Agence de la santé et des services sociaux de Montréal

2010 REPORT OF THE DIRECTOR OF PUBLIC HEALTH

Reach more

Screen more

Treat more

Québec

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SEXUALLY TRANSMITTED AND BLOOD-BORNE INFECTIONS

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A MESSAGE FROM THE DIRECTOR

In Montréal, like in the rest of the province, sexually transmitted and blood-borne infections (STBBI) have reached alarming proportions. Reading this report should be enough to convince you. It shows the extent of the challenge we face.

Hepatitis C virus (HCV) and human immunodeficiency virus (HIV) infections have been wreaking havoc on the island of Montréal. Both infections particularly affect injection drug users (IDU), whereas men who haves sex with men are affected mostly by HIV. Recognizing that the health of these individuals was seriously threatened and that the health of society must be protected, I defined the fight against STBBI as a priority in our 2010-2015 regional action plan. In fact, all 12 of Montréal's health and social services centres (CSSS) were prompted to do the same in their local action plans.

This does not mean that the enormous amount of work accomplished to date has not yielded results. Quite the contrary. However, the situation has evolved over the past 20 years and these efforts are no longer enough. Today, new circumstances require us to review our practices and define strategies adapted to the needs of vulnerable groups as well as to new contexts.

Our actions are situated within a harm reduction perspective. The theme: Reach more, screen more and treat more. It should not come as a surprise that the focus is on access to protective equipment, screening services and treatment. Organizing hepatitis C treatment necessitates the collaboration of numerous partners, especially of primary and specialized health care professionals. Treatment is one of the best ways to reduce HCV transmission and its consequences. In the end, all of society will be better protected!

Finally, it cannot be said often enough: We are counting on the concerted action of all our partners. By placing these actions in a perspective of reducing social inequalities in health and improving living conditions, we can score points in the fight against STBBI, especially against infections caused by hepatitis C and human immunodeficiency viruses.

Director of public health,

Richard Lessard, M.D.

Photo : © Louise Lefort

TABLE OF CONTENTS

Introduction 1

Numbers to Work On 4

Ravages of STBBI in Montréal 6
Hepatitis C 6
Human immunodeficiency virus infection 7
Syphilis 8
Gonorrhoea 9
Genital chlamydia 10

Jennifer, Francis and Vulnerability 11

Vulnerable Groups: Part of Montréal's Social Fabric 13
Persons who inject drugs 13
Men who have sex with men 14
Other vulnerable groups 15
Street youth 15
People from countries where HIV is endemic or HCV prevalence is high 15
Incarcerated persons 16
People from Aboriginal communities 16
Youth aged 15 to 24 years 16

Taking Action 18

Six Strategies for the Control of HCV and HIV 20
1. Expand efforts to reach the most vulnerable groups 20
2. Increase access to protective equipment 22
3. Enhance access to screening services and to psychosocial outreach services 23
4. Improve treatment organization 25
5. Foster empowerment 27
6. Influence public policy 29

Conditions for Success at an Organizational Level 32

Conclusion 37

Bibliography 39

LIST OF **FIGURES**

Hepatitis C virus infection, incidence and case distribution by sex
By CSSS territory, Montréal, 2009 6

Distribution of reported cases of HCV infection for Montréal,
by main category of exposure (2006 to 2009) 7

Infectious syphilis, incidence and case distribution by sex
By CSSS territory, Montréal, 2009 8

Incidence of gonococcal infection in Montréal, 1996 to 2009 9

Incidence of genital chlamydia in Montréal, 1996 to 2009 10

Photo : © Louise Lefort

In Québec, especially in Montréal, sexually transmitted and blood-borne infections (STBBI) have reached alarming proportions. This is particularly true for hepatitis C virus (HCV) and human immunodeficiency virus (HIV) infections, which affect mostly persons who inject drugs. Men who have sex with men (MSM) remain the group most affected by HIV and syphilis, of which an unexpected resurgence has been observed. The consequences of STBBI can be devastating and even fatal.

Over the past 20 years, a tremendous amount of work has been done on STBBI control, in both the community and health networks. In fact, community organizations have intensified their prevention efforts and clinical settings have substantially developed their expertise on HIV. Also, surveillance and monitoring activities at the Direction de santé publique de Montréal (DSP) have enabled stakeholders to track the situation closely. These combined efforts, to which the DSP added support for promotion and prevention activities, have resulted in clear gains. For instance, among persons who inject drugs, HIV incidence and injection equipment sharing have significantly declined since 1995.

Despite these undeniable gains, work must go on. The resurgence of syphilis has created fears about an increase in HIV transmission among MSM. The high number of hepatitis C cases will have very serious consequences for persons who inject drugs and for the health care system if no additional efforts are made. Furthermore, Montréal has changed considerably. Indeed, community action that was so vigorous in the early 1990s has weakened; improvements in HIV treatments have lead to an overall slackening of safer sex practices, particularly among MSM; and the epidemic wave of HCV has hit persons who inject drugs. Community involvement related to this infection is rather recent and follow-up of infected individuals is not generalized. Moreover, substances used for injection have become more varied and have considerably changed over the past few years. This has had the effect of multiplying the risks of infection and overdose. Venues where men meet to have sex with other men are more numerous and diverse than ever before—especially because of the Internet—making it increasingly difficult to reach groups who are most at risk. Concomitant physical, mental health and social problems in a growing number of vulnerable individuals complicate prevention efforts, care and treatment provided by a health network that has just undergone major reorganization. Finally, social pressures have caused vulnerable individuals to disperse throughout the city, to sever links with their environments and to isolate themselves even more, thereby making them even more vulnerable.

The resurgence of syphilis has created fears about an increase in HIV transmission among MSM.

The high number of hepatitis C cases will have very serious consequences for persons who inject drugs and for the health care system if no additional efforts are made.

In this context, without denying what has been accomplished, it must be admitted that efforts expended on prevention, screening and treatment over the past 20 years are no longer enough. We have no choice: The health and social services network and its partners have to transition to new realities and be more innovative in their response. To achieve this goal, it is imperative to better understand the needs of vulnerable populations, to set intervention priorities and to review STBBI control strategies, especially those targeting hepatitis C and HIV.

In Montréal, the health needs of the most vulnerable groups are huge and pressing. Much remains to be done to reduce STBBI transmission. The urgent need for more action is evident.

JENNIFER IS 28 YEARS OLD.
SHE HAS BEEN INJECTING DRUGS DAILY
FOR AT LEAST FIVE YEARS.

At first, drugs were just a distraction. Today, for Jennifer, it's the only way she can cope. The only way she can deal with end-of-the-month stress. The only way she has enough energy to feed her child after school. The only way she reluctantly lets a few clients into her home every week. Some clients insist on having sexual relations without condoms, but they pay well. It's especially important that the neighbours don't find out. She has only one friend, with whom she shares everything, even her needles... What about the future? What about her health? She'll think about it later. Life's too complicated for now.

FRANCIS IS A 40-YEAR-OLD MAN WHO IS JUST LIKE MANY OTHERS HIS AGE. HE PREFERS TO HAVE SEX WITH MEN.

Francis has a job in a small business that gives him financial security. His colleagues respect him and he feels his job is rewarding. Recently, he split up with his wife so he could have more freedom. He lives alone. He finds partners in saunas, in bars and on the Internet who, like him, are looking for anonymous encounters. Little by little, he's stopped using condoms even though he's worried about HIV. Sometimes he tells himself that he should get tested. At the same time, he thinks that taking risks is part of life and that you'd have to be truly unlucky to come across someone who has the virus.

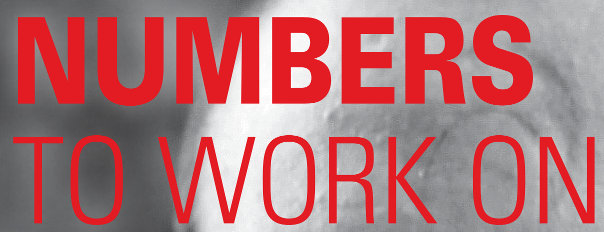

Photo : © Louise Lefort

Since 1998, infections caused by hepatitis C and human immunodeficiency viruses, syphilis, gonorrhoea and chlamydia have reached alarming proportions on the island of Montréal. For example,

- 68% of persons who inject drugs have HCV infection, and 25% of them are unaware they are infected;
- 18% of persons who inject drugs have HIV, and 26% of them do not know it;
- 15% of MSM have HIV, and 13% of them are unaware of it.

In 2009, of new HIV and syphilis cases diagnosed in the province, over 50% were from Montréal; similarly, the figure for gonorrhoea was 50%, 45% for HCV and 28% for genital chlamydia.[1]

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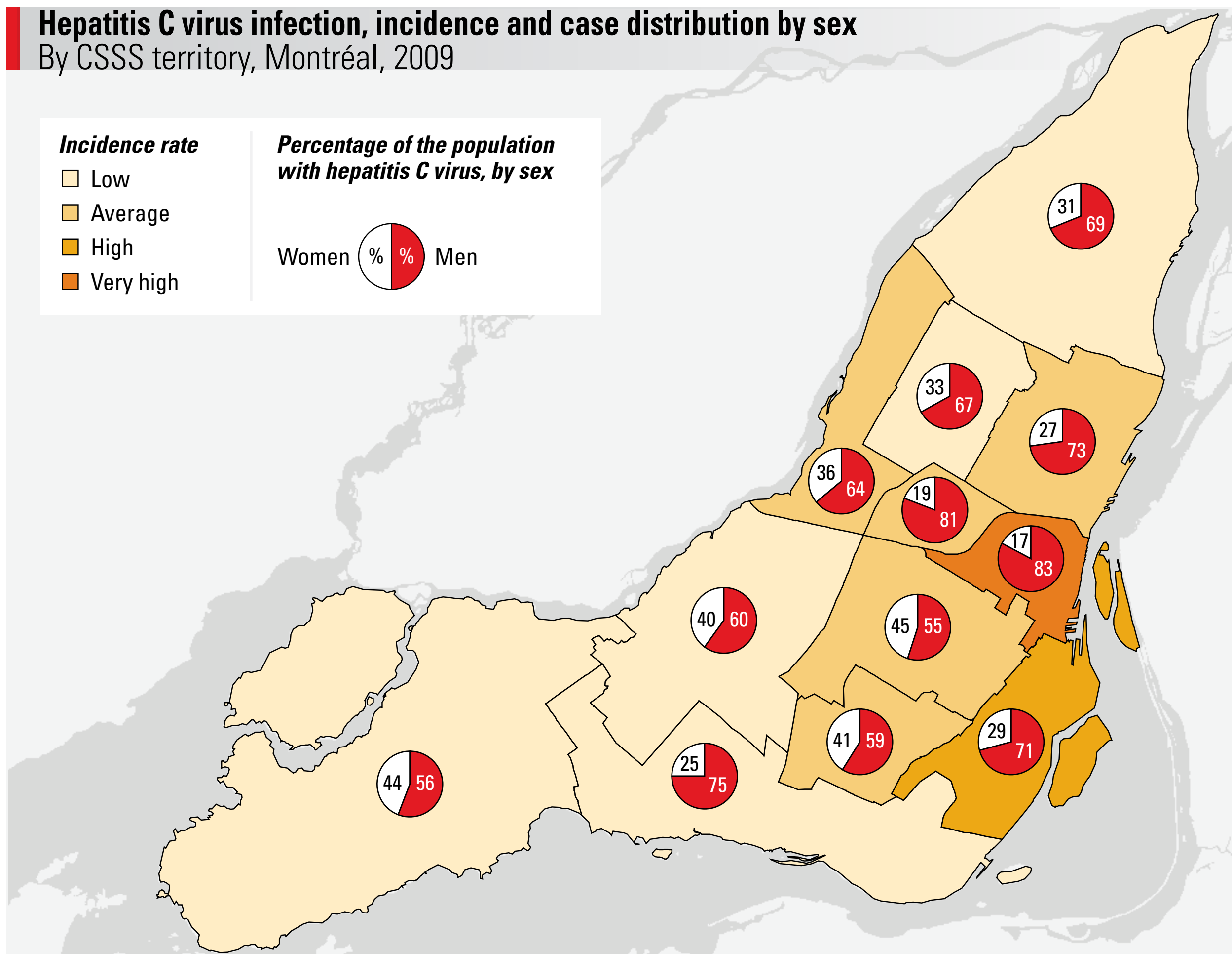
1 Data cited in this document are taken from the database of reportable diseases (MADO) for 2009, and from the results of the most recent epidemiological surveillance projects.

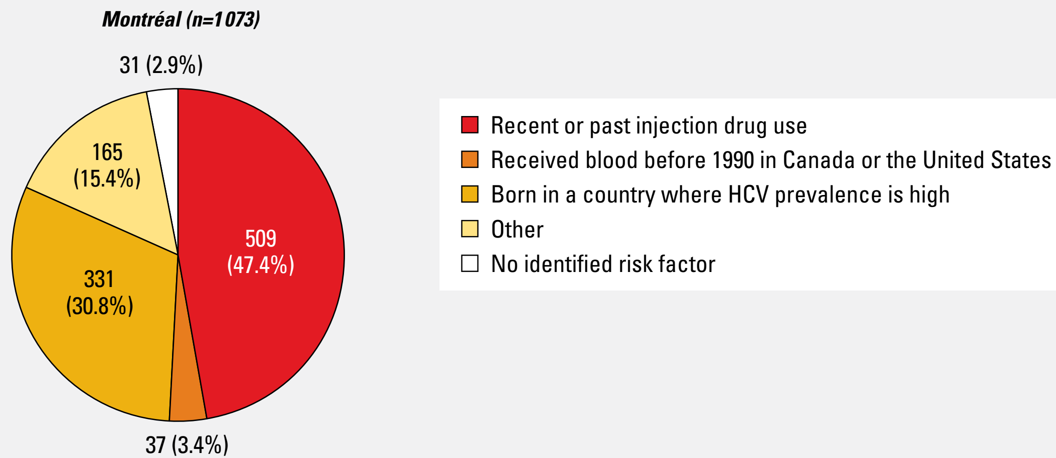
Hepatitis C

Hepatitis C virus is spread by percutaneous exposure to infected blood. Although possible, sexual transmission is rare. In 75% to 85% of cases, individuals develop chronic infection and can transmit HCV. The main complication, which affects 20% to 50% of these people, is cirrhosis of the liver that can evolve into liver cancer.



There are cases in all CSSS territories, the most affected being CSSS Jeanne-Mance (very high rate), followed by CSSS du Sud-Ouest–Verdun, where the rate is high.

Distribution of reported cases of HCV infection for Montréal, by main category of exposure (2006 to 2009)



In Montréal:

- Among reported cases, 50% are attributable to drug injection (past or recent).
- 31% of reported cases are people born in countries where HCV prevalence is high.

Human immunodeficiency virus infection

Human immunodeficiency virus is transmitted sexually and through blood. Despite the fact that treatment exists, the infection lasts a lifetime and can also be transmitted to newborns. In 2008 in Québec, the number of cases was estimated at about 17,900. In 2009, 614 cases of HIV infection were reported to the Programme québécois de surveillance de l'infection par le VIH across the province, including 367 (60%) in Montréal.

In Montréal:

- From April 2002 to June 2009, 1855 new cases of HIV infection were diagnosed.
- During the same period, 72% of new diagnosed cases were MSM. This percentage is 3% higher if we include individuals who are both MSM and injection drug users.
- Close to 60% of women who have the infection are from countries where HIV is endemic.
- Each year, 3 out of 100 persons who inject drugs are newly infected with the virus.

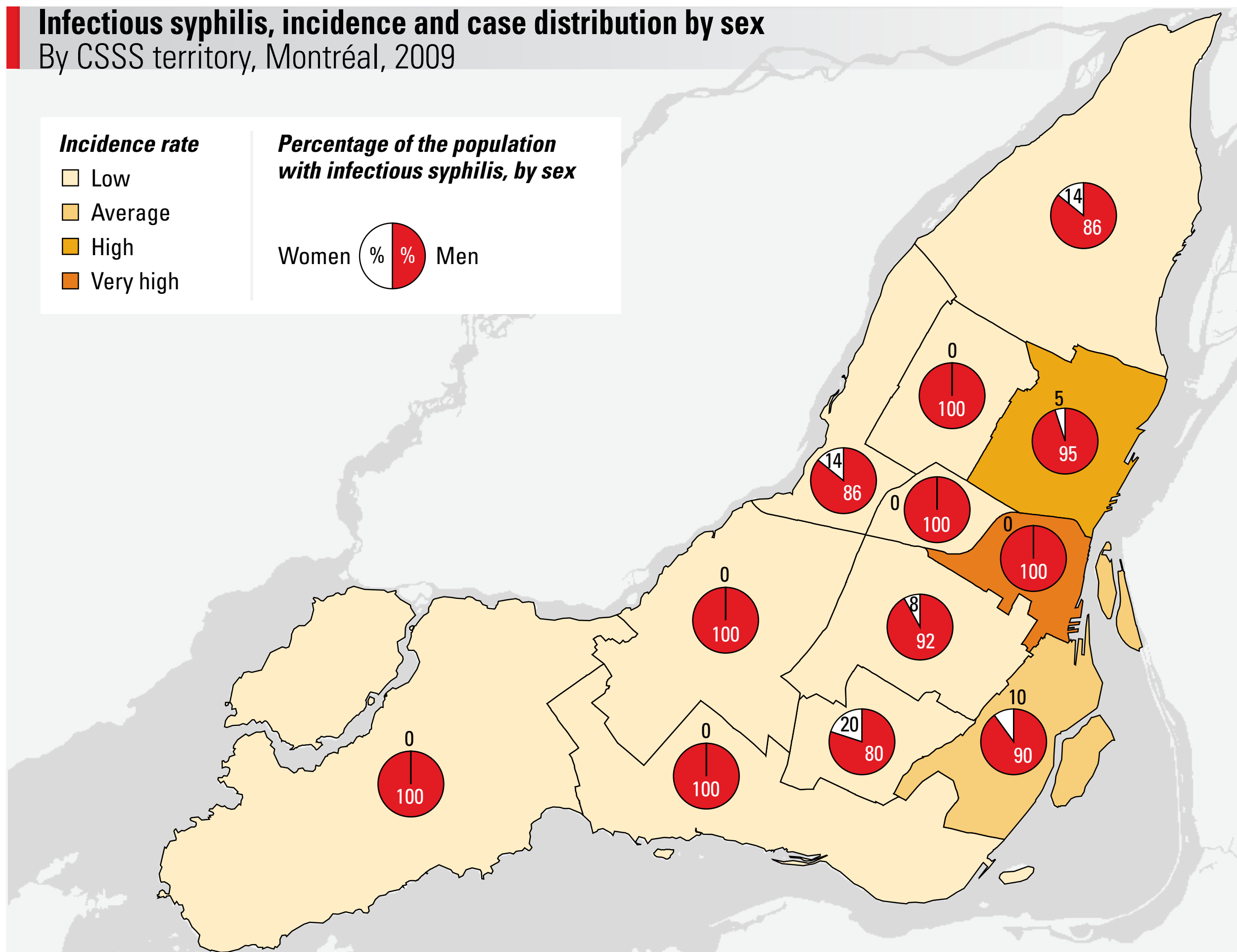
Syphilis

Over the past 10 years, there has been an unexpected increase of syphilis cases. If left untreated, syphilis can cause very serious cardiac and neurological complications and significant malformations in newborns. Lesions caused by this infection can increase the risks of contracting or transmitting HIV and other sexually transmitted infections.

In Montréal:

- MSM account for 94% of cases of syphilis who were the subject of epidemiological investigations following case reports to the DSP.
- 49% of these cases reported having HIV infection.
- 64% of them had had sexual relations in saunas in the past 12 months.
- In 2009, the rate of syphilis among men was almost 40 times higher than in 2000.

Infectious syphilis, incidence and case distribution by sex
By CSSS territory, Montréal, 2009



Among men, syphilis is clearly progressing in the three territories where incidence rates are high or very high, as well as in two other CSSS territories.

Syphilis is also on the rise among women. In 2009, for the first time, cases were reported in women in six different CSSS territories.

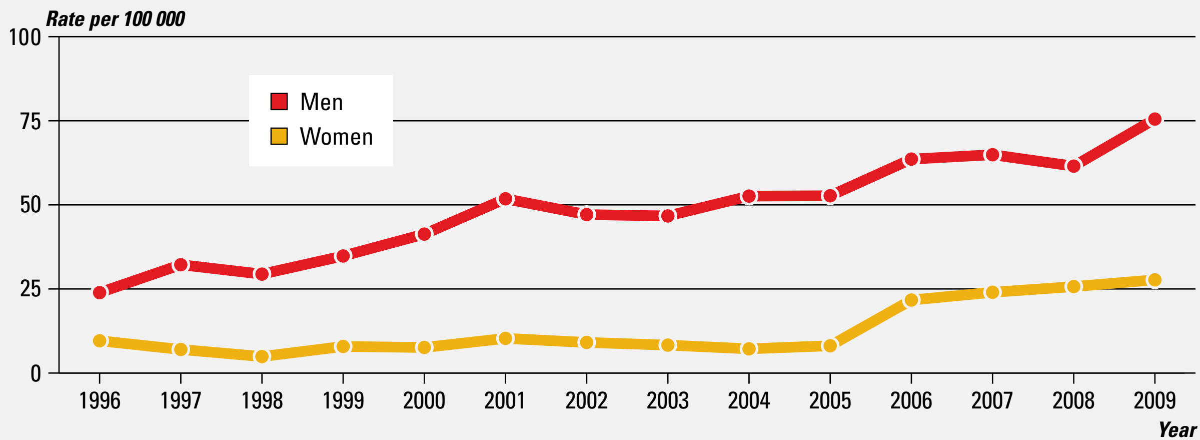
Gonorrhoea

Gonorrhoea is transmitted sexually and can cause complications such as infertility, ectopic pregnancy and chronic pelvic pain in women. It can be passed on to newborns. HIV transmission is enhanced in people with gonorrhoea.

In Montréal:

- In 2009, 973 cases were reported, which represents almost half of the cases in the province.
- 38% of reported cases were young people aged 15 to 24 years.
- In 2008, 6% of MSM were diagnosed with gonorrhoea in the past 12 months.

Incidence of gonococcal infection in Montréal,
1996 to 2009



Incidence is increasing significantly in Montréal. Figures have been rising almost continuously since 1996 among men; the numbers for women started rising in 2006.

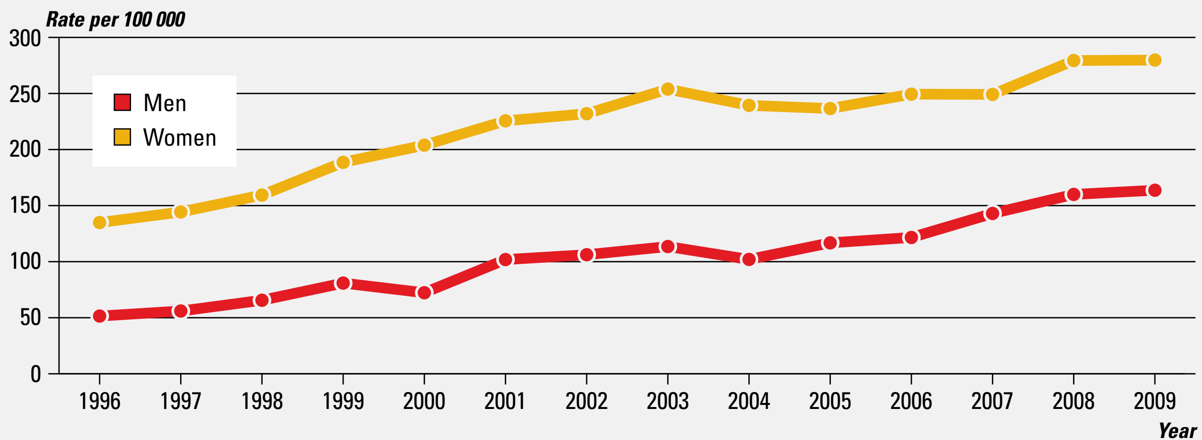
Genital chlamydia

Like gonorrhoea, genital chlamydia is often asymptomatic. It is the main cause of pelvic inflammatory disease in women. This infection can cause complications, particularly infertility.

In Montréal:

- There were 4252 new cases in 2009, 64% of whom were women from all age groups.
- 43% of diagnosed cases affect young women aged 15 to 24 years.

Incidence of genital chlamydia in Montréal,
1996 to 2009



Since 1996, incidence has increased significantly in Montréal, among men as well as women.

JENNIFER, FRANCIS AND **VULNERABILITY**

In addition to individual risk factors, other factors related to HIV vulnerability—cultural norms and social inequality, for example—can foster STBBI transmission. When STBBI epidemics occur in Montréal, persons who inject drugs like Jennifer and MSM like Francis are among the most vulnerable populations. However, STBBI affect other groups of people also defined as vulnerable: street youth, people from countries where HIV is endemic or HCV prevalence is high, incarcerated persons, people from Aboriginal communities and young people aged 15 to 24 years. They are defined as vulnerable, that is, more likely than other groups to be exposed to STBBI, mostly due to three factors:

The marginal status that poverty, homelessness, prostitution and incarceration impose creates contexts that favour the spread of STBBI.

- **Living conditions,** some of which work against adoption of safer behaviours and reduce opportunities for individuals to protect themselves, and to get tested and treated. The marginal status that poverty, homelessness, prostitution and incarceration impose creates contexts that favour the spread of STBBI.
- **Psychosocial factors** that foster risk taking, isolation and social exclusion, such as lack of self-esteem and stigmatization experienced by persons who inject drugs and MSM because of the illicit or taboo nature of their activities.
- **Risky behaviours** that heighten the risks of contracting an STBBI, such as having unprotected sexual relations, especially with multiple partners, and sharing injection equipment, which is reported by almost a third of persons who inject drugs. Like for alcohol consumption, drug use often leads to abandoning safer sexual behaviours.

As we can see in the statistics, persons who inject drugs have high HCV and HIV infection rates. For their part, MSM are the group most affected by HIV and syphilis-HIV coinfection.

HCV and HIV infections have particular characteristics and can lead to serious consequences...

HCV and HIV infections have particular characteristics and can lead to serious consequences:

- These infections are often asymptomatic and become chronic.
- There is no vaccine to protect against these infections.
- If left untreated, the resulting complications are significant (e.g. cirrhosis, liver cancer, other cancers) and the outcome can be fatal.
- Treatment is long, complex and requires constant follow-up. HIV treatment lasts a lifetime and is very expensive. HCV treatment is effective in 50% to 80% of cases, but too few people are tested and treated.
- Recovery from hepatitis C does not confer lasting immunity, and reinfection is always possible.

- The side effects of HIV treatment can be physical (e.g. lipodystrophy, diarrhoea), psychological (e.g. stigmatization, anxiety) or social (e.g. loss of employment, isolation); those of hepatitis C antiviral treatment range from general flu-like symptoms and fatigue, for example, to neuropsychiatric disturbances that produce sleep disorders, anxiety, depression and other problems.

For all these reasons, people like Jennifer who use injection drugs, and men who have sex with men, like Francis, are priority clienteles among groups who are vulnerable to STBBI.

VULNERABLE GROUPS: PART OF **MONTREAL'S SOCIAL FABRIC**

Photo : © Éric St-Pierre

We sometimes choose to turn a blind eye to the situation of vulnerable groups and to remain silent. Even worse, it is not unusual for us to see them as being responsible for their own situation: this feeds prejudices, encourages discrimination and contributes to their exclusion and isolation. And yet, these groups are part of our living environments. Data clearly show that there are persons who inject drugs and MSM in all health and social services centre territories in Montréal, even though their demographic weight varies among these territories. It is also known that the presence of large ethnocultural groups can influence epidemiological profiles in some territories. Variations observed over time and from one territory to another indicate the degree to which the situation regarding STBBI is constantly evolving.[2]

Persons who inject drugs

Persons who inject drugs are mostly affected by HCV and HIV. In Montréal, like in the rest of the province, sharing injection equipment is the main cause, despite gains such as the reduction of incidence of HIV infection (from 6 to 3 people per 100 yearly) and the decline in the proportion of persons who inject drugs who share their needles (from almost 50% in 1995 to 27% in 2007). People who share equipment are likely to come into contact with contaminated blood when they use non-sterile needles or drug preparation equipment. The risk of injecting with used equipment has grown over the past five years because of increased consumption—by injection—of pharmacological opioids that are normally taken orally (like Dilaudid®). Cocaine use, which has been widespread since the appearance of HIV infection, also contributes to raising this risk because the effects of the drug are short lasting and lead to more frequent use. Drug use, especially the constant search for money to buy drugs, sometimes leads to sex work, abandonment of safer sexual practices and financial precariousness.

> In 2007, one in four IDU had injected with a used needle in the past six months.

Moreover, the illicit nature of drug possession and the stigmatization, or even repression, directed toward persons who inject drugs cause these individuals to inject in inappropriate conditions, for instance, to inject quickly in public places. This practice jeopardizes their safety and can lead to overdose or stroke. Drug use can also sometimes be a coping strategy to deal with personal, family, social or economic problems, as is the case for Jennifer. Conversely, drug use can be the cause of these problems.

Although most persons who inject drugs are in the downtown area, there are some in all boroughs. Because of the gentrification of central boroughs and of large real-estate development projects, people living in precarious situations—especially persons who inject drugs—move to adjacent boroughs.

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2 To review the detailed profile of a CSSS territory, see the territory's 2009 local STBBI profile.

Although most persons who inject drugs are in the downtown area, there are some in all boroughs.

This is a growing phenomenon that has negative effects since it brings about isolation and causes persons who inject drugs to be further away from services intended for them. Indeed, many of the peripheral neighbourhoods do not necessarily have as many resources for persons who inject drugs as do downtown areas.

Persons who inject drugs feel excluded and do not have extensive support networks. They are often struggling with mental health problems and low self-esteem. Overall, they scarcely use health services and have often had negative experiences when they did use them. Although two-thirds of persons who inject drugs have already been infected with HCV, screening is rare and 27% of those who have the infection are not aware of it. Medical follow-up of individuals who know they have HCV is not very widespread: fewer than 10% of persons who inject drugs and who have HCV have initiated treatment and 50% of those with HIV are being treated.

...fewer than 10% of persons who inject drugs and who have HCV have initiated treatment and 50% of those with HIV are being treated.

Men who have sex with men

Photo : © Éric St-Pierre

A 2008 survey of men who have sex with men and who frequent gay socialization venues revealed that 47% of sexually active respondents had had one or several oral or anal sexual relations with at least six partners in the past six months. Furthermore, almost 1 in 3 MSM had had unprotected anal sex during the same period.

Risky sexual behaviours make this heterogeneous group—composed of homosexual, gay, bisexual or heterosexual men of all ages and origins, and from various cultures and socioeconomic statuses—one of the most vulnerable to STBBI, especially HIV and syphilis-HIV coinfection. In addition, 1 in 25 MSM has hepatitis C and, among them, HCV infection appears to be mostly linked to injection drug use.

MSM are overrepresented among individuals who have syphilis and gonorrhoea. Indeed, the 2008 survey revealed that 1 in 20 participants had syphilis or had had it in the past. From 2003 to 2006, the number of cases of syphilis among this group rose significantly in Montréal. The rate for gonorrhoea rose continually from 1996 to 2009 on the island of Montréal, and the rate for MSM is rather high.

Currently, no decline in the number of new HIV cases diagnosed yearly has been observed. Several reasons could explain this situation. First, the perception of HIV/AIDS as a chronic rather than fatal disease has resulted in a scaling down of protection efforts. Second, the relatively recent proliferation of venues where men meet to have sex—particularly saunas—and Internet meeting sites has greatly contributed to increased risk-taking. Third, there are indications that having sexual relations under the influence of alcohol or drugs is a common occurrence, and its negative impact on risk-taking, especially in terms of condom use, is well documented. Finally, it is important to note that the number of reported cases is only a partial reflection of reality: the most vulnerable MSM are those who are the hardest to reach and, consequently, who are not screened.

> HIV screening remains low among MSM and many of them do not know they are infected.

Sexual taboos and prejudices about homosexuality persist and continue to be barriers to testing and treatment. This is particularly true for people whose cultures and religions condemn homosexuality or consider it a crime.

HIV screening remains low among MSM (43% of new cases diagnosed from 2002 to 2008 had never undergone prior screening) and many of them do not know they are infected. Among those who have HIV, two-thirds take medication to control the infection.

Other vulnerable groups

Street youth

Photo : © Éric St-Pierre

It is estimated that each year in Montréal, between 4000 and 5000 youth aged 14 to 25 years have to look for a place to sleep or regularly use the services of community organizations. From 2001 to 2004, 32% of street youth who participated in a study conducted in the city had exchanged sex for money or for some other form of payment. There are many reasons why they end up on the street. Emotional, physical or sexual trauma, parental neglect during childhood and presence of a mental health or substance abuse problem in a parent are all aggravating circumstances. Drug use and risky sexual behaviours are very common among this group, and drug injection is the most serious problem. For instance, among IDU street youth, 36% have HCV and 2% have HIV. Consequently, it is important to strengthen interventions designed to prevent transition to injection among street youth.

People from countries where HIV is endemic or HCV prevalence is high

Data from Montréal show that 1 in 5 newly diagnosed HIV cases is a person from a region where HIV is endemic such as the Caribbean, including Haiti, or sub-Saharan Africa. As for hepatitis C, the highest rates are in Asia and Africa, in parts of the world where use of non-sterile injection equipment for care delivery is frequent, and in regions where needle sharing to inject drugs is common. In Montréal, 40% of infected individuals were born in these places. Religious beliefs, cultural differences, language barriers, difficulties linked to integration and the ensuing isolation, fear of being judged and being the object of discrimination, and culturally insensitive services are all major obstacles to reaching these populations, informing them about safer behaviours and offering screening services and treatment.

Incarcerated persons

A study of the prison population conducted in 2003 showed that over a quarter of men and nearly half of women have had sexual relations with injection drug users. The study also indicated that 28% of men and 43% of women have injected drugs at least once in their lives. While risky sexual and drug injection behaviours decline among drug users when they are in prison, over half of individuals who use injection drugs share their needles. In fact, 10% of incarcerated persons who have ever injected drugs are infected with HIV. Among injection drugs users in prisons, 56% have HCV; the practice of tattooing is common among these individuals, about a third of whom use non-sterile equipment.

People from Aboriginal communities

Aboriginal people who engage in risky sexual practices or who use drugs are another population vulnerable to STBBI. It is estimated that provincially, reported cases of gonorrhoea and genital chlamydia among Aboriginal people are proportionately 12 to 16 times higher than among the population as a whole. Over the past few years, an increase in the number of HIV cases has been observed among Aboriginal people living in urban areas in Canada. Although to date no such increase has been documented in Montréal, an outbreak of HIV among this group is very possible. A lack of markers upon their arrival in the city, poverty and language barriers accentuate their isolation. Furthermore, they rarely go to community organizations or use health services.

Youth aged 15 to 24 years

Since 1996, we have seen a startling increase in rates of genital chlamydia and gonorrhoea among young people aged 15 to 24. Aside from a failure to maintain safe behaviours, the rise in cases can be explained by more effective screening and greater test sensitivity. These infections affect young women in particular. Ignorance of STBBI, magical thinking and finding it difficult to inform a partner are all well-documented factors that explain the persistence and progression of these infections. What is more, alcohol use and low self-esteem contribute to increasing young people's risks of contracting an STBBI. These data demonstrate the pertinence of and need for sex education in schools. They confirm the importance of offering services designed for this population to support prevention efforts and adoption of healthy lifestyle habits.

Photo : © Éric St-Pierre

This brief profile of different groups vulnerable to STBBI in Montréal shows that two groups are particularly at risk—persons who inject drugs and MSM. Yet, many individuals included in other vulnerable groups inject drugs or are men who have sex with men. The vulnerability of these individuals and their particular needs (especially regular screening and early treatment) require adapted care and services that are accessible in their living environments as well as through primary care in institutions and private clinics. This is the rationale for the DSP's decision to implement, on a priority basis, six strategies that especially target persons who inject drugs and MSM.

Photo : © Louise Lefort

TAKING **ACTION**

Photo : © Louise Lefort

First and foremost, we must acknowledge that while we are not starting from scratch, much remains to be done. To take action is to build on the outcomes of community work and promising strategies, like outreach services. It is to rely on interprofessional and intersectoral collaboration and to work in concert with all our partners. It is even to accept to review how services are organized.

To make gains against the HCV epidemic and active HIV transmission in Montréal, the Direction de santé publique is seeking the collaboration of all its partners. It is counting on its long-standing partnership with community groups and its other partners in the health and social services network who play crucial roles in implementing strategies and related actions. The theme: Reach more, screen more, treat more.

SIX STRATEGIES FOR THE CONTROL OF **HCV** AND **HIV**

To increase intervention effectiveness, the DSP has prioritized **six strategies** adapted to targeted populations and to the situation in Montréal:

1. Expand efforts to reach the most vulnerable groups
2. Increase access to protective equipment
3. Enhance access to screening services and to psychosocial outreach services
4. Improve treatment organization
5. Foster empowerment
6. Influence public policy

Each strategy must be supported by **concrete actions** that involve all partners and stakeholders in the health care network.

1. Expand efforts to reach the most vulnerable groups

Like Jennifer and Francis, many persons who inject drugs and MSM seldom use public or community health services. Although several factors are involved, services (if they exist) do not always meet all of these clients' needs. Consequently, these groups elude screening efforts. They must be reached in their own environments, where they live. To achieve this goal, we must step up outreach services and offer adapted services.

Community organizations have identified outreach as a priority for action for the next five years. They are in a better position to review outreach practices and strategies in light of the new context described earlier and marked by the following issues: movement of some vulnerable groups from the downtown core to adjacent boroughs; severed contacts and increased difficulty to reach them; fewer visits to community services; and multiplication and diversity of venues that facilitate sexual encounters. New socioeconomic realities and new technologies present additional challenges since it is vital not only to keep in touch with vulnerable individuals but to reach even more of them. The goals of having community workers in public places (parks, lanes, bars, saunas and other venues where people meet for sexual encounters such as sex clubs), private places and sex parties are essentially for purposes of risk and harm reduction, promotion of sexual health and safer injection, distribution of protective equipment, and accompaniment and referral of individuals to health care services. We cannot emphasize enough the importance of intensifying the intervention efforts of community organizations. They are on the front line and play a determining role in efforts to reach vulnerable individuals in their communities.

Like Jennifer and Francis, many persons who inject drugs and MSM seldom consult public or community health services.

Integrated STBBI screening and prevention services (SIDEP) teams are also on the front line. SIDEP teams were initially created as part of the HIV/AIDS strategy to focus on screening; six teams responded to the needs of territories (especially in the downtown core) where vulnerable groups were located. The situation has changed, but financial and human resources have not been expanded. There are now persons who inject drugs and MSM in all territories, HIV is still rampant, and hepatitis C has reached alarming proportions. In

short, the current situation requires us to review our mandates and focus our efforts on the most vulnerable groups. To do this, SIDEP teams must be set up in all CSSS territories. The same holds true for outreach nurses, who are the designated health care navigators within interdisciplinary teams. The navigator is pivotal to ensuring continuity of services and functions as a bridge between clienteles and medical and psychosocial resources.

At this time, we note that the services generally offered to persons who inject drugs and MSM are not always adapted to their needs. Aside from access to protective equipment, which is far from optimal, there are several shortcomings related to access: complicated procedures, restrictive schedules, strict eligibility criteria, long waiting periods and lack of continuity. This is the justification for a service organization that would emphasize adaptation—that is, curtail obstacles to and requirements for admission—and accompaniment of individuals as they make their way through the health system. We know from experience that such organization yields positive results not only when dealing with the health system but also with community groups.

FOR EFFECTIVE AND CONCERTED ACTION:

- Step up outreach efforts.
- Diversify methods used to reach the most vulnerable groups.
- Set up SIDEP teams in all CSSS.
- Offer services adapted to persons who inject drugs in all CLSCs and tailor procedures to access institutional services.

2. Increase access to protective equipment

Access to protective equipment (condoms and sterile injection equipment) is still too limited. Therefore, distribution sites and methods (mobile services, delivery to homes or to venues where drugs are used, peer distribution, installation of vending machines) should be diversified. Accessibility should be extended to 24 hours a day, 7 days a week in places where this equipment should be available. For instance, we know that a million needles are distributed yearly in Montréal but that 15 million are actually needed, and that condoms are not accessible enough in all targeted sites (e.g. saunas and venues that facilitate sexual encounters). Currently, community organizations distribute 90% of the needles; 13 out of 29 CLSC sites offer injection equipment to persons who inject drugs; and only about a quarter of pharmacies offer MIP kits (personal injection equipment).

Photo : © Éric St-Pierre

Increasing access to protective equipment implies close collaboration among community organizations, CSSS and pharmacies. Collaboration is based on shared responsibility for prevention as well as on CSSS supporting community interventions. All CLSC sites are asked to help distribute injection equipment with the support of well-trained staff that can welcome persons who inject drugs in an appropriate manner.

FOR EFFECTIVE AND CONCERTED ACTION:

- Diversify injection equipment distribution methods.
- Increase the quantity and availability of condoms in saunas and other venues for sexual encounters.
- Distribute sterile injection equipment in all CLSCs and collect used equipment.
- Adapt the way persons who inject drugs are greeted in all CLSCs.
- Expand the number of pharmacies that sell protective equipment kits.

3. Enhance access to screening services and to psychosocial outreach services

Almost 30% of persons who inject drugs who have HCV or HIV do not know they are infected, and 13% of MSM who are infected do not know they are carriers of HIV. Forty-two per cent of new infections diagnosed are in MSM who have never been tested. Over 200 nurses have received training that qualifies them to screen individuals, but most of them do not work in conditions conducive to intervention. This situation is often due to the absence of a service corridor that would enable them to easily refer individuals requiring treatment to a physician.

Screening is an opportunity to reinforce adoption of safer behaviours and provide support for diagnosis disclosure to partners. It is also an opportune time to explore with these individuals the various ways of notifying partners in their social networks so that they too can also undergo screening and get treated, if necessary.

Photo : © Éric St-Pierre

Despite efforts made to date, delivery of screening and psychosocial services for persons who inject drugs and MSM remains scarce. Given the responsibility of CSSS to respond to the needs of the most vulnerable groups and their privileged relationship with community organizations in the promotion of screening, it is clear that we must jointly develop these services, which have indeed proven to be effective. CSSS and community organizations are invited to share their knowledge of local populations and environments so that a common vision can be reached to guide the expansion of services. The objective is to reach more, screen more and treat more.

Individuals with hepatitis C and the people close to them are also confronted with specific difficulties that are often—but not exclusively—linked to treatment. In terms of prevention, the educational work undertaken by psychosocial professionals encourages vulnerable individuals to protect themselves as well as others, and especially to avoid reinfection once their first course of drug treatment has ended. Psychosocial treatment itself can extend over a long period (from preparation for treatment to post-treatment) and include support in such area as psychosocial assessment, adaptation to a new lifestyle, accompaniment, psychological support, referral to other professionals, and organizational assistance. People with hepatitis C and those close to them have to adapt to new living conditions. Given the current situation, psychosocial workers are indispensable to SIDEP teams.

Despite efforts made to date, delivery of screening and psychosocial services for persons who inject drugs and MSM remains scarce.

Yet, only half of CSSS in Montréal have SIDEP. The epidemiological situation has changed, as explained above. Screening and psychosocial services would be more accessible if the number of screening sites were increased and located in places where the most vulnerable individuals could be more easily reached. Outreach nurses could have an expanded role: to perform

screening activities in CLSC, community groups and living environments, and vaccinate people at risk of contracting, or who now have, hepatitis C. Exercising their roles as pivotal resources can greatly contribute to the provision and continuity of adapted outreach services.

FOR EFFECTIVE AND CONCERTED ACTION:

- Implement SIDEP outreach nursing services in all territories especially to augment screening and vaccination activities.
- Entrust nurses with a central role that allows them to accompany and guide persons who inject drugs and MSM toward appropriate medical and psychosocial resources, and to provide follow-up during treatment.
- Increase the number of screening sites and locate them in more appropriate venues.
- Develop psychosocial interventions, in particular for people with hepatitis C.

4. Improve treatment organization

As already stated, although two-thirds of persons who inject drugs have already been infected with HCV, screening is uncommon and 27% of those who have the infection are not aware of it. Moreover, follow-up of individuals who know they have the infection is not widespread: fewer than 10% of persons who inject drugs and who have HCV have initiated treatment. HIV screening among MSM remains low (43% of new cases diagnosed from 2002 to 2008 had never undergone prior screening) and many of them do not know they are infected. This situation alone justifies better organization of treatment, particularly for HCV infection. Not only could treatment improve the quality of life of infected individuals, it could also lower the total number of cases, thus reversing the current trend and reducing transmission. In addition, it could have positive results on the health system.

In the fight against HCV and HIV, prevention, screening, psychosocial support and treatment can only be effective if provided within a framework of continuity and harmony. This is what is commonly referred to as the continuum of care and services. This continuum implies networks and the integration of services to ensure rapid access to assessment and treatment for persons who inject drugs and MSM through collaboration of professionals and respect for each individual's skills. Yet, whether there is such harmony is unclear: expanding efforts to reach the most vulnerable groups remains a challenge; physical and mental health services are less accessible to persons who inject drugs and MSM than to other populations; drug addiction treatments are nonexistent or difficult to access; in many cases, the service corridors that nurses require to prescribe laboratory tests and refer individuals to treating physicians do not exist. In most territories, the situation regarding psychosocial services is not much better. As for human and financial resources, they too are not always sufficient, especially in the areas of housing and social reintegration. Cooperation efforts among CSSS and community organizations are increasing and are beginning to have positive effects. In some clinical settings, cooperation is still fragile, even if it is to the medical profession's advantage to recognize nurses' competencies related to screening activities and

LET'S TALK ABOUT IT!

At the Heart of the Continuum of Services

Since 2007, CSSS Cœur-de-l'Île has focused on collaboration between primary and secondary services, and community organizations. This collaboration was formalized by creating a forum for coordinating efforts (local STBBI table) and then by improving the service corridor. At the heart of the continuum of services are three key words: screening, accompaniment and case management. Three groups of stakeholders sit at the same table: nurses and physicians from CLSC Villeray and Petite-Patrie, and community workers from Pact de rue and Gap-vies. Every two weeks for the past year, the same SIDEP outreach nurse has been going to Pact de rue, where an examination room has been set up. She performs screening of asymptomatic individuals who wish to be tested. The samples collected are sent to a hospital laboratory, and upon receiving the results, the nurse refers the individuals to primary care physicians. In complex cases, such as hepatitis C infection for example, a worker from Pact de rue might provide support to infected individuals as they come to terms with the situation, or accompany them to their hospital appointments.

Pact de rue works with young people mostly in the areas of sexual health, substance abuse and violence. For its part, Gap-vies's contribution to the local table is mostly focused on cultural adaptation of HIV prevention messages and intervention strategies aimed at a clientele of Haitian origin.

LET'S TALK ABOUT IT!

to support them in this role.

In other respects, while medical follow-up of people with HIV is relatively well organized, few HCV treatments are available, and management of people with the infection is too complicated and time-consuming for primary care physicians, who are ill-prepared to carry out assessments and provide follow-up. In many cases, the service corridor that leads to specialized secondary services is lacking.

FOR EFFECTIVE AND CONCERTED ACTION:

- Set up HIV and HCV screening services for MSM and persons who inject drugs; connect these services with specialized private and public sector clinics.
- Integrate curative services for people with HCV and HIV into networks.
- Increase availability of hepatitis C treatment through specialized secondary and tertiary services.
- Increase primary care physicians' involvement by offering them the support needed for evaluation and follow-up of infected individuals.
- Set up service corridors that enable nurses to perform real screening activities, rapid referrals to physicians and easy access to psychosocial services.
- Make sure that all professionals in SIDEP teams and in clinical settings apply clinical preventive practices (CPP) related to STBBI.

5. Foster empowerment

Fostering empowerment entails mobilization of persons who inject drugs and MSM and their active participation in associations, programs and initiatives that concern them on social, economic and health levels. Community organizations encourage individuals to discover the power they have over their lives from a perspective of social inclusion, citizenship and human rights. This fifth strategy has a particular meaning for persons who inject drugs. Shunned and forgotten, these people and their loved ones often feel rejected and tend not to defend their rights.

It is thus recommended to support associations whose mission is to assert the rights of drug users, fight discrimination and improve their living conditions at all levels. Moreover, these associations have roles to play in planning services and programs designed for persons who inject drugs. We must support interventions organized to encourage empowerment, which allow individuals to develop skills and competencies related to training, raising awareness about safer injection practices and conducting peer activities.

Among MSM, peer intervention is also an empowerment strategy that produces positive effects. Given the heterogeneity of this group, peers are often in better positions to reach MSM who do not want to be identified as such. Appropriation of prevention messages by peers who are HIV-positive fosters message reception, promotion of screening and disclosure of diagnosis to partners, because these men are credible sources of information.

FOR EFFECTIVE AND CONCERTED ACTION:

- Support associations that promote human rights, social integration and improvement of living conditions.
- Encourage associations to participate in planning services and programs intended for persons who inject drugs and MSM.
- Value empowerment strategies (self-help and support groups, human rights groups, peer interventions) among persons who inject drugs and MSM.

6. Influence public policy

It is in society's best interest to accept STBBI control as a priority and to support the public health initiatives required. Promoting health and fostering access to treatment for infected individuals reduces STBBI transmission in the community. In the end, society as a whole is better protected.

When it comes to hepatitis C and HIV, all public policies that foster the well-being and health of vulnerable groups should be supported. Such policies must be inclusive and non-discriminatory. In practice, this involves, first and foremost, recognizing two basic points: that minority groups and marginalized individuals—MSM and persons who inject drugs in particular—as well as people from HIV–endemic countries and Aboriginal people are full citizens; and that, as full citizens, they have the same rights to health and social services as other citizens.

Public policies involve many active partners within the health network or from other milieus (e.g. municipalities, communities) that pursue different objectives, in accordance with their respective mandates or interests. However, it is feasible to work toward a certain harmonization while taking into consideration the needs of MSM, street youth, homeless people, sex workers and persons who inject drugs. And these needs are very real. In Montréal, for instance, 47% of persons who inject drugs report having slept in a shelter, on the street or in a squat during the previous six months; 20% of street youth had slept outdoors or in a shelter most of the time during the same period; 10% of MSM said they had sought help or stayed at a shelter or elsewhere in the past 12 months; 1 in 5 MSM reported having experienced violence or discrimination (insults, harassment) in the past six months.

...47% of persons who inject drugs report having slept in a shelter, on the street or in a squat during the previous six months...

It is clear that vulnerable groups have specific needs to which the health and social services network must adapt. Consequently, it is important that policies be harmonized and result in better coordination of health and public safety initiatives, as well as of initiatives undertaken by municipalities and civil society to fight poverty, social exclusion and discrimination, and to improve the living conditions and social environments, particularly for persons who inject drugs and MSM. Access to curative and prevention services (e.g. injection equipment distribution program) by these individuals depends on it.

Aside from the fact that repressive measures are not always the most appropriate choice, especially when aimed at people with mental health problems, such measures usually have harmful consequences: people who end up in prison for failing to pay a fine (for sleeping on a park bench, for example) move to another part of the city, isolate themselves and, as a result, become more difficult to reach. Persons who inject drugs frequently put themselves in danger, for instance by injecting in public places (60% of them do so), thus increasing the risk that they use non-sterile equipment, with the expected consequences, and the risk of overdosing.

...1 in 5 MSM reported having experienced violence or discrimination (insults, harassment) in the past six months.

Here is an example that clearly illustrates the influence public policies can have on risk taking. If vulnerable individuals like persons who inject drugs don't have anywhere to go or access to safe injection sites, they take

risks that put them in danger and, at the same time, expose themselves to repressive measures. It is preferable to adopt an approach that fosters both continuity of prevention services for persons who inject drugs and creation of innovative programs to prevent addiction, disease and death. In this regard, social integration projects are in and of themselves advisable and productive.

Moreover, the lack of affordable housing and social housing, especially in Montréal's downtown core, is a concern the DSP shares with several partners from the health and social services network. There is very little temporary housing for people undergoing hepatitis C treatment. And yet, this is often a condition for beginning treatment. The homelessness and poverty occasioned by this situation foster social exclusion as well as the spread of STBBI. For these reasons, strategies and programs that promote large real-estate development projects that include social housing units must be encouraged.

The Agence de la santé et des services sociaux de Montréal, community organizations and the health network share a common vision regarding the need for collaboration among various sectors and harmonization of public policies. Besides, they already participate, along with City of Montréal services, in intersectoral initiatives that have significant impacts on the living conditions and environments of groups vulnerable to STBBI. For example, the Comité de liaison en itinérance is working to implement measures to improve living conditions and access to social and health services for homeless people, such as creating emergency shelters and a respite and sobering up facility, and setting up a mobile multidisciplinary team. The Comité intersectoriel pour la réduction des seringues à la traîne is focussing on reducing the number of used needles discarded in public, institutional and commercial spaces. Results: 35 needle-disposal containers have been installed in strategic locations in public places in collaboration with boroughs and various partners, and committees have been set up in the boroughs most affected. The number one priority of the Table de concertation du Faubourg Saint-Laurent is to work with the community. Through dialogue initiated by this group, the relocation of Cactus Montréal was done in full consideration of persons who inject drugs involved with the organization and of residents.

Photo : © Éric St-Pierre

By the same token, public policies and programs must be based on prevention rather than repression. To manage tensions related to occupation of public spaces, we must encourage public discussions that involve all people concerned, including marginalized individuals. Improving the quality of life of Montréal families and the tranquillity of boroughs requires collaborations that involve marginalized people to ensure their needs are also taken into consideration.

FOR EFFECTIVE AND CONCERTED ACTION:

- Promote public policies and programs that are geared toward prevention rather than repression.
- Support policies that tackle poverty and social exclusion.
- Support public policies that favour the safety and physical and psychological well-being of vulnerable groups, as well as those that foster social integration and cooperation.
- Encourage strategies and programs that promote social housing projects as well as temporary housing for individuals undergoing hepatitis C treatment.

CONDITIONS FOR SUCCESS AT AN ORGANIZATIONAL LEVEL

There are some who may believe that Montréal's fight against STBBI is too ambitious, especially when it comes to HIV and HCV. This plan is feasible but only under certain conditions. It bears repeating that what is most important is undoubtedly the collaboration of all regional and local actors and partners of the DSP. These include decision makers, managers and groups who are responsible for a number of decisions.

Agence de la santé et des services sociaux de Montréal

The Agence de la santé et des services sociaux de Montréal and its various departments, including the public health department, have their own responsibilities regarding the application of the six strategies and resulting actions. The DSP is firmly committed to including, in its **regional action plan**, STBBI control as a priority for the next five years, especially regarding hepatitis C and HIV.

Moreover, the Agence acknowledges that the current situation also requires immediate proactive action and support for a sexual education program that takes into account the following issues: difficulty coming to terms with one's sexual orientation, violence in intimate relationships, and drug and alcohol use, to name a few. The DSP will continue to mobilize stakeholders from the health and education networks to work together toward putting in place and scaling up effective prevention and promotion strategies to promote healthy and responsible sexuality.

The DSP intends to support implementation of CSSS local action plans through different means, including research, surveillance and monitoring activities; knowledge sharing and development of skills for workers in community organizations, CSSS and school boards; training for nursing, psychosocial and medical staff, as well as professionals in schools; knowledge sharing, in conjunction with Ministère de la Santé et des Services sociaux, Direction régionale du ministère de l'Éducation, du Loisir et des Sports and Institut national de santé publique; planning, coordination, facilitation and support activities within different cooperative structures; and management and collection of injection equipment.

The DSP's commitment to STBBI control in Montréal contributes to achieving the objectives of the Agence, in conformance with regional strategic priorities to reduce social inequalities in health, the **Plan d'action interministériel en itinérance 2010-2013** and the **Programme service-dépendance**.

Various regional bodies can also contribute to the success of planned actions. They include the regional pharmaceutical services committee (as regards access to prevention kits in pharmacies), institutions responsible for biomedical services, whose collaboration is essential to facilitate access to laboratory testing for diagnostic and management purposes, and the Table des directeurs des services professionnels.

Health and social services centres

Health and social services centres, whose mission is population-based, have specific and up-to-date knowledge of their local population and environment. This knowledge allows each CSSS to have a more complete understanding of the situation that prevails in its territory and to identify the groups to target. CSSS are invited to share this knowledge with community organizations to arrive at a common vision so as to jointly develop a broad service offer that takes into account realities in their territories. With this in mind, local public health directors mobilize the administrators concerned and work closely with local STBBI committees.

As for the Conseils des médecins, dentistes et pharmaciens (CMDP), their contribution should formally target service corridors so as to facilitate evaluation and treatment of HCV and HIV. CMDP in all institutions are encouraged to support nurses in their various STBBI prevention activities such as screening, collective prescriptions and referrals of positive cases for evaluation and treatment.

Clinical settings

We cannot emphasize enough the central role that clinical settings have in terms of screening, treatment and management of people with STBBI. Be they AIDS research programs, teaching and hospital care units (UHRESS), such as those at the Centre hospitalier de l'Université de Montréal and the McGill University Health Centre, STBBI medical clinics or specialized hospital microbiology, gastroenterology or substance addiction teams, they are all key players.

Photo : © Éric St-Pierre

Since the fight against HIV began, these players have made invaluable contributions to the development of expertise and clinical management. The vital role they have played in the treatment of HIV–HCV co-infection and, more recently, in defining hepatitis C treatment provision holds great promise for future developments related to the management of infected individuals and support for primary care by specialized secondary services, and to the implementation of effective service corridors in collaboration with CSSS, particularly with outreach teams, including nurses and primary care physicians.

Community organizations

Photo : © Éric St-Pierre

Community organizations are valued partners, especially in light of their knowledge of and experience in the field, and their capacity for reaching vulnerable people. They are invited to carry on their work as per the **Cadre de référence régional 2010–2015, Volet communautaire** for STBBI prevention, which sets out the following objectives:

- Pursue and intensify prevention efforts among vulnerable populations to encourage them to adopt and maintain safer sexual and drug use behaviours
- Support a concerted intervention to meet the health needs of people with risky sexual and drug use practices
- Contribute to the reduction of social health inequalities.

Montréal and its boroughs

The City of Montréal and its boroughs have played an important role in the development of public policies that support interventions for vulnerable populations, particularly MSM and persons who inject drugs. Over the past several years, the City has helped consolidate the presence and preventive actions of community groups. Its role has been all the more important because municipal policies have a significant influence on major public health issues such as social housing, homelessness and urban development that encourages neighbourhood social mix. There are many opportunities for collaboration that, in view of the current situation, pose new challenges to both the City of Montréal and the DSP.

In terms of STBBI control, the DSP invites the City of Montréal to maintain its collaboration and to encourage all its departments to work in the same spirit. When all is said and done, these objectives benefit us all: providing better access to health services, lowering the number of people with HCV and HIV throughout the island of Montréal, and improving the environments and well-being of these individuals.

A table summarizing the six strategies for HCV and HIV infection control in Montréal is included with this report, as is a list of the concrete actions identified to support these strategies. A quick glance at the table will enable our main partners to quickly spot the actions that are of concern to their sectors.

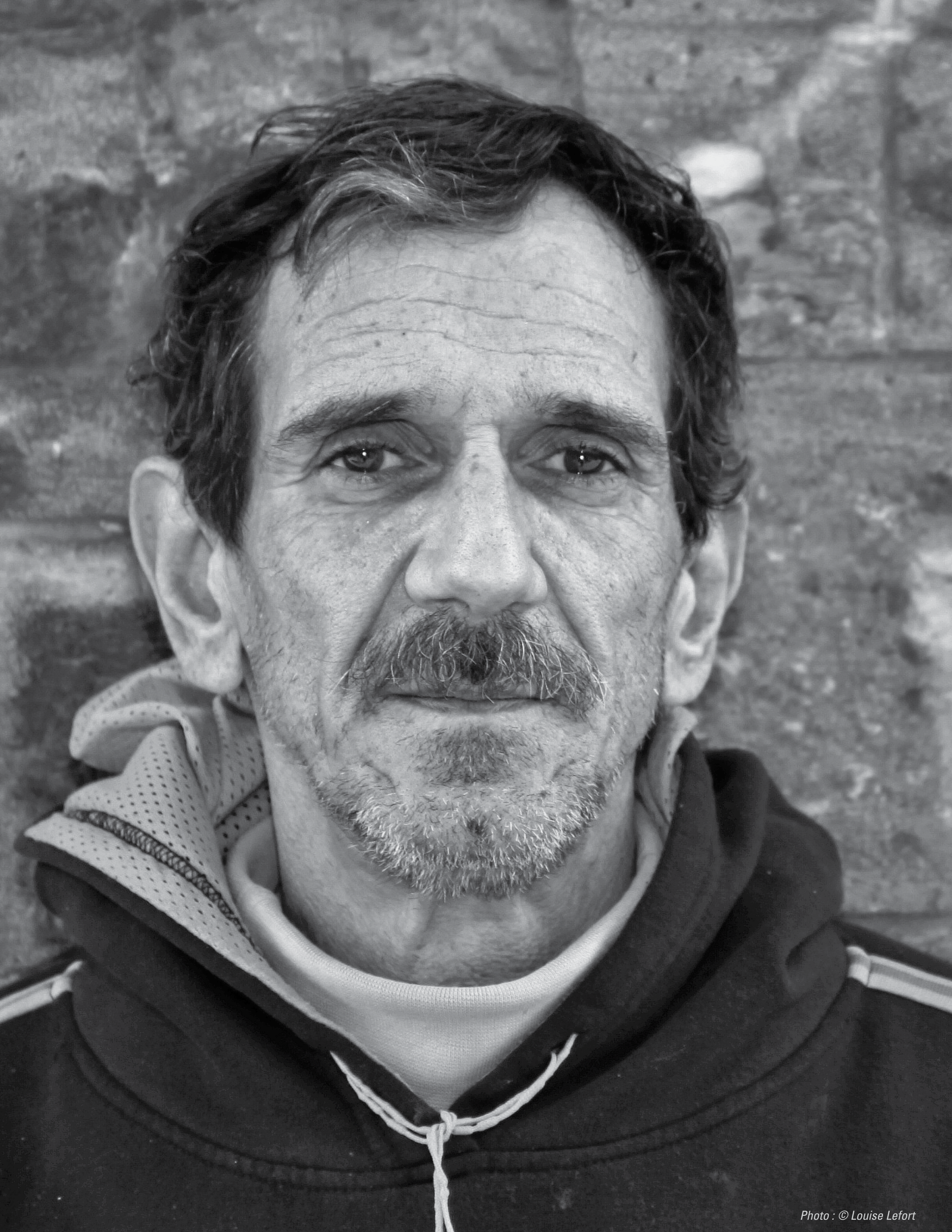
Photo : © Louise Lefort

Because of factors that make them vulnerable, persons who inject drugs and MSM take certain risks. By orchestrating effective and concerted action, we have more opportunities to reach them, screen them for infections and treat them early. In other words, we increase our chances to score points against STBBI, especially hepatitis C and HIV. In so doing, we are taking a path that leads to measurable health improvement not only for the people directly affected but for all Montrealers.

Jennifer and Francis are not the only ones who take risks. In Montréal, so do Ben, Caro, Isabelle, Fred and many others...

The organizational aspects of the proposed approach can lead to a variety of measures, for instance, increasing access to services and protective equipment; adapting services; strengthening the pivotal role of outreach nurses; creating service corridors; and improving treatment organization. Nonetheless, these organizational aspects should not make us lose sight of two important points: the crucial role of community groups—long-term partners—in the success of this approach; and our collective responsibility to adopt an approach based on the social integration of vulnerable groups and improvement of their living conditions. When all is said and done, when one group of people is rejected, all of society suffers.

...our collective responsibility to adopt an approach based on the social integration of vulnerable groups and improvement of their living conditions. When all is said and done, when one group of people is rejected, all of society suffers.

We thus encourage all health professionals, community groups and administrators of institutions to get actively involved in STBBI control. Being open to vulnerable groups, working truly cooperatively and organizing services to facilitate access are all evidence of effective concerted action in our region.

Bibliography

ADRIEN A (2001). Stratégies de prévention des infections au VIH dans les communautés ethnoculturelles. Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal. Rapport de consultation interne, 3 pages.

ALARY M, GODIN G, LAMBERT G, et al. (2005). Étude de prévalence du VIH et de l'hépatite C chez les personnes incarcérées au Québec et pistes pour l'intervention. Ministère de la santé et des services sociaux du Québec, 70 pages.

ALLARD P-R, NOËL L (2006). Portrait de situation de l'hépatite C au Québec 1990-2004, Analyse de la demande de services par les personnes atteintes du virus de l'hépatite C. Institut national de santé publique du Québec. ISBN-13: 978-2-550-47832-4 (print version) ISBN-13: 978-2-550-47833-1 (PDF)

BITTERA R, ALARY M, FAUVEL M, PARENT R (2009). Programme de surveillance de l'infection par le virus de l'immunodéficience humaine (VIH) au Québec. Cas cumulatifs 2002-2008. Institut National de Santé publique du Québec. ISBN: 978-2-550-57605-1 (print version) ISBN: 978-2-550-57606-8 (PDF version).

BITTERA R, ALARY M, FAUVEL M, PARENT R (2010). Programme de surveillance de l'infection par le virus de l'immunodéficience humaine (VIH) au Québec. Mise à jour des données au 30 juin 2009. Institut National de Santé publique du Québec. ISBN: 978-2-550-58407-0 (print version) ISBN: 978-2-550-58408-7 (PDF version).

BITTERA R, ALARY M, FAUVEL M, PARENT R (2010). Programme de surveillance de l'infection par le virus de l'immunodéficience humaine (VIH) au Québec. Cas cumulatifs 2002-2009. Institut National de Santé publique du Québec. ISBN: 978-2-550-59938-8 (print version) ISBN: 978-2-550-59939-5 (PDF version).

BOISCLAIR M (2008). Problématique de la prise en charge des personnes toxicomanes infectées par l'hépatite C. Stratégie pour une planification de services et de soins en réseaux. Rapport de consultation, École nationale d'administration publique, 27 pages.

CLOUTIER R, GILBERT H (2009). Membres du Comité conseil sur la prévention du VIH et du VHC chez les personnes qui font usage de drogues. Actions proposées pour la prévention du VIH-sida et de l'hépatite C chez les personnes utilisatrices de drogues. MSSS. ISBN: 978-2-550-56015-9 (print version) ISBN: 978-2-550-56016-6 (PDF version).

CSSS JEANNE-MANCE (2008). Le phénomène de l'itinérance au Québec – Mémoire présenté à la Commission des affaires sociales. Audience - le 1er octobre 2008, 38 pages.

DIRECTION DE SANTÉ PUBLIQUE DE L'AGENCE DE LA SANTÉ ET DES SERVICES SOCIAUX DE MONTRÉAL (2010). Cadre de référence 2010-2015. Programme de prévention du VIH, des hépatites et des autres infections transmissibles sexuellement (ITS) pour la région de Montréal, volet communautaire, 40 pages.

JOSEPH G, ADRIEN A, TREMBLAY C, LECLERC P (2010). Les infections transmises sexuellement et par le sang chez les Québécois d'origine haïtienne : surveillance biologique et comportementale. 2e édition. Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal. ISBN: 978-2-89494-848-4 (print version) ISBN: 978-2-89494-849-1 (PDF version).

GUTIERREZ N, MORISSETTE C (2007). Consultation pour le Mémoire de l'Agence de la santé et des services sociaux de Montréal sur le projet Plan d'action famille de Montréal. Document interne. Direction de santé publique, Health Protection sector, 3 pages.

LAHAIE C, MORISSETTE C, LECLERC P, GUTIERREZ N, PERREAULT M (2007). Implanter un réseau de santé montréalais pour les personnes utilisatrices de drogues par injection. Unité hospitalière de recherche, d'enseignement et de soin sur le sida, Centre hospitalier de l'Université de Montréal in collaboration with Direction de santé publique, Health Protection sector and Douglas Mental Health University Institute. Consultation report submitted to Agence de la santé et des services sociaux de Montréal, 111 pages.

LAMBERT G, COX J, MIANGOTAR Y, FRIGAULT LR, TREMBLAY C, et al. (2010). ARGUS 2008: Enquête sur l'infection par le VIH, les hépatites virales et les infections transmissibles sexuellement et par le sang (ITSS) ainsi que sur les comportements à risques associés chez les hommes québécois ayant des relations sexuelles avec des hommes (HARSAH). Agence de la santé et des services sociaux de Montréal, Direction de santé publique, Institut national de santé publique du Québec and Public Health Agency of Canada. Preliminary version of the final report – August 2010, 40 pages.

LECLERC P, TREMBLAY C, MORISSETTE C (2009). Monitorage des centres d'accès au matériel stérile d'injection. Rapport régional : avril 2007 à mars 2008. Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal. ISBN: 978-2-89494-832-3 (print version) ISBN: 978-2-89494-833-0 (PDF version).

LECLERC P, TREMBLAY C, MORISSETTE C (2010). Portrait local ITSS 2009. Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal.

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LECLERC P, MORISSETTE C, ROY É (2010). Le volet montréalais du Réseau SurvUDI. Volume 2 – Données au 30 juin 2008. Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal, 2010. ISBN 978-2-89494-686-2 (ensemble) ISBN 978-2-89494-911-5 (Vol. 2) (print version) ISBN 978-2-89494-912-2 (Vol. 2) (PDF version).

LECLERC P, MORISSETTE C, TREMBLAY C (2006). Le matériel stérile d'injection : combien faut-il en distribuer pour répondre aux besoins des UDI de Montréal ? Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal. ISBN: 2-89494-498-5 (print version) ISBN: 2-89494-499-3 (PDF version).

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX DU QUÉBEC (2002). Les infections transmissibles sexuellement à déclaration obligatoire, Prévenir et enrayer, Situation et orientations, Gouvernement du Québec, 104 p. ISBN 2-550-41456-X.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX DU QUÉBEC (2004). Stratégie québécoise de lutte contre l'infection par le VIH et le SIDA, l'infection par le VHC et les infections transmissibles sexuellement, Orientations 2003-2009, Gouvernement du Québec, 56 p. ISBN 2-550-42020-9.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX DU QUÉBEC (2006). Guide québécois de dépistage, infections transmissibles sexuellement et par le sang, Gouvernement du Québec, 149 p. ISBN: 2-550-46494-X (print version) - ISBN: 2-550-46495-8 (PDF version).

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX (2008). Programme national de santé publique 2003-2012 – mise à jour 2008, Direction générale de la santé publique, Gouvernement du Québec, 103 p. ISBN 2-550-42815-3.

MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX DU QUÉBEC (2009). Portrait des infections transmissibles sexuellement et par le sang (ITSS) au Québec - Année 2008 (et projections 2009), Gouvernement du Québec, 100 p. ISBN: 978-2-550-57739-3 (PDF version).

MORISSETTE C, PAQUETTE N (2008) Rapport de la tournée 2007-2008. Sous-comité ITSS de la Table régionale de santé publique. Version préliminaire, 39 pages.

NOËL L, LAFOREST J, ALLARD P.R (2007). Usage de drogues par injection et interventions visant à réduire la transmission du VIH et du VHC. Revue systématique de la littérature et validation empirique. Institut national de santé publique du Québec, 151 p ISBN 13: 978-2-550-49822-3 (print version) - ISBN 13: 978-2-550-49823-0 (PDF version).

NOËL L, LAFOREST J, ALLARD P-R (2007). L'accès au suivi et au traitement pour les personnes atteintes de l'hépatite C au Québec. Analyse de l'offre de services. Institut national de santé publique du Québec, 110 p. ISBN: 978-2-550-50654-6 (print version) - ISBN: 978-2-550-50655-3 (PDF version).

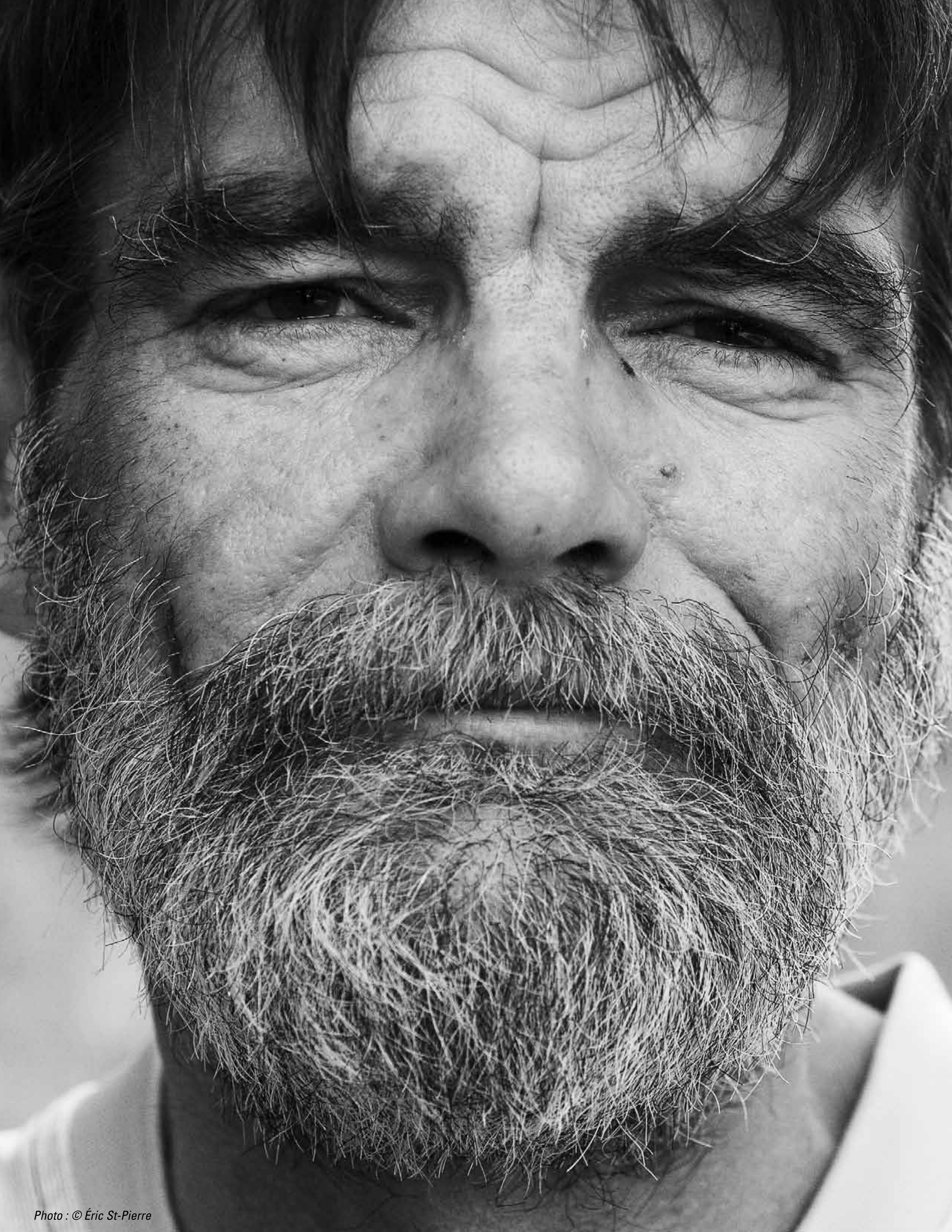
PARENT R, ALARY M, MORISSETTE C, ROY É, LECLERC P, ALLARD P-R (2008). Surveillance des infections transmissibles sexuellement et par le sang, Surveillance des maladies infectieuses chez les utilisateurs de drogues par injection, épidémiologie du VIH de 1995 à 2008, épidémiologie du VHC de 2003 à 2008, Institut national de santé publique du Québec, Gouvernement du Québec, 69 p. ISBN: 978-2-550-57678-5 (print version) – ISBN: 978-2-550-57679-2 (PDF version). ISSN: 1918-4549.

POIRIER A, DONTIGNY A (2010). Quatrième rapport national sur l'état de santé de la population du Québec – ITSS, L'épidémie silencieuse. La Direction du développement des individus et de l'environnement social du ministère de la Santé et des Services sociaux and Institut national de santé publique du Québec. ISBN: 978-2-550-58806-1 (print version) ISBN: 978-2-550-58807-8 (PDF version).

ROY É, HALEY N, GODIN G, BOIVIN J-F, et al. (2005). L'hépatite C et les facteurs psychosociaux associés au passage à l'injection chez les jeunes de la rue. Rapport d'étape #4. Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal. ISBN: 2-89494-467-5.

ROY É, HALEY N, GODIN G, BOIVIN J-F, et al. (2008). L'hépatite C et les facteurs psychosociaux associés au passage à l'injection chez les jeunes de la rue. Rapport final. Direction de santé publique de l'Agence de la santé et des services sociaux de Montréal. ISBN: 978-2-89494-638-1 (print version) – ISBN: 978-2-89494-639-8 (PDF version).

SAUVÉ J, LAFONTAINE G, et al. (2010). Rapport de la directrice de santé publique de la Montérégie. Épidémie d'infections transmissibles sexuellement et par le sang – Inversons la tendance ! ISBN: (print version) 978-2-89342-462-0 – ISBN: (PDF version) 978-2-89342-463-7



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Six Strategies for the Control of Hepatitis C and HIV for Montréal

STRATEGY	FOR EFFECTIVE AND CONCERTED ACTION:	RESPONSIBILITIES			
		ASSSM	CSSS (including CLSC)	Clinical settings	Community organizations
1. Expand efforts to reach the most vulnerable groups	Step up outreach efforts		•		•
	Diversify methods used to reach the most vulnerable groups		•		•
	Set up SIDEP teams in all CSSS	•	•		
	Offer services adapted to persons who inject drugs in all CLSCs and tailor procedures to access institutional services		•		•
2. Increase access to protective equipment	Diversify injection equipment distribution methods	•	•		•
	Increase the quantity and availability of condoms in saunas and other venues for sexual encounters	•	•		•
	Distribute sterile injection equipment in all CLSCs and collect used equipment	•	•		•
	Adapt the way persons who inject drugs are greeted in all CLSCs	•	•		
	Expand the number of pharmacies that sell the protective equipment kits	•	•		
3. Enhance access to screening services and to psychosocial outreach services	Implement SIDEP outreach nursing services in all territories especially to augment screening and vaccination activities	•	•		
	Entrust nurses with a central role that allows them to accompany and guide persons who inject drugs and MSM toward appropriate medical and psychosocial resources, and to provide follow-up during treatment	•	•	•	
	Increase the number of screening sites and locate them in more appropriate venues	•	•		•
	Develop psychosocial interventions, in particular for people with hepatitis C	•	•	•	•
4. Improve treatment organization	Set up HIV and HCV screening services intended for MSM and persons who inject drugs and connect these services with specialized private and public sector clinics	•	•	•	
	Integrate curative services for people with HCV and HIV into networks	•	•	•	•
	Increase availability of hepatitis C treatment through specialized secondary and tertiary services	•	•	•	
	Increase primary care physicians' involvement by offering them the support needed for evaluation and follow-up of infected individuals	•	•	•	
	Set up service corridors that enable nurses to perform real screening activities, rapid referral to physicians and easy access to psychosocial services	•	•	•	•
	Make sure that all professionals in SIDEP teams and in clinical settings apply clinical preventive practices (CPP) related to STBBI	•	•	•	
5. Foster empowerment	Support associations that promote human rights, social integration and improvement of living conditions	•	•	•	•
	Encourage associations to participate in planning services and programs intended for persons who inject drugs and MSM	•	•		•
	Value empowerment strategies (self-help and support groups, human rights groups, peer interventions) among persons who inject drugs and MSM	•	•		•
6. Influence public policy	Promote public policies and programs that are geared toward prevention rather than repression	•	•	•	•
	Support policies that tackle poverty and social exclusion	•	•	•	•
	Support public policies that favour the safety and physical and psychological well-being of vulnerable groups, as well as those that foster social integration and cooperation	•	•	•	•
	Encourage strategies and programs that promote social housing projects as well as temporary housing for individuals undergoing hepatitis C treatment.	•	•	•	•