From Access to Equity:

A Think Tank on Policies, Programs, and Research issues facing Immigrant & Refugee PHAs

June 9th, 2006
Oakham House, Ryerson University, Toronto

Committee for Accessible AIDS Treatment
Ontario HIV Treatment Network
Acknowledgments

Co-Sponsoring Partners:
Committee for Accessible AIDS Treatment, Ontario HIV Treatment Network, Canadian HIV/AIDS Legal Network, Ontario Council of Agencies Serving Immigrants, Centre for Addiction and Mental Health, Joint Centre of Excellence of Research on Immigration and Settlement

Funding Partners:
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Preface

On June 7th, 2006, the Committee for Accessible AIDS Treatment (CAAT) and the Ontario HIV Treatment Network (OHTN) co-sponsored a one day think tank on HIV and immigration issues titled: “From Access to Equity: A Think Tank on Policies, Programs, and Research issues facing immigrant & Refugee PHAs” at the Ryerson University in Toronto. The think tank brought together over 60 PHAs, service providers, policy makers and researchers to critically examine the current policies, programs, research on HIV and immigration, to share perspectives on the challenges facing immigrant, refugee and non-status PHAs and to identify strategic issues for collaborative actions.

A detail literature review on relevant public policies affecting people living with HIV/AIDS who are immigrants, refugees or without status in Canada (IRN PHAs) titled “Status, Access and Health Disparities”, was released at the think tank. The report laid the groundwork and context to facilitate discussion on the relevant policy and program issues. Participants also learnt about the experiences of the African and Caribbean Council on HIV/AIDS in Ontario and the preliminary data from a study on mental health issues and access barriers affecting IRN PHAs.

The think tank provided important forum for stakeholders from different sectors to identify policy and practice changes required to improve access to services and care for IRN PHAs, formulate relevant research questions to facilitate evidence based advocacy and improved programming, and develop framework for coordination on policy, program and research planning amongst stakeholder groups working with I & R PHAs.

The organizers pledge to broadly disseminate this Think Tank Summary Report, actively seek interest of collaboration in the list of directions identified, and further develop additional actions based on the findings of this first HIV/AIDS Think Tank on Immigrant and Refugees PHAs in Canada.

The Committee for Accessible AIDS Treatment wishes to acknowledge funding support from the Ontario HIV Treatment Network, the Public Health Agency of Canada ACAP Program (Ontario Region) and the Canadian Institute of Health Research, Infection and Immunity Institute for additional funding support for this important think tank.
Meeting Summary

Introduction

Immigrant and refugee people with HIV/AIDS are one of the fastest growing populations affected by HIV/AIDS in Ontario. Mode of HIV transmission amongst people from endemic countries of origin accounted for 19.4% of new HIV infections in Toronto in 2004, second only to Men who have sex with men (MSM). Further, previous research studies conducted by the Committee for Accessible AIDS Treatment (CAAT) have demonstrated the complex interplay of the many systemic barriers faced by these vulnerable PHA populations in accessing basic legal, social and health services, resulting often in horrendous and tragic health outcomes.

Dr. Alan Li from CAAT and Dr. Sean Rourke from the OHTN provided background on the sponsoring organizations, welcome the participants and outlined the objectives of the Think Tank. CAAT is a network of over 30 service organizations in Toronto working together to address access barriers faced by people living with HIV/AIDS who are immigrants, refugees or without status in Canada. Through collaborative research and projects, the network has successfully established several innovative initiatives to address these barriers, including the HIV Medication Access Project at Toronto PWA Foundation. At the Think Tank Meeting, CAAT also released a policy review paper that analyzes the impacts of different government policies on immigrant and refugee PHAs and helps identify potential positive public policy changes.

As a co-sponsoring partner, the Ontario HIV Treatment Network is committed to promote excellence and innovation in treatment, research, education and prevention to optimize the quality of life of people living with and affected by HIV in Ontario.

The Think Tank was designed to identify and address the gaps and underlying factors related to HIV and immigrant and refugee populations (See appendix A for Meeting agenda). The goal was intentionally broad allowing the participants to determine what the needs are rather than imposing a specific focus on the group. The invitees and participants represented a diverse body of expertise ranging from immigrant/refugees living with HIV, service providers, agency management, researchers and policy makers whose works or involvements will impact on our target populations.

Morning Panel Presentation

The morning plenary session provided context and background on the issues and challenges facing immigrant, refugee and non-status PHAs (IRN PHAs). The Think Tank started with stories of lived experiences of immigrants and refugee PHAs. Entitled “Challenges and Inspirations”, Amutha and Gabriel shared the multiple barriers of living with HIV in accessing services and managing their own health, and the support and resilience in coping under such challenges.
**Josephine Wong**, research consultant for CAAT, presented the findings from the preliminary research on the mental health challenges facing IRN PHAs and access barriers in addressing their mental health needs in a presentation titled: “Intersecting sexuality, gender, race & citizenship: Mental health issues faced by immigrants & refugees living with HIV/AIDS”.

**Matthew Perry**, research consultant for CAAT, presented the newly completed in-depth literature review report on relevant policies and programs affecting IRN PHAs titled: “Status, Access and Health Disparities”. The report examined the legislative and policy structures/systems in the areas of immigration, health care, social assistance, social housing, education and employment and how they impact the lives of IRN PHAs. The report highlighted the negative policy impact as well as apparent contradiction amongst some of these policies and identified potential recommendations to address policy gaps.

These presentations provided context and background information on the range of issues and social environment affecting our target populations. After the plenary session, participants worked in small groups to engage in discussion on gaps and strategies.

**Morning Small group Discussion**

The purpose the morning small group discussion is to examine existing work and identify gaps in policies, services and research areas. Participants were divided into three smaller discussion streams: A [Services], B [Research] and C [Policies]. Participants are allowed to choose which discussion streams they would like to participate.

Through facilitation, two focus questions were discussed in each stream:

- What are the existing barriers and gaps in [A: providing better services or programs for; B: in the research on issues affecting & C: policies affecting] our target population?
- What are the underlying factors that contribute to such barriers and gaps?

After the identification of the list of gaps and challenges, each participant was asked to choose 3 items amongst the identified gaps that he/she considered being the most important or urgent that need to be addressed. (Please refer to Appendix C for a full list of gaps/challenges identified). After discussion amongst the small group participants, the list of prioritized items were synthesized into one list for sharing with the large group.

**Gaps and Challenges**

Here is a list of prioritized gaps and challenges identified by the different streams:

**Stream A:** Key Gaps and Challenges in Services

1. **Systemic Challenges**: related to institutional/organizational barriers that affect resource allocation, service design, lack of accountability structures, and social exclusion and discrimination along the lines of race, socioeconomic status and sexual orientation.
2. Challenges in the mobilization of services: including the lack of resources, integrating HIV/AIDS to legal and settlement services, and the lack of information, and awareness on intersecting issues.

3. Challenges in the Delivery of Services: including language barriers, communication challenges and the coordination of services.

**Stream B: Key Gaps/Challenges in Research**

1. Disclosure of HIV status issues: at different settings including: immigration testing and follow up, insurance, within and outside own communities, and the impacts of stigma and discrimination.

2. Resiliency and coping strategies: such as strategies to deal with discrimination and social disadvantages and exploring empowerment models of marginalized groups.

3. Cost/Contribution Analysis, such as framework to evaluate financial and social contributions of IRN-PHAs, and how to contextualize the analysis to inform higher level policies development nationally or globally.

4. Community Norms and Contexts: related to cultural norms and practices, their impact on sexual behaviors, communication and disclosure, and exploring culturally specific/appropriate models for disclosure and communication on sexual issues.

**Stream C: Key Gaps/Challenges in Policy**

1. Impact and Implementation of Policies: such as silos of policy and service structures that need better coordination, fractured policies and systems that do not recognize the whole person, gatekeepers who lack understanding of peoples’ realities, discrepancy in different policies, mismatch of timeframe due to ODSP and immigration status changes, and the lack of evaluation and accountability in policy implementation.

2. Specific Policy Issues: including the gaps in the recognition of foreign credentials in academic achievement and employment, the lack of evidence and studies in costs and benefits of immigration, and whether HIV infection is acquired inside and outside of Canada.

3. How Policies are made: including the lack of transparency of government processes, the political agenda that drives policy development and the lack of access for affected groups to effect policy changes.

After the reporting back session, the participants broke for lunch and listened to the keynote address by the Honourable George Smitherman, Minister of Health and Long Term Care.

**Afternoon Panel Presentation**

The afternoon session started out with the sharing from a group of presentation on the existing innovative models for community based research and actions:
Amy Casipullai from the Ontario Coalition of Agencies Serving Immigrants (OCASI), spoke of the current strategies from the immigrant and refugee rights and service sectors including efforts by the Status Campaign, the No-One is Illegal Campaign and the campaign on a ‘Don’t Ask Don’t Tell policy’ for emergency public service access.

Esther Tharao from the African and Caribbean Council on HIV/AIDS in Ontario (ACCHO) spoke on the experiences of how the African and Caribbean communities organized themselves and successfully advocated for and developed a provincial/national AIDS strategy to address the challenges and barriers facing the African and Caribbean Canadian communities.

Alan Li from the Committee for Accessible AIDS Treatment (CAAT) spoke on the previous action research to improve treatment access for IRN-PHAs and how CAAT effectively engage multisector stakeholders and advocated for the development of compassionate medication access for PHAs experiencing access barriers as a result of their immigration status.

The afternoon panel presentation highlighted the successes and some of the best practice models in our existing target communities and related marginalized communities in overcoming some of the barriers in access, and served as a springboard to the afternoon discussion for participants to explore innovative strategies to further reduce the multitude of barriers affecting IRN-PHAs.

Afternoon Working Group Discussion
After the afternoon panel presentation, the participants are divided once again into the three streams similar to the morning discussion. Based on the prioritized gaps and challenges identified in the morning, each small group are focused on the discussion of actions with the following discussion question:

What Advocacy, Programming and Research will help address the following three gaps/challenges?
- Lack of quantitative research on cost/benefit analysis of I & R PHAs
- Lack of organizational policies reflective of cultural practices and diversity of I& R PHAs
- Lack of coordination and integrated responses in addressing systemic discrimination, stigma, risks (structural and social determinants)

Each stream of discussion groups have come up with a list of action steps which they have highlighted and reported to the larger group [Please see Appendix D for a full list of the actions from each stream of discussion]
Key Priority Direction and Actions:

In summary, the participants have identified the following three priority directions and related actions in addressing services, policies and research:

- **Ensure access to culturally competent and coordinated services for immigrant and refugee PHAs:** The key challenge was the lack of accountable, culturally responsive and relevant service infrastructure for I/R/N-PHAs. Research needs to monitor and evaluate the effectiveness and accessibility of current services and help establish standards of best practices in HIV testing, support and health care management for these PHA populations.

- **Develop holistic research agenda that addresses social determinants of health:** Major gaps exist in culturally relevant research that will integrate the cross-sectionalicity of the social determinants on people’s lives, shed light on social norms and behaviours that impacts on sexuality and sexual practices, the impact of stigma and disclosure barriers to HIV prevention and care as well as coping strategies and protective factors that promote resiliency of these vulnerable groups in the face of such compounded social exclusion.

- **Develop effective evidence based advocacy framework:** Public policy development framework needs to include I/R/N-PHAs and coordinate amongst the different levels of government, possibly through better coordinated provincial, federal and territorial planning network. To effectively prevent further HIV infection and reduce barriers to care amongst these vulnerable groups, governments and service delivery organizations need to work together to identify discriminatory policies and practices that put PHAs at risk, and to collaborate with broader campaigns that promotes “Access without Fear” for all populations.

Follow up

The organizers is fully committed to broadly disseminate the Think Tank Summary Report, actively seek interest of collaboration in the strategic directives identified, and further develop additional actions based on the findings of this first HIV/AIDS Think Tank on Immigrant and Refugees PHAs in Canada.
Appendix A: Agenda for Think Tank

From Access to Equity

A Think Tank on Policies, Programs and Research issues facing Immigrant & Refugee PHAs
9 a.m. to 5 p.m., June 7th, 2006
Oakham House, Ryerson University (55 Gould Street)

Co-Sponsoring Partners:
Committee for Accessible AIDS Treatment
Ontario HIV Treatment Network
Canadian HIV/AIDS Legal Network
Ontario Council of Agencies Serving Immigrants
Centre for Addiction and Mental Health
Joint Centre of Excellence of Research on Immigration and Settlement

Funding Partners:
ACAP, Ontario region, Public Health Agency of Canada
Canadian Institutes of Health Research, Institute of Infection and Immunity
Ontario HIV Treatment Network

Objectives:
- Identify key issues/gaps facing people with HIV/AIDS who are immigrants, refugees or without status in Canada
- Identify policy and practice changes required to improve access to services and care for I & R PHAs
- Identify relevant research questions to facilitate generating evidence and knowledge for effective programming for I & R PHAs
- Facilitate improved coordination on policy, program and research planning amongst stakeholder groups working with I & R PHAs

Agenda:
9 a.m. Introduction and Objectives of the Day (Alan Li, Sean Rourke)
Plenary session:
- Challenges and Inspirations: Lived experiences of immigrant/refugee PHAs (Amutha and Gabriel)
- Current work and gaps: Summary of current research and program scans for affected populations (Josephine Wong, Y.Y. Chen)
- Cross-cutting Systemic barriers: Report on the compounding impact of different government policies and programs (Matthew Perry)

10:30 a.m. Small groups: examining challenges and gaps in policies, services & research
12:45 p.m.  Keynote address: Hon. George Smitherman, Minister of Health and Long Term Care

1:00 p.m.  **Innovative Models** for community based research and action:
- Immigrant & refugee rights: (Amy Casipullai, OCASI & CCR)
- Aboriginal communities: (Laverne Monette, OAS)
- African & Caribbean communities: (Esther Tharao/Winston Husbands, ACCHO)
- Immigrant, refugee & non-status PHAs: (Alan Li, CAAT)

2:00 p.m.  Small groups: identify priority action in policies, services & research
3:00 p.m.  Summary report back from small groups
3:30 p.m.  **Strategic action planning**: facilitated discussion on key strategic directions on
- Advocacy focus on public policies
- Practical programming models and best practices
- Research questions and process for CBR development

4:20 p.m.  Evaluation/ Follow up plans
4:30 p.m.  Adjournment
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Appendix C: Morning Workgroup Discussion Note

Gaps and Challenges identified

Stream A (Service)
What are the existing gaps in providing better services or programs for our target populations?

- Language barrier
  - Affects communication with service providers
  - Access to documentation
  - Francophone Africans communities
  - Interpretation
  - Affects confidentiality
- Lack of information and resources
- Lack of awareness (front line workers) about HIV/AIDS/under resourced
- Prejudice and racism
- Gaps in legal, resources to pay for filing PRRA
- Advocacy
- Diversity of service providers
- No ownership in different service sectors about HIV/AIDS
- HIV/AIDS services vs. health care services (communication gap, lack of mobilization and collaboration)
- Translators/interpreters don’t have specific training on HIV/AIDS/sexuality
- Disconnect between ASO, health services and social service providers
- Values, attitudes and beliefs of ASO service providers/service users in relation to HIV/AIDS and immigration
- Right to complain, lack of information about complaints process
- Mixed identities and ownership? (PHAs and staff)
- Racism-cultural and sexual identity

What are the underlying factors that contribute to such barriers or gaps?

- Race
- Cultural values
- Homophobia
- Social economic class
- Rights vs. responsibilities
- Value judgment
- HIV status vs. sexual identity and immigration
- Stigma and discrimination (race, religion)
- Mental health needs
- Invisible poverty (reluctant to seek services/support-shame)
- Status disclosure (fear, addiction)
- Living with uncertainty
• Misinformation from lawyer/consultants
• Staffing/human resources vs. demand

**Stream B (Research)**

**Issues of concerns:**

• Types of research questions that need to be answered in order to inform policy and service provision

• HIV testing and diagnosis
  - Late diagnosis among I&R-PHAs and thus affecting their prognosis.
  - Lack of pre- and post- HIV testing and support for individuals who are tested through the immigration process or insurance examination process, particularly for individuals with language and cultural barriers.

• Disclosure: fear of disclosure within own ethnoracial communities and distrust of mainstream services (including mainstream ethnic, and mainstream health and AIDS)

**Research Gaps/Questions**

The participants recognize that the voices of marginalized populations must be present in research about I&R-PHAs. The brainstormed list of research gaps or questions can be organized into the following themes:

• Experiences of living with HIV
  - Compare the experiences of I&R-PHAs living in Canada and the experiences of PHAs in their countries of origin or similar ethnocultural communities in other countries

• Culture & sexual practices
  - How do cultural beliefs and norms influence behaviour (sexual practices, drug use, condom use, etc.)?
  - How does stigma affect individuals and communities in terms of HIV prevention (e.g. partner disclosure, safer sex negotiation)
  - How do different communities vary in their level of awareness of HIV/AIDS and their attitude towards HIV/AIDS

• Social exclusion
  - Explore stigma and denial at individual and community levels -- how do they affect PHAs both within and outside their own communities
  - Social isolation and experiences of alienation of refugees, especially those living outside of GTA
  - Very few studies on effective strategies to combat discrimination
  - Not enough research on the extent of discrimination related to HIV/AIDS
• Quality of life/Strengths of I&R-PHAs
  o Resiliency and coping strategies of I&R-PHAs against different barriers, discrimination and oppression
  o The influence of spiritual practices and religious beliefs on the quality of life of I&R-PHAs

• Determinants of health
  o What are the effects of the different intersecting social and economic determinants on the health and wellbeing of I&R-PHAs

• Resources/Population Data
  o Cost and benefit analysis of I&R-PHAs, to be done in the context of broad public policy (i.e. the cost and benefit analysis of immigration and not just PHAs)
  o Need more data on demographic characteristics of HIV affected subpopulations within the immigrant/refugee population.

• Services provision/Service barriers
  o To what extent do frontline service providers working with I&R-PHAs document the problems and barriers encountered by their clients
  o Access to services and patterns of service utilization among I&R-PHAs who do not live in the GTA. What are the influencing factors?
  o The quality and availability of HIV pre- and post-test counselling for individuals tested through the immigration processes and insurance processes?
  o Needs assessment for service planning
  o Needs assessment of barriers to participate in research

Underlying factors for the research gaps:
• Lack of knowledge of cultural beliefs, sexual practices amongst established research communities
• Fear of stigma associated with HIV research: negative impact of research on community
• Severity of access barriers poses major harm in people’s health, and most frontline services are overburdened with direct services with insufficient resources to embark on research activities
• Distrust of researchers based on negative experiences in the past or a lack of partnership experiences.
• Distrust may also result from negative experiences in other area of service delivery, i.e., the lack of support in the HIV testing processes, lack of sensitivity
and cultural competency in programs/services; participant communities may associate their experiences of access to appropriate services with research.

- Disclosure: fear of disclosure within own ethnoracial communities and distrust of mainstream services (including mainstream ethnic, and mainstream health and AIDS)
- Denial of barriers and access problems by the mainstream communities

**Stream C (Policies)**

**What are Gaps in Policies?**
- Exclusionary policies that deny access
- Individual gatekeeper interpretation
- Organizational policies do not reflect changes in demographics
- Reactive governments – short-term solutions/actions, not well thought out, not long term
- Lack of coordination between 3 levels of governments
- Lack of research (costs/benefits of immigration; HIV acquisition in/outside of Canada – relates to PHA stories: assumed bringing HIV into Canada, it is assumed they knew they were HIV+)
- Lack of information – communication about IR-PHA entitlements, rights
- Complexity of policies
- Policies do not recognize whole person- fractured system – different officials, service providers
- Gaps between policy and implantation e.g. human rights
- Evaluation/accountability
- Lack of recognition of foreign credentials, by gov’ts and professional bodies; refugees who have skill but no documentation
- Gaps are expanding, policies in decline, worsening
- Uncertainty/discrepancies (same stories, different decisions) with immigration officials
- Timeframe extremely long for processes

**What are the underlying factors that contribute to such barriers and gaps?**
- Immigrants and immigration policies not a priority for government
- Lack of inclusion, of understanding of policy-makers
- Resistance to respond, lack of ability, not enough expectation to change by agencies to respond to changing diversity, epidemic
- Reducing access because of expense – influences all policy
- Stereotypes – economic drain vs. benefits
- Lack of plain, simple language re policies, information
- Economic refugees due to globalization, displacement, “undeserving” vs “deserving” refugees
• Needs are getting worse, policies and attitude more reactionary, moving away from family class, humanitarian approach to attracting immigrants with money; not responding to the needs, undermining rights: shift to the Right
• Racism, sexism, homophobia, classism
Appendix D: Afternoon Session working group notes

Strategies to address barriers

Discussion Questions:
What Advocacy, Programming and Research will help address the following three gaps/challenges?
1. Lack of quantitative research on cost/benefit analysis of IRN PHAs
2. Lack of organizational policies reflective of cultural practices and diversity of IRN PHAs
3. Lack of coordination and integrated responses in addressing systemic discrimination, stigma, risks (structural and social determinants)

Identified Strategies:

Stream A (Service)

- Lobby governments (all levels) for funding to ASOs to increase service provision for target populations and to re-instate funding that was cut from settlement agencies
- Influencing the local health integrated network (timely)
- Forming coalitions and collaborating for related services eg: mental health
- Linking and networking with related services (young scientists researchers, diversity health practitioners network, settlement agencies, OHTN, ASOs) (Feasible)
- Identify community partners/MPs
- User the post think tank feedback for health promotion and education in community/share information with other partners (timely)
- Better coordination between federal and provincial governments (IFH)
- Develop a report care system of best practices models from agencies, ASOs (feasible)
- Lobby governments to show the cost benefit of IR / IR PHAs on the economy in the long term (strategic)
- Organizations share those cultural interpreters who understands the intersecting issues faced by target populations (feasible)

Stream B (Research)

Participants began by naming a number of research topics related to I&R-PHAs:

- Community needs assessments/program evaluation
- Social determinants of health
- Epidemiology
- Mental health service access for IRPHAs
- Access to health care
• Stigma and discrimination affecting black communities
• Ethnoracial MSM (prevention)
• Migration and youth
• Needs of caregivers to PHAs
• Review of HIV programs
• Marginalized populations such as IDUs and prisoners
• Social services for PHAs
• Epidemiological tracking of endemic populations
• Estimation of non-insured PHAs
• Role of MOHLTC in advising Citizenship and Immigration Canada on HIV related issues
• Research priority setting
• Racial identities and sexual practices
• CBR and community capacity building on research

Participants discussed and agreed that for us to be effective in terms of advocacy, programming and research, we need to do research based on a framework with shared values and guiding principles that acknowledge existing barriers and embrace social justice principles. It was agreed that our key goal is to look at how research fits into advocacy and practice, and the key objectives are:

- Improve quality of life/health of I&R PHAs
- Prevent transmission within the I&R communities

Participants also agreed that the identified topics/issues should be organized according to 3 levels of analysis – individual/community and system

<table>
<thead>
<tr>
<th>Individual</th>
<th>Community</th>
<th>Systemic</th>
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</thead>
<tbody>
<tr>
<td>Holistic treatment and prevention framework</td>
<td>Cultural norms/behaviors and impact on sexuality and sexual practices</td>
<td>Anti-discrimination framework</td>
</tr>
<tr>
<td>Integrating social determinants and HIV</td>
<td>Public awareness campaigns</td>
<td>Research ethics standard that protect and empower I&amp;R-PHA participation</td>
</tr>
<tr>
<td>Integrating mental health, addictions, HIV &amp; migration</td>
<td>Cultural competency training for service providers to assist with disclosure counseling, partner notification</td>
<td>Reviewing public policies and impact on social determinants</td>
</tr>
<tr>
<td>Identity issues: gender, race, sexual orientation, citizenship status</td>
<td>Service access issues: health care, social services, mental health support</td>
<td>HIV Testing and its impacts</td>
</tr>
<tr>
<td>Best practice in case management and support</td>
<td>Preferred ways of service delivery in mental health/social support</td>
<td>Adherence to practice standards of HIV testing and follow up support</td>
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<tr>
<td>Qualitative research on experience of HIV testing</td>
<td>Tracking changing social norms and practices within cultural communities</td>
<td>Identifying discriminatory policies and advocate for reform</td>
</tr>
<tr>
<td>Coping strategies to deal with complex life challenges and compounding discrimination/marginalization</td>
<td>Evaluation of existing community services (diagnosis of problem)</td>
<td>Define legal and human rights framework for testing</td>
</tr>
<tr>
<td>Stigma -- disclosure to partners</td>
<td>Impact of HIV on social inclusion (family, workplace participation etc.)</td>
<td>Planning framework that includes affected marginalized communities</td>
</tr>
<tr>
<td>Service experiences and access barriers and health service utilization</td>
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**Stream C (Policies)**

**Actions – Priorities with focus on Policy & Coordination**

1. **Research**
   a. Strengthen demographic data and link to funding (get support for serving groups affected)
   b. Conduct research on more countries where documentary evidence lacking re HIV status/impact, link to legal/refugee claim

2. **Services**
   a. Agencies who provide the services be involved in broader campaigns for change
   b. Legal services/clinics to take on more immigration issues; more legal aid

3. **Coordination and Access to care and support**

**Strategies mostly in the short-term**

- F/P/T on HIV/AIDS (any other relevant F/P/Ts?)
  - Prioritize coordination and access: pilot projects
- Services: increased funding – stable, sustainable, core funding
  - Provincial and Pan-Canadian HIV Strategies
- Access without Fear (don’t ask, don’t tell campaign: participants not comfortable with the language that that campaign but allies).
  - Do not deny access to care and services on basis of status
- Local networks – integration of service delivery in local areas through network meetings:
  - Legal - employment – other services – people affected
- Bring demographic info/issues/referral
- Support broader campaign re: 3 months waiting time for services
- Advocate increased services/funding at CHCs. There is a precedent with CHCs to build upon, for people without status.
- Advocate also for monies to ASOs to serve these vulnerable populations (could be based on demand?)
- Link HIV/AIDS groups to broader campaigns.

Long Term
- De-link OHIP and status, treat health care as basic right (like education)
- Regularization and Amnesty
Appendix E: PowerPoint Presentations

1. From Access to Equity – Introduction and Context of Think Tank

2. Intersecting sexuality, gender, race & citizenship: Mental health issues faced by immigrants & refugees living with HIV/AIDS – by Josephine PH Wong


5. Strategies to reduce barriers amongst immigrant, refugee and non-status PHAs – by Alan Li, M.D.
From Access to Equity

A think tank to improve policies, programs and research on issues facing immigrant & refugee PHAs

Co-sponsoring Partners
- Committee for Accessible AIDS treatment
- Ontario HIV Treatment Network
- Ontario Council of Agencies Serving Immigrants
- Canadian HIV/AIDS Legal Network
- Centre for Addiction and Mental Health
- Centre of Excellence of Research on Immigration & Settlement

Funding partners
- AIDS Community Action Program, Ontario Region, Public Health Agency of Canada
- Canadian Institutes of Health Research, Institute of Infection and Immunity
- Ontario HIV Treatment Network

Objectives of the Day
- Identify key challenges/gaps on policies, services and research related to immigrant, refugee and non-status PHAs
- Identify policy and practice changes required to improve access
- Identify relevant research directions to inform policy and service changes
- Facilitate coordination amongst stakeholders

From Personal to Political
- Layers of discrimination and barriers
- Individual and community experiences
- Overwhelming needs
- Research and advocacy
- Building supportive infrastructure to address determinants of health

CAAT
- Formed in 2000 to address access problems faced by immigrant, refugee & non-status PHAs
- 2001 Action research on treatment access led to successful establishments of HIV & Immigration information development, Service access training & HIV Medication Access Project
Relevance of project

- Changing demographics of HIV/AIDS
  - Globally
  - Ontario/Canada
- Impact of HIV Treatment and long term survival
- Complex needs of target groups

Global HIV/AIDS Epidemic

- Over 20 million have died since 1981
- Asia: 7.5 Million HIV+
- Africa: >25 million HIV+
- Eastern Europe: 1.3 million
- Latin America: 1.6 million
- North America/W. Europe: 1.6 million
- (UNAIDS 2004)

Changing Context of AIDS

Cumulative cases of AIDS: 19,344 (Dec 2003)

AIDS Cases:
- White Canadian (86.8% in 1993/54.3% in 2003)
- Black Canadian (8.4% 1993/21.5% in 2003)
- Aboriginal (1.2% 1993/13.4% in 2003)
- Heterosexual (7.5% 1993/13.4% in 2003)
- Women (8.9% 1993/25% in 2003)

Changing Context of HIV/AIDS in Canada

- (HIV & AIDS in Canada: Surveillance report to Dec 2003)
- AIDS Cases:
  - White Canadian (86.8% in 1993/54.3 % 2003)
  - Black Canadian (8.4% 1993/21.5% 2003)
  - Aboriginal (1.2% 1993/13.4% 2003)
  - Heterosexual (7.5% 1993 /36.9% in 2003)
  - Women (8.9% 1993/25% in 2003)

Migration & Settlement

Canada’s changing demographics

- Canada: 18% (or 5.4 million) of the population are immigrants
- Ontario: 26.6% (3 million) of the population are immigrants
- Metro Toronto:
  - 41% of Ontario’s population
  - Receives 77% of Ontario’s immigrants
  - About 59% of Toronto’s population are foreign-born
- (Census 2001)

Migration, HIV/AIDS & Health:

What are the issues?

MIGRATION  HIV/AIDS  HEALTH
Intersecting sexuality, gender, race & citizenship: Mental health issues faced by immigrants & refugees living with HIV/AIDS

Presented by Josephine Pui-Hing Wong
Research & Health Promotion Consultant
CAAT Research Committee &
Toronto Public Health, Planning & Policy

Migration, HIV/AIDS & Mental Health: What are the issues?

What determines our health?

Individual:
- Biological & Genetic factors
- Lifestyle
- Personal Practices

Social & Environmental:
- Income
- Housing
- Food/nutrition
- Education
- Employment
- Healthy Child Development
- Social Inclusion
- Access to services
- Physical environment
- Social environment
- etc.

Our Health

The 4 Ps contributing to Mental Health

Mental Health

Predisposing Factors
Perpetuating Factors
Precipitating Factors
Protective Factors

Knowledge Gaps: Mental Health of Immigrants/Refugees living with HIV/AIDS

- Most of the studies have been done in the US and focus mainly on psychiatric problems among PHAs or the impact of mental health problems on treatment adherence
- Most of the US studies also focus on gay white males
- Research subpopulations are mostly defined by race or ethnicity categories and not citizenship or migration status
- Existing Canadian research tend to focus on HIV screening, risk factors or prevention
- Studies of PHAs with multiple marginalities are virtually non-existent.
- The lack of culturally inclusive research in which the meanings of mental health, sexuality & HIV/AIDS are studied within the social contexts of the marginalized groups

Migration & Settlement
Canada’s changing demographics

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(Census 2001)
Changing Context of AIDS
Cumulative cases of AIDS: 19,344 (Dec 2003)

Mental Health Stressors faced by PHAs
- Body's response to HIV
- Body's response to HIV Treatment
- Social, financial & family responsibilities
- Illness appraisal HC negotiation
- Other.
- Physical, psychosocial & mental health

Stigma & Discrimination
- Social isolation
- Depression
- Financial Hardship
- Internalized Stigma

Illness appraisal HC negotiation
- Physical Quality of Life
- Mental Stress
- Social, financial & family Responsibilities

Anxiety

Increased Stress & Coping Demands
- Physical, psychosocial & Mental health
- Older PHAs: co-existing health conditions (e.g. diabetes, arthritis, loss of loved ones, etc.)
- PHAs with a history of: abuse, violence, mental illness, substance dependency
- Women PHAs: demands related to gender roles, power issues in relationships, financial status

Body's response to HIV
- HIV crosses blood-brain barrier
- Cognitive Impairment
- Dementia
- Mood Changes: agitation, depression, suicide ideation
- Confusion
- Loss of Concentration
- Etc.
Health Outcomes of Immigrants & Refugees are influenced by:

- Pre-migration health determinants
- Pre- & post-migration social status
- Citizenship
- Access to education, employment, housing, health and social services
- Personal coping capacity
- Social support
- Community connection
- Social inclusion
- Social equity

Systemic Barriers faced by Immigrants & Refugees

- Gender
- Class
- Race
- Unemployment & underemployment
  - Underhousing
  - Poverty
  - Health disparity

Multiple Marginalities of Immigrants & Refugees living with HIV/AIDS

- Women
- HIV Status
- Lesbians
- Gay men & MSM
- IDU
- Sex Trade
- Transgendered & Transsexual People
- Racialized Groups
- People with Visible & invisible disabilities
- Citizenship: Immigrant
- Refugee
- Non-Status
- Non-English Speaking Peoples

Community Focus Consultation

**Purpose:** To identify mental health issues faced by I&R-PHAs, their need for mental health services & research priorities in this area.

**Method:**
- 2 focus groups
- 10 PHAs from the 5 ethnospecific communities served by CAAT
- 10 service providers affiliated with primary care, hospice care, and ethnospecific community ASOs; 2 service providers submitted ideas and comments via email

Focus Group Questions

- What is mental health?
- What are the mental health issues faced by I&R-PHAs?
- Based on the mental health issues identified, what types of mental health services do you think I&R-PHAs need?
- What can you tell us about the experiences of I&R-PHAs in using mental health services in the GTA?
- If you were going to choose 3 top issues for research in our community, what would it be?

Key findings

- Key findings from the Focus Groups affirm that the mental health of immigrants & refugees living with HIV/AIDS is greatly influenced by the social determinants of health.
Findings of Service Providers Focus Group

- The concept of mental health is culturally specific; it is related to our individual/collective history and experiences. Our mental health is influenced by social forces and structures as well as our individual ability to cope with change and loss.
- I&R-PHAs experience tremendous stress related to social isolation, immigration processes, systemic barriers and experiences of oppressions; they also experience depression related to multiple losses and their HIV status.
- There is a lack of access to culturally and linguistic appropriate services; inadequate counseling support beyond HIV testing.
- I&R-PHAs are sometimes retraumatized by fragmented and uncoordinated services or abuse of power by some service providers.

I&R-PHA Focus Group

Key Findings: On Mental Health

- Mental health is defined as being integral to our physical, emotional & social health.
- Physical & mental wellness are intertwined:
  - “I have memory loss, it’s like the brain is not working; now I cannot even remember my children’s birthday.”
  - “Physical conditions lead to stress and stress leads to negative thinking that contributes to low self esteem and then it affects our mental health... It happened to me. It [visual impairment] has created a loss of independence for me; I need to rely on others but I don’t want to have to explain to others all the time. One time, I was treated negatively and others thought I was being inappropriate until they realized my condition. Regular incidents will lead to stress and isolation.”

Key Findings: On “Mental Health”

- There are both positive and negative meanings associated with the term “mental health”
  - “Different people in the community have different perspectives. Mental health has something to do with being able to take control, the way we deal with life, the way we do things, or solve problems talk control; it is also about how other people in the community perceive you and how you feel about it.”
  - “When people from other cultures or countries come and do not fit into the ‘norm’, then they think you are crazy.”
  - “Some people will use the words ‘mental health’ as an insult to name an outcast; it means abnormal. Sometimes it refers to an illness that you’ve brought on to yourself, you are responsible for it.”

Key Findings: On Citizenship & Stress

- For refugee and non-status PHAs, the immigration process was identified as the major source of stress; other stressors are related to poverty, under-housing, unemployment, financial and social security
  - “HIV is a big problem in countries such as Africa, Asia; having landed [immigrant] status is a relief; once you arrive Canada, you know there are medication and treatments; you can try to close the chapter of persecution at home [country]. But you now have a different kind of mental distress and needs.”
  - “Housing is a big stress; when you cannot find housing, what do you do? Do you go back to the shelter? You don’t want to go back to the shelter.”

Key Findings: On Stigma & Discrimination

- I&R-PHAs experience depression related to stigma & discrimination related to racism & AIDS-phobia.
  - “People have stereotypes about refugees; they think they are uneducated, ignorant and only want to take advantage of the system.”
  - “Being an immigrant, you don’t want to be on social assistance, but you cannot find work because your home qualification is not being recognized. Once you are HIV positive, the government labels you and says that you can get disability benefit; so that makes you feel you are “disable” and that impacts on your mental health.”

Key Findings: On Social Isolation & Fear

- I&R-PHAs experience multiple fears related to social isolation and exclusion.
  - “Who is going to be with me when I am dying.”
  - “For women, the greatest fear is getting sick and having nobody around to take care of the children”
  - “Sometimes you don’t want to disclose to people who come from the same country; they reject you and then no one can help you; they question how you got infected with HIV and they make you feel ashamed; if they find out you HIV+ status, they think that something is wrong with you... People get kicked out from people’s house.”
Key Findings: On the Quality of Life & Existential crises

• I&R-PHAs experience a sense of deep loss and uncertainty about their health & life in Canada.

  “We live longer but what kind of life are we living?”
  “After immigration, you cannot find work; you need to upgrade in education, but how can you do that when your head is not working as well as before?”
  “When you have HIV, you feel that people wouldn’t date you; but dating is the last thing you worry; the immigration status comes first…”
  “When you find out you have HIV, you feel that you are “not normal”; your own perceptions tell you that you are sick, you cannot handle the job. It could be physical or psychological, but it’s like a self-fulfilling prophecy”

Key findings: Barriers to Accessing Services

• I&R-PHAs experience difficulties in accessing inclusive services

  “Some therapies that are culturally not appropriate may make you end up more depressed. That was my experience. I had to leave the group because it made my depression worse…”
  “The services are there but you cannot get to it because of the complicated processes you have to go through.”
  “Many of the services that promote emotional health [for PHAs] are only provided in English; for example, many of the relaxation & stress reduction classes are only available in English.”

Priorities for Research

• Assessment of existing mental health services for I&R-PHAs
  – What is available?
  – What types of services are effective & why?
  – What needs to be in place to increase accessibility and utilization?
  – How to facilitate a better coordination of existing services?
  – What do service providers know about the intersection of HIV/AIDS, mental health & migration?

• What is the impact of mandatory testing on the mental health of I&R-PHAs?

• How does “time” in the context of migration and living with HIV/AIDS play in the lives of I&R-PHAs?

The 4 Ps contributing to Mental Health
Status, Access & Health Disparities: 
A literature review of legislation and policies affecting immigrant, refugee and non-status People Living with HIV/AIDS (PHAs).
Matthew Perry 
June 2006

Introduction
- Research paper commissioned by the Committee for Accessible AIDS Treatment (CAAT) completed in spring 2006
- Purpose of paper is a review of policy and legislation affecting access to services for newcomer PHAs, including immigrants, refugees and non-status PHAs in Ontario.
- Goal of the work is to identify policy and legislative barriers in order to develop longer term strategies to address these issues

Scope of Research
- Under the guidance of the Committee for Accessible AIDS Treatment, a review of policy and legislation was undertaken to identify barriers to access faced by immigrant, refugee and non-status PHAs in the following main areas:
  - Immigration
  - Health Care
  - Social Assistance
  - Housing
  - Education
  - Employment
- In addition to the review, interviews were conducted with PHA newcomers, service providers and policy makers

Immigration Status
- It is important to recognize the differences in immigration status:
  - Immigrants are individuals who have come to Canada or are applying to come to Canada as permanent or temporary residents.
    - Includes visitors, students, skilled workers, business class and family class (sponsored) immigrants, live-in caregivers
  - As a general rule, those seeking permanent residence have greater access to services than those seeking, or holding, temporary residence
  - Refugees are individuals seeking protection in Canada because they face persecution. Those awaiting a decision on their status as refugees are refugee claimants. Those who are granted refugee status are Convention refugees. They may become permanent residents after.
  - Non-Status are individuals without legal immigration status in Canada
    - Generally are those who have entered Canada with some legal status which has expired
    - Also includes those who have either exhausted or not started any of the processes through which they might gain (or re-gain) legal status in Canada
    - Commonly referred to in the press as “illegals”
The following sections will **briefly** outline the main issues/barriers affecting PHA immigrants, refugees and those without status in each of the main areas.

**Immigration**

- The immigration system is confusing, detailed and complicated which has an immediate and negative impact on health:
  - "when they come in, they’re all so stressed about this issues. And because of the stress levels, and because they’re so depressed and stressed about that [immigration] particular issue, they don’t really care about themselves even though they have all these medication issues which we have to deal with right away, and even though as support workers you try to push them to, you know, take care of yourself, you take a long process. But they’re just not relaxed and they come to the office and you need to calm down, you know and you have to sit down with them for a couple of hours just to calm them down."
  - [ASO Support Worker]

- Legislation: Immigration & Refugee Protection Act
- Policy: Citizenship and Immigration Canada Policy Manuals

**Medical inadmissibility**

- All immigrants are required to undergo a medical testing, including an HIV screening test as part of the immigration medical.
- You are “medically inadmissible” if you are expected to:
  - be a threat to public health
  - be a threat to public safety
  - cause excessive demand on the health and social services
- HIV is not a threat to public health or safety
- Your demand is “excessive” if it would cost more than the annual cost for an “average Canadian” ($4078 in 2004) for a five year period, or 10 in the case of HIV.
- Some people are excessive demand exempt: successful refugees, sponsored spouses, common-law and same-sex partners and dependent children

**Humanitarian & Compassionate Grounds**

- The H&C provision allows minister to grant permanent resident status to someone deemed inadmissible or exempt that person from any requirement of the Act or regulations “if it is justified under humanitarian and compassionate considerations, taking into account the best interests of a child directly affected or by public policy considerations.”
- H&C is the main method by which non-status individuals can try to regularize their status by applying for permanent resident status from within Canada
- H&C applications are complicated, cost money, take years, do not prevent deportation and do not provide access to services or health care, or exemption from excessive demand criteria.
- Successful H&C applications result only in granting of a Temporary Resident Permit in the case of PHAs -- which involves a further three year wait for permanent resident status.
Immigration - Temporary Resident Permits

- Granted to those who are inadmissible, but whose need to enter or remain in Canada “is compelling and sufficient to overcome the risk” of allowing them to enter.
- In 2004, 13,598 TRPs were issued. 1% of these were for those whose inadmissibility was based on health grounds.
- Issued for one year at a time; renewable; must be modified to allow multiple entry to Canada; can be cancelled at any time.
- Do not allow for access to provincial health care or for Interim Federal Health.
- PHAs holding TRPs because of medical inadmissibility can apply for and get PR status at the end of three continuous years if they are not inadmissible on other grounds (including financial).
- Are granted to successful H&C applicants, yet do not allow for access to most important need for PHAs - health care.

Immigration - Sponsorship

- Sponsorship in the family class is one main way for PHAs to secure permanent resident status.
- Can represent one of the only two ways that non-status PHAs can normalize status (the other is an H&C application) by being sponsored by a Canadian citizen or permanent resident spouse, common-law or same-sex partner.
- You cannot sponsor if you are on social assistance (unless it’s because of a disability) and must meet “minimum necessary income” levels to sponsor anyone other than a spouse or partner.
- If your sponsored relative ends up on social assistance, you are required to repay that money.

Immigration - Protected Persons

- Protected persons includes refugees and ‘persons in need of protection’.
- Definition of person in need of protection specifically does not include those who face a risk of death because of a lack of health care in the country of origin.
- Refugee claimants and persons in need of protection are eligible for health care through the Interim Federal Health program.
- IFH eligibility continues until you become a Convention refugee or protected person and eligible for provincial health care; or your claim is denied and you have had a failed a pre-removal risk assessment.
- The Safe Third Country Agreement has meant a 50% drop in refugee claims at land border crossings. Many PHAs will have to face the U.S. immigration system, with poorer results and less access to health care.

Immigration - Interim Federal Health

- The IFH program provides access to essential and emergency health care, treatment and medication for individuals going through the refugee determination process.
- IFH eligibility ceases if a failed claimant makes an application on Humanitarian and Compassionate grounds.
- Access to IFH makes a huge difference in the lives of PHA newcomers:
  “Once you have IFH, you have doctors that would write letters on your behalf or help you out, but when you have no status, hard.”
  [ASS Service Provider]

Immigration - Processing Times and Fees

- Governments have acknowledged that processing times for immigration applications are excessive.
- The Liberal government had committed funds to this issue but the new government may no honour that commitment.
- Fees are significant for most PHAs navigating the complicated stages of the process -- repeated required result in significant expense.
Health Care

- Health care includes primary care, specialists, diagnostic testing, hospitalization, provincial health insurance coverage, dental, medication and the role of public health

Health Care - OHIP

- Eligibility for OHIP for PHAs is limited to citizens, permanent residents, Convention refugees and protected persons, and some temporary residents (some workers)
- TRPs for health grounds are specifically excluded
- OHIP does not provide for any medication
- Canadian-born children of OHIP-eligible parents are eligible for OHIP

Health Care - Trillium Drug Program

- Trillium Drug Program was established to help individuals with high costs for medications
- OHIP eligible is required for Trillium Drug Program eligibility.

Health Care - Hospitalization

- Non-insured PHAs face huge hospital bills if admitted and therefore avoid hospitalization at all costs.

"My personal experience, I was two weeks admitted in hospital and the bill was approximately $36,000, and if I would have signed the documents, today I would be in debt.

Community Health Centres are mandated to provide some service to non-insured patients, but must negotiate regularly to secure hospital services for PHAs

Health Care - Designated Medical Practitioners

- DMPs are physicians certified to conduct immigration medical examinations
- DMPs are often the first point of contact with the medical community in Canada and are often those conducting HIV screening and responsible for pre- and post-test counselling.
- CIC policy confirms these expectations. PHAs, service providers and public health report that pre- and post-test HIV counselling and contact notification is not effectively done by DMPs.
- Negotiate regularly to secure hospital services for PHAs

"[The doctor] called me – he said that there was a problem. He just told me [my HIV status]. I was depressed. I was shocked. I was in denial. So, it was like my head was going to like explode."

PHA newcomer – Female

Health Care - Public Health

- Public Health has a legal mandate to follow up on HIV+ results and verify that contact tracing and partner notification has been/is being done.
- Newcomer PHAs have high levels of discomfort when contacted by authorities regarding health status
- It can be difficult for PHAs unfamiliar with the Canadian system to understand roles of various government agencies which can exacerbate health status.
- There is no legal obligation on public health to inform immigration if a client is without immigration status.
- There can be gender-based differential impact on partner notification and contact tracing especially where sponsorship agreements are in effect.
Social Assistance

• Social assistance and immigration departments are closely linked through information sharing arrangements.
• Receipt of social assistance limits ability to sponsor a family member.
• Receipt of social assistance by a sponsored relative results in significant debt.
• Social assistance provides access to some health benefits, especially medication through the drug and dental cards.

“[PHA newcomer] The greatest help is we are getting our medication.”

• non-status individuals are not eligible for social assistance.
• Receipt of social assistance while on a TRP may result in an inability to be landed after three years.

Social Assistance

• The interaction of social assistance and immigration often leaves PHAs in a bind:

“My question is this. Okay, for example, I am under ODSP. But immigration is questioning why I should be under disability. But I do not have health coverage, I’m HIV positive and I need the medication which I can’t afford… even my wages can’t afford it. So, isn’t that common sense?… Being a single parent with two kids and a son who is HIV positive, you can’t sustain. You can’t support in a country, I mean in a city like this you have $1000 for rent, food and everything and you have to pay $2000 for medication? It’s ridiculous.”

[PHA newcomer on a Temporary Resident Permit]

Social Assistance

• Recent reports about the inefficiency and difficulties with the Ontario Disability Support Program underline many of the other issues faced by PHAs who rely on ODSP for survival:

“Social service is the worst. Just to communicate. To get someone you can communicate with and they don’t disappear on you. You come back promptly with answers. You know, it’s difficult. I go to them [social assistance] any more. I just go to my worker [at PWA or ACT].”

[PHA newcomer]

• Suspension of benefits for minor issues results in suspension of the drug card, which has serious impact on the health of all PHAs.

Housing

• Particular issues facing PHAs regarding access to subsidized, affordable housing (rent geared to income, or RGI housing)
• recent changes have meant citizens, permanent residents, refugees and now refugee claimants and applicants for PR status may apply for and be eligible for RGI housing.
• Those on TRPs who are waiting for the three year mark to come may not fit these criteria and be ineligible for RGI housing.
• To be eligible for housing no single member in the household may be the subject of an enforceable removal order.
• Place on priority list for housing can only occur if otherwise eligible AND medical proof is provided that the PHA has a life expectancy of less than two years to live.
• Conflicting with CIC processes where PHAs are trying to establish that their HIV does not and will not cause an excessive demand.

Education

• Generally, publicly funded education is available to children of school age, regardless of immigration status of parents.
• The Toronto District School Board recently endorsed the adoption of a “don’t ask, don’t tell” policy beginning in the 2006-07 school year.
• Technically those without status or only temporary status are expected to pay a fee to enrol their child, but most PHAs will meet one of the exceptions to the fee requirement.
• For adults, access to student loan programs is limited based on immigration status. Only citizens, permanent residents and protected persons are eligible for OSAP. Refugee claimants, TRP holders, study and work permit holders, PR applicants and non-status individuals are barred.

Employment

• Work permits may be issued to PHAs at various stages in the immigration process.
• HIV can have an impact on issuance of permits, including limitations on types and locations of work (not with children, in kitchens or health care settings).
• PHAs are protected against discrimination in employment on the basis of disability (HIV status).
• Basic workplace legislation does not specifically exclude non-status workers, but their vulnerability means that they are usually unable to use legal protections available to them.
• Insurance programs like Canada Pension Plan and Employment Insurance require valid Social Insurance Numbers – non-status PHAs are unable to access these benefits if they worked under the table (and likely still contributing to the plans)!
Appendix E

Negative Policy & Legislation Interactions: HIV & Immigration

- Eligibility for IFH should be available to TRP holders and not eliminated for failed refugee making applications for landing on H&C grounds. Better yet, why not allow eligibility for TRP holders so that they are OHIP eligible – this would permit access to Trillium, ensure payment of the deductible and make it more likely to be able to work and remain healthy.

- Excessive Demand Exempt (ED) categories of individuals has significantly improved the circumstances of some HIV positive immigrants, those on TRPs are still adversely impacted by the medical inadmissibility provisions. The current system requires that PHAs avoid interactions with the health care system for at least three years. Medication are only available either through the social assistance drug card, clinical trials of medications, or through ad-hoc access programs like the HMAP. Primary care depends on either out-of-pocket payment, or treatment through Community Health Centres.

- TRP holders are granted their permits because there are sufficient reasons to justify their continued presence in Canada. Not providing these individuals with access to provincial health insurance makes little sense. If TRP holders were permitted access to OHIP, they would in turn have access to both the Trillium Drug Program and the Special Drugs Program, as well as primary care. This access is likely to improve health outcomes and prevent these individuals from waiting until their health deteriorates to the point where more expensive care and hospitalization are required.

Recommendations: Immigration

PHAs without status in Canada should be permitted to regularize their status in Canada through means beyond the humanitarian and compassionate provisions.

- The H&C process is insufficient and inefficient and does not provide an effective way for non-status individuals to regularize their status in Canada. Most non-status individuals live and work in Canada with no access to services and very tenuous and fragile lives. PHAs without status are exponentially disadvantaged by this lack of access. A regularization program should be implemented which is comprehensive and does not automatically deny status to individuals with health conditions. Healthy PHAs with access to services are able to function and contribute to their communities and to Canada.

- “Don’t ask, don’t tell” policies adopted by law enforcement and municipal and provincial governments in order to reduce barriers to access for emergency services, education and emergency services and reduce vulnerability of immigrants in situations of domestic violence.

Rationale: The H&C process is insufficient and inefficient and does not provide an effective way for non-status individuals to regularize their status in Canada. Most non-status individuals live and work in Canada with no access to services and very tenuous and fragile lives. PHAs without status are exponentially disadvantaged by this lack of access. A regularization program should be implemented which is comprehensive and does not automatically deny status to individuals with health conditions. Healthy PHAs with access to services are able to function and contribute to their communities and to Canada.

- Individuals with tenancy or no immigration status routinely refuse to access services, or avail themselves of emergency and protective services because they fear deportation as a result of coming to the attention of official structures and being reported to immigration. Those facing domestic violence are more likely to keep quiet and endure the violence, risking death in order not to jeopardize their immigration process. A don’t ask, don’t tell policy would increase the safety and reduce risks faced by immigrants without status.

Rationale: The H&C process is insufficient and inefficient and does not provide an effective way for non-status individuals to regularize their status in Canada. Most non-status individuals live and work in Canada with no access to services and very tenuous and fragile lives. PHAs without status are exponentially disadvantaged by this lack of access. A regularization program should be implemented which is comprehensive and does not automatically deny status to individuals with health conditions. Healthy PHAs with access to services are able to function and contribute to their communities and to Canada.

The excessive demand policy should not be based on a 10-year window of costs and should more closely reflect current Treatment Guidelines for antiretroviral treatment.

Rationale: Medical research into care and treatment for HIV changes rapidly. There is no way to accurately predict the costs in the future and therefore there is a disproportionately negative effect on HIV positive individuals caught by the excessive demand provisions. Immigration policy with respect to HIV and excessive demand was based on 2002 guidelines for antiretroviral treatment. These guidelines were updated in 2005 and establish different parameters for the initiation of treatment which has a downward influence on the estimates for costs for antiretroviral treatment because of revisions to viral load and CD4 indicators for initiation of treatment. The excessive demand definition should include consideration of the economic and social contributions of immigrants and refugees.

Rationale: PHA newcomers contribute to the communities in which they live. Economic contributions include income tax and sales tax. Social contributions are difficult to quantify but have a significant impact.
**Recommendations: Immigration**

**The Right of Permanent Residence Fee should be eliminated.**

**Rationale:** The Right of Permanent Residence Fee constitutes a barrier to newcomers who have difficulty accessing $975 in order to complete their landing process and secure permanent resident status. This financial burden has a disproportionate impact on PHAs whose access to insured health services and medications depends on payment of the fee.

The costs of processing fees for immigration should be eliminated or reduced.

**Rationale:** While there may be some justification for cost recovery on the part of CIC, the current levels of fees for humanitarian and compassionate applications, permanent resident applications, and particularly the costs associated with regularly renewing and maintaining TRPs should be reduced in order to reduce the financial strain on individuals already marginalized by their lack of access to services and their immigration status.

Processing times for all types of applications should be reduced.

**Rationale:** The government has effectively acknowledged that processing times are too slow and that significant backlogs exist. Increases in funding which would facilitate the faster processing of applications would reduce stress levels for PHA immigrants and refugees. A liberal government funding announcement prior to the election indicated this would occur, but the recent change in government leaves this open to question.

**Recommendations: Health Care**

**Eligibility for the Interim Federal Health Program should be continued for failed refugee claimants who have made an application for landing on humanitarian and compassionate grounds.**

**Rationale:** The RPRF currently constitutes a barrier to newcomer PHAs whose claim for protection has been referred to the IRB without expiry until the person is determine to be a protected person or until the conclusion of the PRRA process.

**Eligibility for the Interim Federal Health Program should be continued for failed refugee claimants who have made an application for landing on humanitarian and compassionate grounds.**

**Rationale:** This provision currently results in a loss of housing for an entire household. 14/24

**Recommendations: Social Assistance**

**Expand access to the drug and dental card through the Extended Health Benefits to permit more PHAs on TRPs to work while retaining access to the drug and dental card.**

**Rationale:** For many PHAs who require medical treatment, but are otherwise in good health, access to the drug and dental card through social assistance would allow them to engage in employment.  This would reduce the number of PHAs who rely on social assistance for income support in addition to the drug and dental card. This process would not remedy the lack of access to health care services however.

Ensure continuation of drug and dental card coverage in cases where benefits are suspended for minor issues like a failure to provide information.

**Rationale:** Suspension of the drug and dental card have serious implications for PHAs who rely on social assistance for access to medication. Often this reliance is from categorical ineligibility for provincial health insurance. Social assistance programs can and should develop a method to make suspension of the drug or dental card a method of last resort when dealing with alleged failure to comply with program requirements.

**Recommendations: Housing**

**Eliminate the legislation requirement that an unenforceable removal order against one member of a household results ineligibility for RGI for the entire household.**

**Rationale:** This provision currently results in a loss of housing for an entire household based on the particular immigration status of only one member. While an argument may be made with respect to ineligibility for that one member, this should not jeopardize the affordable housing of all members of the household. Given the difficulties encountered by PHA newcomers and their negotiation of the immigration system, this policy may have a disproportionate impact on PHAs who may find themselves in situations with unenforceable removal orders as a result of a lack of access to good legal information, advice or representation.

**Permit TRP holders to be added to the waiting list for subsidized housing.**

**Rationale:** PHAs on TRPs are normally required to maintain their TRP status for three years before they may be landed. The inability to apply for RGI housing denies these PHAs the opportunity to either find more expensive housing and find funds to pay for medications and health care treatment, or else access social assistance. RGI housing would permit these individuals to minimize impact on social services through work and contribution of 10% of their income to the cost of housing.
Recommendations: Education

Protected persons (Convention refugees and persons in need of protection) should be eligible for the full range of financial supports for post-secondary education, including bursaries and grants.

Rationale: Protected persons have a full legal status in Canada. Recent policy changes to the Ontario provincial and federal student loans programs have extended eligibility to protected persons. There is no justifiable reason why access to grants and bursaries provided through these same structures should not be available to protected persons. Access to financial support for education will increase the capacity of newcomers to establish themselves in Canada through viable employment.

Recommendations: Employment

Employees with no status should be expressly included in workplace protection legislation in order to prevent exploitation of undocumented workers by employers.

Rationale: Employers who exploit undocumented workers, or employees without immigration status can create situations of extreme danger and risk for PHAs with no status. Expressly including these workers would prevent employers from operating unsafe workplaces and working conditions. Combined with a don’t ask/don’t tell policy, this would protect the safety of individual workers while minimizing the negative impact on vulnerable individuals.
Best practice model: How ACCHO organized itself to push policy and research forward to benefit the community

An Emerging Epidemic (cont’d)

- HIV/AIDS and African/Caribbean people in Ontario by the end of 1996:
  - 116 HIV+ mother-infant pairs, 70% of pairs involving mothers from Africa and the Caribbean (1994–96)
  - People from Africa and the Caribbean account for 18% of all people diagnosed with AIDS in 1996
  - African and Caribbean people had higher AIDS-related mortality compared to Ontario population
    - African women constituted 32% of AIDS-related deaths in Ontario in 1996

Engaging African and Caribbean communities

1997
- African Community Health Services and African in Partnership Against AIDS organized the first Community forum:
- Aim of forum – Understand status of epidemic and facilitate community discussion and mobilization in relation to HIV/AIDS

Engaging African and Caribbean communities (cont’d)

1998
- Organized by APAA, ACHES, Women’s Health in Women’s Hands CHC, Black CAP, Ministry of Health, Toronto Public Health
- Follow-up to 1997 conference
- To share information and strategize about African and Caribbean community issues

Engaging African and Caribbean communities (cont’d)

2000
- Working conference on Creating Strategic Partnerships … to Address HIV/AIDS in African and Caribbean Communities

Objectives:
- Build on existing partnerships and identify new partnership opportunities in African and Caribbean communities
- Develop strategies for prevention and support services in context of the determinants of health

Recommendations:
- Increase collaboration among African and Caribbean organizations
- Create coalition of African and Caribbean agencies to advocate on behalf of communities
Appendix E

Origin of ACCHO

- Emerging problem with scattered groups doing and highlighting different things
  - Researchers (CAHR 1997) produced numbers without context
  - Community actions that lacked context and the participation of community stakeholders

- HIV Endemic Working Group (HEWG) formed in 1998
  - African Community Health Services (ACHES)
  - Africans in Partnership Against AIDS (APAA)
  - Black Coalition for AIDS Prevention (Black CAP)
  - Former Laboratory Centre for Disease Control (LCDC), Health Canada - Current Centre for Infectious Disease Prevention and Control (CCDP)
  - AIDS Bureau, Ontario Ministry of Health and Long-Term Care

Origin of ACCHO (cont’d)

- Strategy to Address Issues Related to HIV Faced by People from Countries where HIV is Endemic completed Dec. 2003
- March/April 2005 – ACCHO, the Strategy and “Strategy for Life Campaign” launched

ACCHO Membership

- 18 voting members – mainly organizations and individuals from African and Caribbean communities (at least two-thirds of voting members must be Black African and Caribbean people)
- 4 non-voting members – Public Health Agency of Canada, AIDS Bureau, Ontario Ministry of Health and Long-Term Care, Toronto Public Health and Ottawa Public Health

How the Strategy was Developed

- Telephone interviews with service providers, researchers, and NGOs working with African and Caribbean people
- Survey with a broad range of stakeholders
- Input from community members through a public forum held in Nov. 2001 – “For Us, By Us, About Us”
- Focus groups with (a) African and Caribbean people living with or affected by HIV/AIDS, and (b) service providers in Toronto and Ottawa

Role of ACCHO

1. Coordinate and support Strategy implementation, revision/renewal, monitoring and evaluation.
3. Promote the greater involvement of African and Caribbean people living with HIV/AIDS in the response to HIV/AIDS.
4. Ensure effective functioning of ACCHO.
5. Enhance and maintain the relevance and impact of ACCHO.
Guiding Principles
The Guiding Principles address 4 main areas of concern:

- HIV among African and Caribbean peoples is an urgent issue requiring immediate attention and dedication of resources.
- African and Caribbean communities should be involved in planning and delivering services for people.
- Racism, gender discrimination, homophobia and other forms of discrimination affect the care and services people receive.
- Programs and services should meet the needs of a range of people and groups from the African and Caribbean communities (e.g., youth, women, gay men and other MSM, lesbians, trans people and IDUs).

Goals of the Strategy
Goal:
To reduce the spread of HIV among African and Caribbean people in Ontario and improve the quality of life for people infected and affected by HIV.

Strategic Directions
Objective 1 – Coordination
- Advocate for resources to support the Strategy.
- Create a supportive environment for prevention work.
- Hold organizations accountable for providing services to African and Caribbean people in Ontario.
- Coordinate work with African and Caribbean people through ACCHO.

Strategic Directions (cont’d)
Objective 2 – Community development
- Promote programs that are accessible and sensitive to cultural issues and the circumstances of women.
- Support African and Caribbean communities and organizations to build their capacity to respond to HIV/AIDS.
- Train/educate health care workers to make them more sensitive to cultural issues of African and Caribbean people.

Strategic Directions (cont’d)
Objective 3 – Research
- Establish research priorities that are relevant to the needs of African and Caribbean peoples.
- Promote research that is ethical and respectful.

Moving Forward
- Promotion of strategy to be “owned” by different stakeholders including African and Caribbean communities, service providers, policy makers and researchers.
- Promoting an understanding of HIV that is framed within a broader context — intersection with other factors that impact on how people understand HIV prevention, whether/how people get tested, access to proper care, treatment and support.
  - Migration, Immigration and legal status in Canada.
  - Stigma and discrimination based on race, gender, sexual orientation, disability, HIV status, etc.
  - Psycho-social and cultural based forces.
  - Economic-based forces/poverty.
Moving Forward (cont’d)

- Incorporation of goals and objectives of the Strategy in the work-plans of organizations
- Advocate for more resources to support HIV/AIDS education, prevention, support, care and research in African and Caribbean communities

Setting a Research Agenda (cont’d)

- Capacity Building Project:
  - Research conference (ACCHO/OHTN) – April 28-29th, 2006 – bring together researchers and community members to discuss and develop priorities
  - Prevention guidelines – for service providers and organizations that work with African and Caribbean communities
  - Training manual and training activities – to be done in Toronto, Ottawa and Montreal March 2006

Setting a Research Agenda:

- Research
  - Stigma and discrimination project – partnership between ACCHO and the HIV Unit, University of Toronto
  - Black MSM project

- Epi monitoring and surveillance Activities with CIDPC:
  - Epi Update on Populations from HIV Endemic Countries working group
  - Holding discussions on surveillance needs, gaps, and challenges and enhancement studies that can be undertaken to fill the gaps
  - Development of a status report on populations from HIV Endemic countries as part of PHAC’s efforts in the implementation of Leading Together.

Strengthening HIV Prevention (cont’d)

- Strengthening HIV prevention efforts
  - Funding of more positions in Southern Ontario to support HIV prevention efforts within African and Caribbean communities
    - AIDS Committee of London
    - Hamilton AIDS Network
    - Peel HIV/AIDS Network
    - 3 Black ASOs in Toronto
    - Sumerset West community Health Centre, Ottawa

Creating a National Platform (cont’d)

- Spring-boarding project – preliminary work to develop a national strategy for black, African and Caribbean communities in Canada
Building Global Linkages (cont’d)

- AIDS2006 conference – Developed a global program/Stream similar to the MSM stream with an international Advisory committee to highlight the issues of African and Caribbean people living in western developed countries.
  - satellite/symposium, 4 formal sessions on women, youth, queer populations of African descent, post-AIDS2006 planning
  - booth for distributing resources and other formal and informal activities
  - Documentary viewing & photo exhibit
  - Theatre and pop culture education activities (targeted to youth)
  - Road map to activities of interest

ACCHO membership

- African Community Health Services (ACHES)
- Africans in Partnership Against AIDS (APAA)
- AIDS Committee of Toronto (ACT)
- Black Coalition for AIDS Prevention
- Casey House Hospice
- Centre Francophone de Toronto
- People 2 People Aid Organization (P2P)
- Somerset West CHC
- Women’s Health in Women’s Hands CHC
- Dept of Public Health Sciences, U of Toronto
- 6 unaffiliated community members

ACCHO ex officio members

- AIDS Bureau, Ministry of Health and Long-term Care
- Ottawa Public Health
- Public Health Agency of Canada – Ontario Region
- Toronto Public Health

Thank you!
Strategies to reduce barriers amongst immigrant, refugee and non-status PHAs

Alan Li, M.D.
HIV & Immigration Think Tank
June 6th, 2006

Key Challenges
- Complexity of policies and service systems & difficulty to understand/negotiate access
- Multiple intersecting layers of systemic discrimination compounds vulnerabilities
- Stigma and fear preventing access to information & services
- Lack of cultural competent and appropriate legal, settlement & health services and support system

Key strategies to-date
- Committee for Accessible AIDS Treatment
- OACHA Health Access Working Group
- Ethno-racial Treatment Support Network

Committee for Accessible AIDS Treatment
- Formed in 1999 in response to barriers faced by people with HIV/AIDS (PHAs) who are immigrants, refugees or without status in Canada
- Coalition of health, legal and social services organizations

CAAT Partners
- Access Alliance Community Health Centre
- African in Partnership Against AIDS
- AIDS Action Now
- AIDS Committee Toronto
- Alliance for South Asian AIDS Prevention
- Asian Community AIDS Services
- Black Cap
- Casey House Hospice
- Centre for Spanish Speaking People
- Community care Access centre, Toronto
- Davenport Perth Community Health Centre
- 333 Sherbourne Health centre

CAAT Partners (Cont.)
- 410 Sherbourne Health Centre
- HIV/AIDS Legal Clinic of Ontario
- Metro Toronto Chinese & Southeast Asian Legal Clinic
- National Anti-Racism Council
- Ontario Council of Agencies Serving Immigrants
- Toronto People with AIDS Foundation
- Parkdale Community Health Centre
- Regent Park Community Health Centre
- SHOUT Clinic
- St. Michael’s Hospital
- Toronto Department of Public Health
- Women’s Health in Women’s Hands Health Centre
- Voices for Positive Women
CAAT

- Action Research to improve treatment access for PHAs who are immigrants, refugees or without status in Canada (2000-2001)

Action Research 2000-2001

- To document needs and barriers
- To document existing strategies
- To research other tried strategies
- To bring stakeholders together to problem solve (community mobilization)
- To formulate action plan and pilot new strategies (community action)

Action groups

- Legal Information task force
- Service Advocate Training
- HIV Medication Access Project (Drug depot)

Improving Legal Service Access (CAAT/HALCO/Lawyers)

- Improve legal information
  - Fact sheet on HIV & Immigration issues
  - Status and service eligibility
- Improve access to legal services
  - "Immigration & HIV" chapter in Legal advocate training manual
  - Education session for lawyers via LSUC
  - Advocate to HALCO to provide services on HIV & immigration

Service Accessibility Project

- Developed training modules on HIV, immigration, service access advocacy, cultural competency skill for PHAs and service providers
- Outreach and use train the trainer model to expand knowledge and service network
- Broker specific streamlined referral process and service arrangement
- Develop resource listing on services accessible for the non-insured

HMAP

- HIV Medication Access Program, funded by Glaxo & MOH AIDS Bureau
  - Centralized coordinated compassionate drug access mechanism
  - Government to fund coordination
  - Pharmaceuticals to donate drugs
  - Explore longer term options for “recycling”
  - Now core program at Toronto PWA
Impact
- Hidden issue brought to surface for discussion, advocacy and problem solving
- Improved service providers’ knowledge and mutual support
- Improved access to treatment and care for marginalized PHA populations

Public Policy Review
- Public Policy Analysis: Status, Access & Health Disparities Report
- Examine the intersecting impact of various governmental policies affecting immigrants, refugees and PHAs
- Think Tanks to identify key policy, programming and research directions; build collaborative partnerships amongst stakeholders

OACHA working group on health service access:
- Identify key groups of uninsured I & R PHAs (with different status) and corresponding access barriers
- Develop targeted advocacy strategies
- Study to quantify non-status PHAs

Mental Health Research
- Action Research to improve access to mental health services for I & R PHAs
  - Component 1: needs assessments of PHAs
  - Component 2: needs assessments of service providers
  - Component 3: Literature review and Capacity Building activities to engage PHAs as co-researchers to articulate best practice models
  - Components 4-6: Develop service provider training, pilot innovative service models and develop policy and programming recommendations & best practice guidelines

Mental Health Research
- Community based and driven
- Co-sponsored by ACAS, ASAAP, APAA, Black Cap, CSSP
- Academic partners: McMaster, University Health Network, St. Michael’s Hospital, CAMH
- Funder: OHTN, Wellesley Central

Ethnoracial Treatment Support Network (ETSN)
- Africans in Partnership Against AIDS
- Alliance for South Asian AIDS Prevention
- Asian Community AIDS Services
- Black Coalition for AIDS Prevention
- Centre for Spanish Speaking Peoples
- Canadian AIDS Treatment Information Exchange
Appendix E

**ETSN**

- **Peer Treatment Counselor Training Program**
  - 50 peers trained from 5 ethno-racial communities
- **Peer Leadership & Mentorship Training Program**
  - Over 30 are active staff or volunteers in ASOs or health care field
  - Over 10 has become peer trainers for other peers

**ETSN**

- **Multi-lingual Treatment Information development**
  - Started by ACAS guided by action research on PHA information needs, 4 Asian languages & English (2001 OHTN)
  - Information incorporated into CATIE site and translated into French
  - Needs assessment replicated by 4 other communities (ASAAP, APAA, BCAP, CSSP)
  - New information developed in 2 African and 2 South Asian languages
  - Multi-lingual site to be launched at IAC 2006
  - AIDS Glossary in 9 languages for IAC

**Next Steps**

- Think Tank to review policies and programs on issues affecting immigrants and refugees with HIV/AIDS
- Develop key strategic directions for collaborative action
- Develop comprehensive immigrant and refugee AIDS strategy