Fresh Perspectives: An Experience from an HIV/ AIDS Prevention and Care Course

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Last summer, I took part in an HIV/AIDS prevention and care course offered by the Interprofessional Health and Human Service (IHHS) department at the University of British Columbia. I felt it would be the perfect primer on some of the issues I would encounter in the field of international healthcare, in which I have an interest. The course brought together students from medicine, pharmacy, social work, nursing, and nutrition. We had lectures from some of the leading experts in the field of HIV/ AIDS and engaged with HIV positive individuals and activists. Two days each week were spent in a variety of different clinical settings – the Dr. Peter Centre, the HIV/AIDS ward at St. Paul's Hospital and the Portland Hotel, to name a few – in order for us to gain a sense of the impact that this illness has on the lives of those affected, and the resources available to them.

I met "Jackie" during one of my first clinical placements at St. Paul's Hospital, located in the Downtown Eastside (DTES) inner-city community of Vancouver. Jackie was a 29-year-old sex-trade worker who had a low CD4 count and suspected Tuberculosis. Her youthful features seemed out of context on her sickly frame; her arms and legs were wasted and limp and she had hardly enough energy to open her eyes, as she faded in and out of consciousness. This scene was a vivid reminder that perhaps I did not have to travel as far as I had thought to find people in the midst of a health care crisis. Though Vancouver's burden of HIV/ AIDS is not comparable to that in many other parts of the world, if you take into account the sex trade, homelessness, remove mental health and addiction issues, the city has plenty of problems that have forced people into dire straits.

Another part of my experience during the course involved a visit to INSITE, Vancouver's internationally-recognized safe injection site. I was impressed by the slick stainless steel counters, the boxes of neatly organized medical supplies, and the mirrored cubicles with ample overhead lighting positioned close to the centralized nursing station to ensure adequate supervision. The sterility of this clinical environment was in stark contrast to the warmth and compassion demonstrated by the staff who worked there. They shared information about the organization of the clinic, interwoven with stories of their disappointments, struggles and successes, making the issue of harm reduction come to life. But the experience that perhaps made the biggest impact on me that day happened as I walked down Vancouver's infamous East Hastings Street on my way to INSITE. I distinctly remember being struck by the abrupt transition that occurred as I made my way there; the run-down hotels that were funded by welfare cheques were mere blocks from the ultra-modern high rises of Coal Harbour. How strange it is that the people of the DTES live parallel to such wealth, separated by the physical boundaries of Main and Hastings and by the intangible boundaries of social and financial inequality.

This course gave me the opportunity to get better acquainted with the struggles of the DTES and also with some of the people that have dedicated their lives to working there. During my final placement, I met with two street nurses who delivered antiretroviral medications to patients living in the DTES. The transience of the population to which they minister complicates their seemingly straightforward task. Personally delivering medications to people with a constantly changing address, or perhaps no address at all, requires dedication, patience, and a keen sense of geography. Some were easy to find, as they were not even able to get out of bed, never mind leave their apartment. For others, we combed the streets, looking down alleys, asking acquaintances when they had last seen their friend. The conditions that the nurses work in are often unpleasant: low-income housing complexes that smell of urine and stale smoke, often infested with bed bugs or rats. The street nurses work with the downtrodden and the forgotten - people who have lost faith in others, and often in themselves as well. They meet patients where they are at and provide full service, self-sacrificing care.

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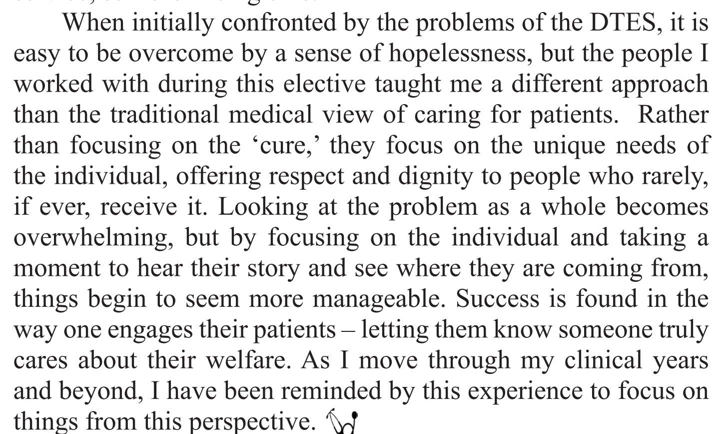
When initially confronted by the problems of the DTES, it is easy to be overcome by a sense of hopelessness, but the people I worked with during this elective taught me a different approach than the traditional medical view of caring for patients. Rather than focusing on the 'cure,' they focus on the unique needs of the individual, offering respect and dignity to people who rarely, if ever, receive it. Looking at the problem as a whole becomes overwhelming, but by focusing on the individual and taking a moment to hear their story and see where they are coming from, things begin to seem more manageable. Success is found in the way one engages their patients – letting them know someone truly cares about their welfare. As I move through my clinical years and beyond, I have been reminded by this experience to focus on things from this perspective.



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