

**HIV and Disability Policy:
Evaluating the Disability Tax Credit and
Medical Expense Tax Credit**

**A Brief Prepared for the Technical Advisory Committee on Tax
Measures for Persons with Disabilities**

**Prepared and Submitted by the
Canadian AIDS Society**

August 2003

The Canadian AIDS Society

The Canadian AIDS Society (CAS) is a national coalition of more than 115 community-based AIDS organizations across Canada. CAS is dedicated to increasing the response to HIV/AIDS across all sectors of society, and to enriching the lives of people and communities living with HIV/AIDS.

Since 1996, the Canadian AIDS Society has served as the national voice for the community-based AIDS movement. The national office advocates on behalf of people and communities affected by HIV/AIDS, develops programs, services and resources for its member organizations, and provides a national framework for community-based participation in Canada's response to AIDS.

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I. HIV is an issue for Disability Policy

The Canadian AIDS Society (CAS) is a national coalition of over 115 community-based AIDS organizations across Canada. As a national voice, CAS is dedicated to increasing the response to HIV/AIDS across all sectors of society, and to enriching the lives of people and communities living with HIV/AIDS. CAS has produced a number of briefs, guides and manuals, as well as conducted reviews and research projects on HIV, disability and income security. Some of the topics of recent initiatives include the Canada Pension Plan Disability Program¹, labor force participation by people living with HIV/AIDS², benefits counseling³ and private insurance⁴.

As leaders in HIV/AIDS, disability and income security, CAS presents the following discussion to ensure that persons living with HIV/AIDS and their caregivers are recognized as stakeholders in the discussion of disability policy. We would like to use this opportunity to highlight the ways in which the Disability Tax Credit does not adequately reflect the disability experience. On behalf of the Canadian HIV/AIDS community, CAS supports the arguments and recommendations that have been put forward by the Canadian Medical Association, the Council of Canadians with Disabilities, the Canadian Association for Community Living, and the Canadian Mental Health Association.⁵ We would like to take this opportunity to build on these discussions and provide insight into the experience of Persons Living with HIV/AIDS (PLWHA).⁶

People living with HIV are living with a disability and all of the corresponding physical, psychological, social and financial challenges⁷. On behalf of the HIV community in Canada, CAS recommends to the Technical Advisory Committee on Tax Measures for Persons With Disabilities that people living with HIV qualify for the Disability Tax Credit.

In the 20 years since HIV was first diagnosed, we have seen a number of significant social, cultural, and scientific changes. The response from the medical and scientific community has transformed HIV from a near immediate death sentence to a chronic yet still terminal illness, increasing both life expectancy and quality of life for many infected individuals. However, despite developments in treatment options for HIV, there is no cure. Despite two decades of public education campaigns, new infections rise. Despite the fact that HIV touches everybody, HIV continues to be associated with stigma and discrimination. Living with HIV is living with uncertainty, and never knowing when illness will set in, and never knowing when discrimination will be encountered. With over 50,000 Canadians living with HIV, and over 2000 new diagnoses every year, the role of HIV in the disability policy forum in Canada is clear⁸. As a health issue, a political issue, a social issue and an economic issue, HIV presents a number of public policy challenges. While some of these are shared by other illnesses and disabilities, many are unique to the HIV virus.

a. Defining Disability

When identifying illnesses as disabilities, HIV stands alongside a variety of illnesses which require a specialized description.⁹ This description must acknowledge that while the illness itself is permanent, it can, and often does result in recurring and unpredictable periods of good health and poor health. While terms such as "cyclical", "episodic" and "recurring" have been used in

conjunction with these illnesses, there has yet to be widely accepted and understood terminology that reflects the complexity of these illnesses. For the purposes of this brief, the term "episodic illness" is used to describe HIV. The terms "lifelong and episodic" were identified as more accurate descriptors than "chronic, episodic and cyclical" by an Advisory Group participating in a Cross Disability Project in 2001-2002.¹⁰ Further investigation into disability terminology needs to include discussion of episodic and lifelong illnesses. In addition, disability terminology is not standardized across government departments and jurisdictions, among medical and rehabilitation providers, and in insurance and government benefit programs.¹¹ The goal of establishing and standardizing definitions is to ensure that terminology used in policy accurately reflects the realities of people living with HIV. If definitions are standardized throughout programs and policies, there is less room for interpretation by policy makers and administrators during the process of building and implementing policies and programs. The term disability however is widely used and interpreted throughout government departments and jurisdictions in Canada, and risks miscommunication and poor understanding of government programs, policies and procedures.

For example, the use of the term disability by Canada Customs and Revenue Agency (CCRA) varies from that of the Canada Pension Plan Disability Program. An individual may qualify for one disability program yet not qualify for another. While the goals of each program may be slightly different, they are both working to recognize that living with a disability has a serious financial impact on an individual. The application process for these programs is not only confusing for medical professionals responsible for completing application forms, but for community workers and benefits counselors assisting people with disabilities as they navigate the income support system. This is even more difficult for individuals who seek financial relief without assistance. The problem with inconsistent disability terminology and eligibility criteria was outlined in the "Disability Policies and Programs: Lessons Learned", an evaluation report produced by Human Resources Development Canada in 2000.

b. HIV as an Episodic Disability

Throughout most of the 1980s and the 1990s, individuals diagnosed with HIV could expect to maintain their health for a limited time, after which they would see their health rapidly decline. During this time, a period of ill health usually resulted in the need to withdraw from the workforce permanently, and eventually rely on full time care or hospitalization. Ill health could include symptoms ranging from mild yet debilitating chronic fatigue and treatment side-effects such as chronic diarrhea, to more life threatening opportunistic infections, pneumonia and cancer leading to death.

Due to advances in treatment research and availability of new treatment strategies during the 1990s, many people living with HIV have a variety of treatment options. A large number of individuals now living with HIV are able to experience extended periods of good health. Furthermore, treatment has enabled many individuals to fully recover from serious and deadly opportunistic infections and reintegrate into an active life. Unfortunately the effectiveness of treatment, the onset of debilitating side effects, psychosocial factors as well as the onset of new HIV related illnesses are unpredictable.

There are three principle factors that define the nature of HIV as an episodic illness that must be taken into consideration when examining the Disability Tax Credit and related tax policies:

1. Even with a variety of treatment options, people living with HIV are vulnerable to periods of debilitating ill health due to physical and psychosocial factors. These factors will increase an individual's reliance and dependence on physical and social support.
2. These periods of ill health for some people are recurring, and many individuals experience successive debilitating illnesses in a short period of time.
3. The nature and progression of HIV, effectiveness of treatment and subsequent vulnerability to debilitating illness are different for every individual, and can not be predicted.

Recommendations:

1. **It is recommended that the CCRA work with government departments and other public and private sectors to develop a community-reviewed and multidisciplinary set of disability terminology that is consistent across government departments and jurisdictions.**
2. **It is recommended that the CCRA work with government departments and other public and private sectors to develop a coordinated, multidisciplinary approach to disability issues that ensures consistent policies and programs.**
3. **It is recommended that the CCRA include HIV as an "episodic illness" in their eligibility criteria, and ensure that people living with HIV are eligible for the Disability Tax Credit.**

II. Eligibility for the Disability Tax Credit

Current eligibility criteria exclude a large number of individuals burdened with the high-costs of living with a disability. The Disability Tax Credit is an effort by CCRA to recognize the increased direct and indirect costs of living with a disability and should be made more accessible to the many Canadians who struggle to balance living with a disability and covering the costs required for independent living. Studies in Canada repeatedly identify a link between poverty and living with HIV. One examination of people living with HIV in Atlantic Canada indicates that a large proportion are living below the poverty line (one third have an annual income of less than \$10,000), and 61% of respondents in this study indicated that they were experiencing financial difficulties meeting the care needs related to HIV.¹² These respondents listed financial difficulty as a barrier to accessing medication, food, housing and utilities, transport, as well as dietary supplements, vitamins and complementary therapy. Another study illustrated the connection between poverty and health among people living with HIV, indicating that *low-income* people living with HIV are more likely than high income people living with HIV to experience depression and helplessness, HIV related discrimination, family tension because of HIV, rejection by family or friends, and alcohol and drug use.¹³ While the Disability Tax Credit is not solely responsible for maintaining the financial security of people living with disabilities, it

is one component of a larger strategy that recognizes the relationship between disability and poverty, and works to alleviate the impact of high costs associated with disability and illness.

a. “Prolonged” impairment

The criteria to determine “prolonged” impairment is too restrictive and does not reflect the experience of living with an episodic disability. As an episodic illness, the onset of debilitating symptoms, side effects and infections are unpredictable. Similarly, the length of time a person will experience a debilitating illness is unpredictable. Some of these illnesses include infections that will result in several months of hospitalization and/or full or part-time attendant care, such as; Pneumocystitis Carinii Pneumonia (a form of pneumonia); Cytomegalovirus (a potentially life-threatening virus and a major cause of blindness among people living with HIV); Mycobacterium Avium Complex (a bacterial infection common among people with advanced HIV disease) and active tuberculosis.¹⁴ Many of these illnesses are rare in the general population and unfortunately are not well understood. Consequently they do not have highly developed and effective treatment. As the HIV virus is present in the central nervous system, there are a number of AIDS-related neuro-degenerative diseases (dementia) that can also result in long-term hospitalization, or full time or part time attendant care.¹⁵ Other physical symptoms and side-effects of HIV and treatment include general pain, weakness and coordination impairments, fatigue, weight loss, cognitive impairments, visual loss, and cardiac and respiratory impairments.¹⁶

For many people the onset of one or more of these debilitating illnesses and symptoms results in periods of recovery and independence, however in many cases will result in the need for assistance part time or on call. While a person living with HIV may experience an individual or series of debilitating illnesses or side effects for less than the 12 months required to qualify an impairment as “prolonged”, he or she may experience recurring infections over a number of years. Individual illnesses and disabilities may not meet the CCRA definition of a prolonged impairment, however HIV is clearly a prolonged illness with a prolonged risk of debilitating illness.

b. “Basic activities of daily living”

The criteria listed as “basic activities of daily living” reflect a narrow perspective towards “living” and do not reflect the significant physical, emotional, and financial challenges that people with disabilities must overcome to engage in activities beyond “basic activities”. For example, in addition to the most serious and debilitating symptoms and side effects of advanced HIV disease and treatment, as many as 30% of people with HIV experience depression (including sadness, changes in sleep and appetite, apathy, and lack of pleasure), and anxiety (insomnia, hyperventilation, shaking, change in appetite and restlessness)¹⁷. While these are not easily physically measured they can play a large role in determining an individual's capacity to engage in an active life, and even more basic activities such as buying groceries, housekeeping and maintaining a healthy and sanitary environment. "Many people with HIV have endured chronic or multiple periods of grief, anticipatory loss, and a host of life changes intrinsic to a degenerative, life-threatening disease."¹⁸

Other psychosocial factors include the changing relationship an individual has with his or her personal identity and body image, a process that can have a serious impact on self-esteem. For

many people, setting life goals can be difficult if not impossible. Living with a sense of failure is not uncommon among people facing these challenges.¹⁹ This emotional stress combined with a lack of social supports has been associated with anxiety and depression. All of these factors can lead to fatigue, poor motivation, apathy and anguish²⁰. When asked to define what activities constitute active living, a group of people living with HIV identified the following²¹: Employment, sexuality, friendships, family, leisure, spirituality, self-determination, health, identify, empowerment and achievement (among others). What this list represents is the movement towards redefining “living”. Just as health means much more than the absence of disease, the basic activities of daily living mean more than being able to feed and dress oneself. Learning to live with HIV requires learning to live with a strict treatment regimen, medication side-effects, unpredictable illnesses, changing body shape and a variety of other physical impairments and disabilities. It also means learning to live with grief and loss, and unfortunately, in the current climate where HIV discrimination still exists, people living with HIV learn to live with stigma and discrimination, and the constant risk of losing employment, friends, family and intimate relationships. Living with HIV for many people means that participation in all of these activities is “markedly restricted”. The challenge that is faced when developing policies and programs for people living with HIV is that each symptom and each experience is individual. For some, the experience of living with HIV will necessitate income support over extended periods, while others will successfully remain in the workforce. What program and policy makers need to ensure is that the range of experiences is recognized, and that those who require increased social and economic support are able to access these resources easily.

c. “Markedly Restricted”

While HIV is a permanent illness, the periods of serious impairment and dependence on financial and social support may “markedly restrict” individuals for varying periods of time. These periods of restricted independence may last for a few weeks, a few months, a number of years, or may be permanent. They may occur multiple times in one year or over a period of time. In most cases, they become more frequent and more serious as HIV progresses. All people living with HIV face the unpredictable onset of an additional impairment and must adjust their lives, including their financial stability, accordingly. This factor should qualify people living with HIV for the Disability Tax Credit.

Recommendations:

- 4. It is recommended that the list of “basic activities of daily living” be expanded to include activities related to active living, such as volunteering, education, employment, housekeeping and social and recreational activities.**
- 5. It is recommended that “markedly restricted” be expanded to include illnesses that experience short-term but recurring episodes of impairment.**

III. Program Awareness and Promotion

a. Program awareness

There have been a number of concerns that the Disability Tax Credit is not adequately promoted, and that many individuals who qualify are not aware that they are eligible for the credit. A study of persons living with HIV conducted in New Brunswick illustrated that almost all participants were confused about the tax benefits available to them²². Few had applied for and understood the

benefits. Those who were aware they existed were not sure if they qualified or how to apply. Clearly there is a lack of awareness of the Disability Tax Credit and how individuals can apply. Effort needs to be made by CCRA to ensure that all Canadians who may be eligible are aware of the credit, and are able to navigate the application process easily and comfortably. Integrating AIDS Service Organizations (ASOs) into the planning and development of communication strategies can be an effective way of ensuring that messages and information targeting people living with HIV are appropriate. Working with ASOs to provide training, information and support to front-line workers and benefits counselors is another strategy to ensure that people living with HIV are aware of the tax benefits available to them and how to apply. The Disability Tax Credit is currently being promoted by front-line workers and benefits counselors, however the lack of funding to conduct this work results in a lack of consistent knowledge and understanding of the tax system, and a lack of available expertise throughout communities (particularly in rural and remote communities).

b. CCRA Information Support

It has been reported by one group of people living with HIV in New Brunswick that while the CCRA attempts to help individuals with many complex tax issues, the overall level of service was not satisfactory. The experience of this group noted that while information line workers were helpful, they were not very prompt, taking up to four days to respond to a message.²³ It is important that CCRA recognize that navigating the tax system can be emotionally and physically challenging for many people, especially for those living with disabilities. Small steps such as ensuring that individuals seeking information are contacted promptly is one way of maintaining a positive and respectful relationship. In cases where information will require research or preparation, an immediate reply or update can assure the individual that his or her question is valuable and that efforts are being made to respond.

c. Working with community AIDS Service Organizations

Working in partnership with local AIDS Service Organizations (ASOs) can be a useful tool for CCRA administrators and communications personnel promoting and processing the Disability Tax Credit and related tax policies. CAS strongly promotes community involvement in all aspects of government programming, policy development and decision making. Consultation and partnership building between the government and the community can be a win-win relationship, and the Disability Tax Credit is no different. ASOs such as the Canadian AIDS Society can provide information to DTC administrators on the needs and lived experiences of people with HIV, and can provide information about the DTC directly to their clients. By integrating ASOs in peer consultations, decision making opportunities and overall communication, policy makers and benefit administrators can ensure that the needs of the community are being integrated, and can ensure that information is disseminated at the community level. Unfortunately many ASOs are underfunded and have limited ability to provide extensive training and education sessions, as well as staff time to contribute to partnerships. Nevertheless, their participation in decision making, the development of training and education sessions, as well as conduits of information to people living with HIV is essential. Efforts at working with ASOs must respect their lack of resources and ensure that services are reimbursed. Funding to develop and provide educational programs for DTC employees and administrators must be secured.

d. Medical Assessment Fees

Charging medical assessment fees to applicants works against promoting the Disability Tax Credit. Individuals applying for tax relief should not be charged to do so. If successful, it reduces the actual value of the credit. If unsuccessful, the applicant has incurred an out-of-pocket, non-refundable expense. Furthermore it acts as a deterrent and barrier to individuals who have not applied but would like to do so. Persons with low-incomes who require tax relief the most may not have the resources to cover the expense of applying.

Recommendations:

- 6. It is recommended that the CCRA conduct a community driven promotional campaign to promote the Disability Tax Credit.**
- 7. It is recommended that that all calls that are received by the CCRA are responded to in a timely matter.**
- 8. It is recommended that CCRA involve the community in all stages of policy development and implementation to ensure that current features and future changes to the Disability Tax Credit and related tax policy reflect the needs and realities of people living with disabilities.**
- 9. It is recommended that CCRA involve the community in the development of communication strategies to ensure that information about the Disability Tax Credit and related tax policy is accessible, useful and meaningful.**
- 10. It is recommended that CCRA establish, fund and maintain supportive relationships with community organizations, front line workers and benefits counselors to expand the network of leaders with knowledge of Disability Tax Credit and the ability to encourage and support individuals wishing to apply. One component of this initiative is to provide training or funding for training to community benefits counselors.**
- 11. It is recommended that all fees that are associated with an application be absorbed by the CCRA.**

IV. Medical Expense Tax Credit

The current list of allowable expenses for the Medical Expense Tax Credit does not reflect the actual expenses incurred when living with a disability, and materials needed to ensure comfort and independent living.

a. Complementary and Alternative Medicine

Many people living with HIV are finding relief for symptoms and side-effects in complementary and alternative medicine (CAM), therapies which are not always covered as allowable expenses²⁴. With the large variety and frequency of illnesses and side effects experienced by many people living with HIV, combined with the toxicity of current HIV chemotherapy, alternative and complementary medicine plays an important role in the management of HIV illness and discomfort. It is imperative that individuals maintain control of their treatment and have the flexibility to choose from a range of treatment options. These include acupuncture, vitamins and non-prescription diet supplements and natural health foods to manage side effects such as nausea and diarrhea. For example, it is estimated that 18 percent to 39 percent of people living with HIV rely on complementary and alternative medicine.²⁵ Among the population

involved in this particular study, 77 percent of patients used a form of CAM (excluding micronutrients such as vitamins and minerals), and 90 percent used CAM that included micronutrients in conjunction with conventional medicine. These participants identified the use of CAM for general health and well-being, relaxation, and stress relief and energy, as well as the physical and psychological effects of the illness, and the side effects of treatment. Unfortunately due to the costs of complementary and alternative medicine, they remain out of reach to many Canadians, particularly low-income people living with HIV. This study reported monthly out-of-pocket costs of CAM up to \$250.00.²⁶

b. Therapeutic Cannabis

Despite regulations allowing for the use of therapeutic cannabis, the lack of product available to patients has resulted in significant costs that are not covered as allowable expenses. Many patients have been granted permission by the Office of Controlled Substances to legally access and use cannabis for therapeutic use since 1999. As of May, 2003, over 500 Canadians have been authorized to possess therapeutic cannabis, and 375 Canadians have been authorized to cultivate/produce therapeutic cannabis.²⁷ People living with HIV are a large proportion of these users. Of the number of medical practitioners approving Category One²⁸ patient applications to possess therapeutic cannabis, 38% work in the field of HIV (41% in Cancer), and of those approving Category Two²⁹ patient applications, 26% work in HIV (28% in Multiple Sclerosis).³⁰ Health Canada has attempted to increase access to therapeutic cannabis, however current regulations continue to place the onus and expense of purchasing and growing therapeutic cannabis on patients. For an individual who cultivates his or her own crop, or for a designated grower, this results in costly expenses, both to invest in cultivation equipment, as well as crop maintenance, harvesting and distribution. Until Health Canada is able to provide therapeutic cannabis either directly as producers and distributors, or indirectly by facilitating access to product at no cost to the patient, people living with HIV are burdened with these expenses.

Recommendations:

- 12. It is recommended that the range of items that qualify under allowable medical expenses be expanded to include alternative and complementary therapies.**
- 13. It is recommended that the purchase of therapeutic cannabis and equipment related to its cultivation allowable as a medical expense, until such time that product is made available to patients.**
- 14. It is recommended that CCRA work closely with the Office of Controlled Substances and Health Canada to ensure that changing policies and availability of therapeutic cannabis are reflected in tax policy.**

Appendix I – Summary of Recommendations

1. It is recommended that the CCRA work with government departments and other public and private sectors to develop a community-reviewed and multidisciplinary set of disability terminology that is consistent across government departments and jurisdictions.
2. It is recommended that the CCRA work with government departments and other public and private sectors to develop a coordinated, multidisciplinary approach to disability issues that ensures consistent policies and programs.
3. It is recommended that the CCRA include HIV as an “episodic illness” in their eligibility criteria, and ensure that people living with HIV are eligible for the Disability Tax Credit.
4. It is recommended that the list of “basic activities of daily living” be expanded to include activities related to active living, such as volunteering, education, employment, housekeeping and social and recreational activities.
5. It is recommended that “markedly restricted” be expanded to include illnesses that experience short-term but recurring episodes of impairment.
6. It is recommended that the CCRA conduct a community driven promotional campaign to promote the Disability Tax Credit.
7. It is recommended that that all calls that are received by the CCRA are responded to in a timely matter.
8. It is recommended that CCRA involve the community in all stages of policy development and implementation to ensure that current features and future changes to the Disability Tax Credit and related tax policy reflect the needs and realities of people living with disabilities.
9. It is recommended that CCRA involve the community in the development of communication strategies to ensure that information about the Disability Tax Credit and related tax policy is accessible, useful and meaningful.
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11. It is recommended that all fees that are associated with an application be absorbed by the CCRA.
12. It is recommended that the range of items that qualify under allowable medical expenses be expanded to include alternative and complementary therapies.
13. It is recommended that the purchase of therapeutic cannabis and equipment related to its cultivation allowable as a medical expense, until such time that product is made available to patients.
14. It is recommended that CCRA work closely with the Office of Controlled Substances and Health Canada to ensure that changing policies and availability of therapeutic cannabis are reflected in tax policy.

Appendix II – Bibliography

A Comprehensive Guide for the Care of Persons with HIV Disease: Module 7, Rehabilitation Services. Toronto: Wellesley Central Hospital, 1998

A. Theriault. *From Policy to Practice: Enhancing the Income Security of New Brunswick PLWHIV/AIDS through Participatory Action Research* Fredericton: AIDS New Brunswick, 2001

Defining Active Living: Workshop Report from the 2003 Canadian AIDS Society Annual General Meeting Ottawa: The Canadian AIDS Society, 2003

Disability Policies and Programs: Lessons Learned, Final Report: Evaluation and Data Development Strategic Policy, Human Resources Development Canada, 2000

Force for Change Ottawa: The Canadian AIDS Society, 1998

M.D. Furler, T.R. Einarson, S. Walmsley, M. Millson, R. Bendayan. *Use of Complementary and Alternative Medicine by HIV-Infected Outpatients in Ontario, Canada* AIDS Patient Care and STDs. 17(4):155-168.

HIV as an Episodic Illness: Revising the CPP(D) Program Ottawa: The Canadian AIDS Society, 2003.

C. Olivier. *Relationships Between Income Level and the Social Well-Being of Persons Living with HIV/AIDS*. Poster Presentation, Canadian Association of HIV/AIDS Researchers, 2001. Downloaded from <http://www.pulsus.com/cahr/abs/abs476p.htm> 19/21/03 12:30

C. Ploem. *HIV/AIDS and Palliative Care in the Atlantic Region* Canadian Palliative Care Association, 2000.

M. Prévost and C. Perron. *AIDS 101, 2nd edition* CPAVIH Committee of People Living with HIV in Quebec, 2000

P. Proctor. *Beyond the Silos: Disability Issues in HIV and Other Lifelong Episodic Illnesses*. Toronto: The Canadian Working Group on HIV and Rehabilitation, 2002

Project Inform Perspective Vol 27 April 1999 Downloaded from <http://www.thebody.com/pinf.april99/ois.html> 19/21/03 14:08

Office of Cannabis Medical Access *Statistics* Drug Strategy and Controlled Substances Program of Health Canada: Feb 2003

Office of Cannabis Medical Access *Statistics* Drug Strategy and Controlled Substances Program of Health Canada: May 2003

Appendix III - Endnotes

- ¹ *HIV as an Episodic Illness: Revising the CPP(D) Program* Ottawa: The Canadian AIDS Society, 2003.
- ² *Force for Change* Ottawa: The Canadian AIDS Society, 1998
- ³ J. Zamprelli *Benefits Counseling "Train the Trainer" Regional Workshops* Edmonton, Vancouver, Winnipeg, Regina, Fredericton, Toronto: Hosted by the Canadian AIDS Society, 2000. Training manual to be published and distributed in fall, 2003.
- ⁴ *HIV/AIDS: A Guide to Insurance Benefits* AIDS Committee of Toronto and Canadian AIDS Society, 1998
- ⁵ H. Haddad *Disability Tax Credit Program: CMA Submission to the Sub-Committee on the Status of Persons with Disabilities (House of Commons)* Canadian Medical Association, 2002
- W. Steinberg *Position Paper on Federal Income Security Programs* Canadian Mental Health Association, 2001
- No Miracles as Yet: People with Disabilities Still Treated Unfairly* Council of Canadians with Disabilities, 2001
- The DTC and Other Supports to Families* Canadian Association for Community Living, 2001
- ⁶ Portions of this text were originally published in a brief presented to the Parliamentary Sub-committee on the Status of Persons with Disabilities: *HIV as an Episodic Illness: Revising the CPP(D) Program* Ottawa: The Canadian AIDS Society, 2003.
- ⁷ For more discussion on how HIV is considered a disability, please see P. Proctor. *Beyond the Silos: Disability Issues in HIV and Other Lifelong Episodic Illnesses*. Toronto: The Canadian Working Group on HIV and Rehabilitation, 2002.
- ⁸ Health Canada. *HIV/AIDS in Canada: Surveillance Report to December 31, 2002* Division of HIV/AIDS Epidemiology and Surveillance, CIDPA, PPHB, Health Canada, April 2003.
- ⁹ Other illnesses which can be considered as "episodic disabilities" include Multiple Sclerosis, cancer, mental illness, Crohn's and Colitis, arthritis, diabetes, fibromyalgia. For more information on how these illnesses are similar, please see P. Proctor. *Beyond the Silos: Disability Issues in HIV and Other Lifelong Episodic Illnesses*. Toronto: The Canadian Working Group on HIV and Rehabilitation, 2002.
- ¹⁰ For more information regarding this group and this discussion, see P. Proctor. *Beyond the Silos: Disability Issues in HIV and Other Lifelong Episodic Illnesses*. Toronto: The Canadian Working Group on HIV and Rehabilitation, 2002.
- ¹¹ P. Proctor. *Beyond the Silos: Disability Issues in HIV and Other Lifelong Episodic Illnesses*. Toronto: The Canadian Working Group on HIV and Rehabilitation, 2002.
- ¹² C. Ploem. *HIV/AIDS and Palliative Care in the Atlantic Region* Canadian Palliative Care Association, 2000.
- ¹³ C. Olivier. *Relationships Between Income Level and the Social Well-Being of Persons Living with HIV/AIDS*. Poster Presentation, Canadian Association of HIV/AIDS Researchers, 2001. Downloaded from <http://www.pulsus.com/cahr/abs/abs476p.htm> 19/21/03 12:30
- ¹⁴ M. Prévost and C. Perron. *AIDS 101, 2nd edition* CPAVIH Committee of People Living with HIV in Quebec, 2000
- Project Inform Perspective* Vol 27 April 1999 Downloaded from <http://www.thebody.com/pinf.april99/ois.html> 19/21/03 14:08
- ¹⁵ Ibid.
- ¹⁶ *A Comprehensive Guide for the Care of Persons with HIV Disease: Module 7, Rehabilitation Services* Wellesley Central Hospital: Toronto, 1993
- ¹⁷ Ibid.
- ¹⁸ *Force for Change* Ottawa: The Canadian AIDS Society, 1998
- ¹⁹ P. Proctor. *Beyond the Silos: Disability Issues in HIV and Other Lifelong Episodic Illnesses*. Toronto: The Canadian Working Group on HIV and Rehabilitation, 2002
- ²⁰ *A Comprehensive Guide or the Care of Persons with HIV Disease*. Toronto: Wellesley Central Hospital 1998
- ²¹ *Defining Active Living: Workshop Report from the CAS AGM 2003* Ottawa: The Canadian AIDS Society, 2003
- ²² A. Theriault. *From Policy to Practice: Enhancing the Income Security of New Brunswick PLWHIV/AIDS through Participatory Action Research* Fredericton: AIDS New Brunswick, 2001
- ²³ Ibid.
- ²⁴ For more information on the use of alternative and complementary medicine for HIV/AIDS, please see: A Theriault. *From Policy to Practice: Enhancing the Income Security of New Brunswick PLWHIV/AIDS through Participatory Action Research* Fredericton: AIDS New Brunswick, 2001

R. Crouch, R. Elliott, T. Lemmens and L. Charland *Complementary/Alternative Health Care and HIV/AIDS: Legal, Ethical and Policy Issues in Regulation* Canadian HIV/AIDS Legal Network: 2001

²⁵ M.D. Furler, T.R. Einarson, S. Walmsley, M. Millson, R. Bendayan. *Use of Complementary and Alternative Medicine by HIV-Infected Outpatients in Ontario, Canada* AIDS Patient Care and STDs. 17(4):155-168.

²⁶ Ibid.

²⁷ These statistics include both valid Marijuana Medical Access Regulations Authorizations to Possess, and Section 56 exemptions (the Controlled Drugs and Substances Act). This data was compiled using statistical information produced by the Drug Strategy and Controlled Substances Program of Health Canada, through the Stakeholder Advisory Committee on Medical Marijuana, May 2003

²⁸ Category 1 of the Marijuana Medical Access Regulations refers to patients who are in the end stages of a terminal illness.

²⁹ Category 2 of the Marijuana Medical Access Regulations refers to a specific set of illnesses and symptoms, in which HIV is included.

³⁰ This data was compiled using statistical information produced by the Drug Strategy and Controlled Substances Program of Health Canada, through the Stakeholder Advisory Committee on Medical Marijuana, Feb 2003.