Experiences of HIV Care in Northern & Rural Saskatchewan

Dr. Stuart Skinner and Dr. Mona Loutfy
July 18th, 2015; Vancouver, BC

(Slide: Experiences of HIV Care in Northern & Rural Saskatchewan)

Helmut Albrecht: Next, we have a tag team – Dr. Mona Loutfy and Dr. Stuart Skinner. Dr. Loutfy is an Associate Professor, Clinician Scientist, and ID Specialist at Women's College Hospital and the University of Toronto. Dr. Stuart Skinner is an ID Specialist working at the Regina Infectious Diseases Clinic. He's also a Clinical Assistant Professor at the University of Saskatchewan. Their title is "Experiences of HIV Care in Northern & Rural Saskatchewan."

Mona Loutfy: Elder Roberta and Katherine, I'm in the short club here [*laughs*].

(Slide: Acknowledge)

Stu and I would like to start by acknowledging that we are on the unceded territory of the Coast Salish peoples, which includes Squamish, Musqeam, Tsleil-Waututh, and other coastal peoples' territories. I was given a tobacco tie yesterday by a colleague from Saskatchewan – Margaret Poitras. I was honored to be given a tobacco tie. The teaching to me is that when you're given a tobacco tie, and you come up to a new land, I'm looking for my place to make my offering for my welcoming here. Thank you for welcoming and for having us here on this land. And so now I'm going to hand it over to Stu.

(Slide: Rate of HIV cases by year [graph])

Stuart Skinner: Thanks very much. I'm going to try and summarize this in about six minutes, in terms of – give you some background of what's happening with the HIV epidemic in Saskatchewan and some of the work that we're doing, in particular in a couple of First Nations communities. For those of you who aren't aware, Saskatchewan has the highest rates of HIV in Canada, pretty steady for the past seven or eight years, two and a half to three times the national average.

(Slide: HIV in the Prairies is Different)

It's not just because of the geography and the fact that Saskatchewan is the largest rectangle in the world that makes the epidemic different and more challenging. It's mostly related to addictions – 80% are self-reported Aboriginal youth, about 60% co-infection with Hepatitis C. There's some communities that are 25% co-infected with tuberculosis, 40% are women, and plus we're trying to manage this in, kind of, this extensive geography with a general shortage of healthcare practitioners.

(Slide: Rates of HIV Cases by Year, Saskatchewan First Nations On-Reserve and Overall Saskatchewan, 2004 to 2011 [graph])

This is the Health Canada on-reserve data. In Saskatchewan, there's a split – South Central First Nations and Northern First Nations, which is also called NITHA. In 2011, you can see the data

went up to about 98 per 100,000. This is really driven by the program I'll tell you about, which was testing within two communities.

(Slide: Map of Saskatchewan)

So this is our province. It's a population of – it's growing, finally. So we're over a million people. The two major urban centers, Saskatoon and Regina, account for about 500,000 people. The other half million people are dispersed throughout the province. So we do run – I particularly have six different rural centers and clinics I run. I'm going to talk particularly about two, but there are other physicians who do rural clinics as well. I don't think Kris Stewart is here but he goes far up north. The two communities we talk about is Big River First Nation and Ahtahkakoop First Nation – and Prince Albert, which is here – and they sit here. They're about two hours from Saskatoon but not as remote as some of these fly-in communities up north.

(Slide: Know Your Status)

So really, where this started, it was a lack of access to testing, so they're seeing high rates of substance use, along with sexually transmitted infections, and no one was being tested, because there's no access to testing and no access to care. So this is driven by one of the nurses, Leslie Ann Smith, who approached chief and council initially and said "We need to do something about it" and "Can we do testing in the community?" and they were fully supportive. Then it spread to the subsequent community, Ahtahkakoop First Nation, and so these two communities did testing in their communities, and it was fully supported by chief and council and the communities. They subsequently found high rates of both HIV and Hep-C – incident rates one year approaching 1000 per 100,000 with HIV and 1100 per 100,000 with Hepatitis C.

(Slide: Picture of Big River Health Centre)

No one was really accessing care, so the chief and community had approached, at the time, the province, when I was working with the province, and we said, "Well no one is coming to care. How does it make sense that all these people who had trouble accessing care come to me? Why don't we take the care to the community?" So this is Big River Health Centre.

(Slide: Mobile Clinic)

The program is kind of run through a combination of on-site clinics where we drive up and work with the nurses. Health Canada has put in nurses within the communities to provide case management testing and adherence support. I don't have the time to go into the specifics, but then we used technology in between to kind of link – and this is me and there's Clarence, who's one of the nurses in Ahtahkakoop – and we used this one little device, it's called the 'Doctor in a Box', and it allows linkage outside of – so we used Telehealth – but then this connects to the 3G, and you can also do physical exams through that. For Hepatitis C, we used this little device, which is a portable Fibroscan, and everyone is keen and interested in getting the testing done, knowing what's going on, but when we booked them for ultrasounds an hour away in Prince Albert, nobody will make it, because of transportation issues.

(Slide: HIV Cascade of Care)

So using this model, which I've summarized in about one minute, we've had actually tremendous success.

(Slide: Number of Patients)
We have more than 90% of people retained in care. Of those, more than 90% are on treatment. On treatment, more than –this is Ahtahkakoop – 83% are undetectable. Big River's about 67%. Given the challenges with that population, we're treating successfully. The difference between the two communities is Ahtahkakoop has a site called Cree Nations Treatment Haven, which provides addiction and treatment services and methadone. So there's about 24 patients who get directly through therapy through methadone, whereas Big River they have to commute 30 kilometers a day, sometimes having to hitchhike in Saskatchewan. This just highlights the difference.

(Slide: Success of FN Community Based Care)
So I know this is talking about challenges and opportunities, but what really has driven these communities is the success. It's successful because this is community-led and community-driven. Everything we do is in close partnership and led by the chief and council, and then coming back to that is the partnerships. To have success, we need everybody on board – provincial government, federal government, communities, and healthcare providers – all looking to do things a little bit different.

(Slide: On-Going Challenges)
But there are a tremendous amount of challenges. The biggest one is there is no primary care. These communities have one day of nurse practitioner a week. One community is 2500 people, the other community has 1500 people, so about 50 people will show up and only about 20 get seen, and the rest go to walk-in clinics or emergency departments. There's no lab or ability to do phlebotomy, to do blood work, and access to kind of all those other additional health services. Mental health and addiction services is a big gap, and the other big challenge is jurisdictional. There's a lot of back and forth, and passing the buck, if you will, between governments and health regions. With that, I will pass it over to you.

(Slide: Proportion of HIV cases reported by selection health regions [graph])
Mona Loutfy: Thanks Stu. So Stu is from Saskatchewan. He lives in Regina and travels to the different communities. I was invited by the Saskatchewan Prevention Institute and Stu's team in 2012 to give a talk on HIV and pregnancy. When I found out what was happening with HIV – I think we all knew about the epidemic of HIV in Saskatchewan – and then when I came out, I said, "Well, I have to do something." I'm an infectious disease specialist from Toronto but I got my medical license to practice in Saskatchewan, and I fly out there every two months and I do a clinic in Ahtahkakoop.

(Slide: Number of Patients)
I was telling Stu earlier, "Do you see the difference between these retention and care numbers? This is without Mona and this is with Mona." [*Laughs*]. I have to tell you, Ahtahkakoop – I'm not

sure if you have this is BC – but in Saskatchewan and Manitoba, it might be the only First Nations community with an addictions treatment center in the community. I think it's the only one led by the community and this makes such a huge difference. They have inpatient care, outpatient care, and I can't stress about having treatment by their community members in the community, how tremendous that is. And you're right, I think that's what the effect here is.

(Slide: Proportion of HIV cases reported by selection health regions [graph])
So the other community – so Stu brought me out to Ahtahkakoop Cree Nation, and Chief Larry and the Council accepted me to work there, so I worked there with Stu. The other place that I work is in Prince Albert here, so this is the distribution of the cases of HIV in Saskatchewan. Saskatoon is the largest city, then Regina, and then Prince Albert's the third one.

(Slide: My SK Clinical Practice #3)
I work in Prince Albert, which is – I'm not sure if you saw the map – but it's the most northern city in Saskatchewan. However, it doesn't even make it to the halfway mark of the province in terms of distance north. It's about 40% of the way, 35% of the way, up north, and then 65% of the land is north of that. It's the third largest city in Saskatchewan with a population of 35,000. So by your definition, Katherine, it's still potentially rural. Although it has the third highest proportion of cases at 12%, if you actually count the cases – for example, in 2013, there were sixteen new cases of HIV – so that makes an incident rate of 45 per 100,000 in Prince Albert. And the preliminary data for 2015, the cases haven't all been confirmed and where they're from, there are 20 cases in Prince Albert of HIV since June this year.

(Slide: CBC article)
So you might have seen that I was quite vocal this year on CBC about what was happening with HIV in Saskatchewan. So this is an article specifically on Prince Albert.

(Slide: Why PA?)
Why Prince Albert? So Prince Albert is considered the gateway to the north. There's fifty First Nations communities north of Prince Albert. Stu's talked about two or three communities that have done heavy testing of HIV, that we know the rates of HIV, but there's probably seventy others where we don't know what's happening with HIV in the First Nations communities. There's three correctional institutions in Prince Albert. There's nine gangs; six anti-gang squads. The proportion of the population that's First Nations and Métis is 25% and increasing, which is a great thing, but the communities need to be supportive, because there's still a lot of unresolved issues that have only been limitedly spoken about in this session today, which include tremendous racism. Coming from Toronto, where it's really multicultural, I never really experienced much racism growing up. It was a shock to me to see this degree of racism in Canada – the degree of historical and multigenerational trauma, the education and income gap, 90% of First Nations people that haven't finished high school, the violence, the gender power imbalances, the heavy hand of child protection agency. I think there's so many unresolved issues that are contributing to the high rates of HIV that we need to discuss this afternoon. It's also under resourced, so there's no ID physician in Prince Albert full time. There's two family

physicians locally, and four HIV doctors, including myself, who go in for a half-day, or a day or two a month. Limited primary care. There's no family planning, so there's no active discussions about contraception, so there's probably about 20 women with HIV who are pregnant every couple of months, and limited outreach. However, on the bright side, there is a great team. There's an HIV public health nurse, an HIV nurse, hepatitis-C nurse, social worker outreach, the nurse-led clinic. But I think we're just at the beginning of trying to ramp things up in Prince Albert and we look forward to working on the issues there.

(Slide: Thank you)

This is the road that Stu and I take between Ahtahkakoop and Prince Albert and it's a long and straight road. Thank you very much.