting youth with elders. Having community events which bring people together to share information, but also just to connect in an informal way. We have these workshops and these times together, but the magic really happens in these one on one conversations we have.
2. **Addressing stigma:** Here we are in 2018 still talking about addressing stigma, how ridiculous. What do we have to do especially, in rural communities? We take for granted the freedoms we have in more populated communities. In some communities, it's not safe for women to access services, blood work, etc. The group felt YouTube videos, webinars, podcasts, and videos around stigma/self-stigma for women, doctors, and HCPs would be helpful. Some HCPs are still in the 80s. There's sometimes a mixed message in being trained on universal precautions but also being told not to stigmatize.
 - a. Sharing U=U education and patient resources. We need more education and patient resources on this.

- b. Life and Love with HIV – getting that information out.
 - c. Reactivating HIV education in schools.
3. **Women-centred spaces** – e.g. Women’s Lounge at PLBC – we also looked at how we get women accessing women’s spaces. Transform the space into a hub of communication and action, province-wide, use office as a media room for virtual peer support, provide a safe space for women to share stories, free lunch program. Bringing women together pulls women out of isolation, and let them know that they are not alone.

Ideas for growth, changes for the better can happen when we come together like this.

Our future focus will be these three areas.

Q&A

Q, R.: When you were talking about getting education to teachers in Pro D Day, how are we talking about doing that? We can’t go through the school board, we can’t go through different departments. Doing the Pro D Day would probably be the most successful way to do that.

A, Shannon: I don’t believe it’s impossible for us to get into schools. When I first learned about HIV/AIDS, it was in school. There must be a way. It’s been done before, it needs to be done again.

A, R.: I know in my experience in speaking to youth in Healing Our Spirit and YouthCO, the evaluation was great. That is one of the great places to start, educating the children. We need to push something through to not have the barriers in our way. If I had had that information, I might not be HIV positive today.

A, Shannon: I think it’s important that children bring this back, because it’s still a bit like saying the F word. Bringing that information home – can be a source of reducing stigma.

Q, Tom: Are we really talking class privilege in all of this conversation? It seems that society in general doesn’t care about poor people, mental health, addiction... maybe what we can do in the future is find some really meaningful champions. One of the things the AIDS community has not done is find big names to join our movement.

Close - Dance

Patience: We all know that women handle pain differently than men. We are gifted in singing and dancing. We ended every day after dinner at the Forum with dancing. It helped, and it is therapy. This is to show how we are women outside of the discrimination we face in our communities.

<Members from the Women’s panel led the floor in dancing, and it was a beautiful, hopeful thing>

11:15-12:30pm Provincial Panel

Jason Wong, BCCDC, Epidemiology Updates

HIV update:

- 60% of new diagnoses in the year will be in GbMSM population.
- Is PrEP driving reduction in new cases? We don't know yet.
- There have been increases in HIV testing since 2010, aiming for the concept of normalizing STI/HIV testing.

Hepatitis C update:

- In 2018; 1800 new diagnoses are expected.
- Men represent 2/3 of cases.
- Acute Hep C is presenting in a younger age group: 30-39 years old are presenting with acute hepatitis C, based on a previous negative test in 12 months.

Syphilis update:

- BC is seeing the highest number of cases in the last 25 years. 90% of these cases are in gbMSM, although there has been some increase in females as well.
- It's not that testing is finding more syphilis, there IS more syphilis in communities.
- Most diagnoses occur in those aged 40-49 years.
- There is an overlap of HIV and syphilis. 30% of those with syphilis have HIV too. This is lower than in previous years, when it was 30-50%. Serosorting behaviour could be contributing to this change.
- There is a provincial syphilis action plan to address the increase in syphilis. Seven goals include:
 - Enhancing the surveillance and better describing spatial epidemiology of syphilis in BC.
 - Understand the drivers of the current outbreak.
 - Develop new syphilis prevention strategies especially among core groups.
 - Increase early detection screening including offering testing reminders for those with previous infections.
 - Maintain high treatment completion by improving collaboration with clinical partners.
 - Optimize care of partners including improving testing and treatment outcomes.
 - Increase syphilis awareness by developing targeted communication strategy and engaging providers who diagnose most syphilis in BC.

Co-infection:

There is a strong correlation of crystal meth use and HIV seroconversion. Less is known about correlation of syphilis. There is "biological plausibility" but we don't know it yet.

Junine Toy, BC Centre for Excellence in HIV/AIDS, on PrEP

- Overview of PEP (post-exposure prophylaxis) for one instance of exposure for a limited time and PrEP (pre-exposure prophylaxis) for those who have ongoing risk. Use of PrEP is ongoing with monitoring.
- BC Centre for Excellence information on PrEP and eligibility criteria: <http://cfenet.ubc.ca/hiv-pre-exposure-prophylaxis-prep>
- Review of PrEP application and approval process takes 2-3 days.

- For those living outside the Lower Mainland, medication is couriered to prescriber, and in remote areas, prescribers get a little bigger supply at outset to ensure treatment and care follow up won't be interrupted.
- Of the 2704 on PrEP as of October 1, 2018, 600 clients had been on PrEP previously.
- About 250 people are being enrolled per month in BC.
- New prescribers of PrEP continue to grow. About half of them have no prior HIV treatment prescriber experiences.
- Median age in first 6 months of PrEP program: 17-81 years old; median is 35.
- 98.7% are cisgender males.
- Reported discontinuation is 1.3%; 25 people.
- Reasons for discontinuing include "No longer at risk" or intolerance of meds.
- There has been a rapid uptake of PrEP that still hasn't plateaued.

Miranda Compton, Overdose Emergency Response centre (OERC)

- 2018 on track to have similar number of OD deaths as 2017.
- OERC was launched in Dec 2017.
- OERC was developed in partnership with Health Authorities and cross-ministerial partnerships.
- There are four coordinated priority approaches:
 - Naloxone: make it be everywhere. Innovate.
 - Overdose prevention services: BC is supportive of OPS. There doesn't need to be fixed site, they could be as well placed in a community centre.
 - Acute overdose risk case management: anywhere a person is at risk, reaching out to help connect people with services and support.
 - Treatment and recovery.
- Community Action Teams are working in 20 priority areas.

Robin Yates, Ministry of Health

- There have been changes over the last year. There was the creation of a new ministry and the start of a new Public Health Officer (Dr. Bonnie Henry). There is also a new Executive Lead and new Executive Director.
- Annual *Hope to Health* report not finalized yet; waiting for some data to be able to do that. Over last year there has been work with health regions and BCCDC.
- \$19.9 million was distributed to partners over the year. There is no foreseeable change to that funding.
- The refresh of the viral hepatitis c strategy is on its way.
- Over past year there has been work done on hep c testing recommendations in clinical settings, which is important in light of testing for baby boomer populations, as well as treatment options for those living with HCV in BC.
- Province is working from a sexual health strategy rather than STI prevention focus.
- Overall, things have been delayed over the past year with changes in personnel and government.

Joshua Mann, PHAC

Broad snapshot:

- Pan-Canadian framework for action was released on June 29, 2018.
- “Stigma needs to be the focus of everything that is being done right now”.
- At International conference in September, PHAC Canadian rep wore U=U shirt.
- PHAC funding focuses on systems and community level work.
- \$289 million is invested in BC.
- CAF: 8 projects funded at 8.9 million.
- CAF projects that were funded for 3 years will hear within the next few weeks about the future of funding.
- Harm Reduction Fund \$984,000 for three years.

Learning from the agency as a whole:

- Recognize that funding was not rolled out effectively. In Harm Reduction fund reviews, PWLE were included in reviews of applications.
- CAF review includes recognition that timely response is needed.
- Looking at funding of a clean drug supply project. If evidence shows a lot of promise, more funding could come through.
- Comment that it is too bad that PHAC won't be re-engaging with groups that were impacted/lost funding as a result of CAF losses.