MEDICAL MARIJUANA AND ABORIGINAL PEOPLE LIVING WITH HIV/AIDS

BACKGROUND PAPER

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A Publication of the Canadian Aboriginal AIDS Network

THE CANADIAN ABORIGINAL AIDS NETWORK (CAAN)

Organizational Overview

The Canadian Aboriginal AIDS Network is a national, not-for-profit organization:

- Established in 1997
- Represents over 200 member organizations and individuals
- Governed by a national thirteen member Board of Directors
- A four member Executive Board of Directors
- Provides a National forum for members to express needs and concerns
- Ensures access to HIV/AIDS-related services through advocacy
- Provides relevant, accurate and up-to-date HIV/AIDS information

Mission Statement

As a key national voice of a collection of individuals, organizations and provincial/territorial associations, CAAN provides leadership, support and advocacy for Aboriginal people living with and affected by HIV/AIDS. CAAN faces the challenges created by HIV/AIDS in a spirit of wholeness and healing that promotes empowerment, inclusion, and honours the cultural traditions, uniqueness and diversity of all First Nations, Inuit and Métis people regardless of where they reside.

Vision Statement

A Canada where First Nations, Inuit and Métis people, families and communities achieve and maintain strong, healthy and fulfilling lives free of HIV/AIDS and related issues where Aboriginal cultures, traditions, values and Indigenous knowledge are vibrant, alive, respected, valued and integrated into day-to-day life.

Acknowledgements

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1. Executive Summary

As with other HIV/AIDS organizations across Canada, the issue of Medical Marijuana has appeared on the Canadian Aboriginal AIDS Network's (CAAN) radar screen over the years. In an effort to begin addressing the issue, the *Medical Marijuana and Aboriginal People Living with HIV/AIDS (APHAs) Background Paper (2006)* was deemed necessary to provide a background on the issue for CAAN's Board of Directors.

The paper found that Medical Marijuana was indeed an issue for many Aboriginal community service organizations, although not all. Through CAAN's Care, Treatment and Support Issues Study (CTS CAAN, 2005), we know APHAs have reported benefits from smoking medicinal marijuana for appetite, sleep, pain relief, spiritual and mental effects. Through a tabling of an AGM resolution at a CAAN Annual General Meeting, CAAN's membership has indicated a desire for the organization to produce a Position Statement on Medical Marijuana. This Background Paper was deemed as a necessary first step.

CAAN's CTS Study showed that a third of the APHAs in the study group used medicinal marijuana, male APHAs tend to use/need Medical Marijuana at higher rates than female APHAs and those with higher viral loads show higher rates of use. APHAs also reported many logistical barriers to access to Medical Marijuana. With this in mind CAAN conducted a small focus group of APHAs and distributed a small questionnaire to a number of Aboriginal Community Service Organizations who serve APHAs across Canada.

The responses to CAAN's organizational questionnaire and small focus group seemed to support much of the analysis in CAAN's CTS Study. In the focus group, it was discussed that not all people at Aboriginal gatherings, conferences and meetings are comfortable with seeing Medical Marijuana use, likely due to stigma or issues around recovery from substance addictions. It was suggested that Aboriginal people's history with substance use and its destructive legacy may contribute to some difficulty for our people to accept the medical use of marijuana.

> "We should also educate public and service providers so they understand that this exists and that we have the right," - focus group APHA

In CAAN's Aboriginal Organizational Questionnaire, half of respondents said Medical Marijuana was an issue while the other half said it is not. While those Aboriginal community organizations serving APHAs view Medical Marijuana as an issue, some have not made any attempts at opening dialogue. CAAN could support this dialogue through this background paper and later a position statement. Most individuals and organizations involved in this effort expressed a need for more information.

2. Purpose of the Background Paper

The purpose of this paper is to provide some background on medicinal marijuana. It is a result of direction from the Board of Directors of the Canadian Aboriginal AIDS Network who will, at some point, consider stating a position on the subject.

This background paper used three main methods of data collection: a review of the Canadian Aboriginal People Living with HIV/AIDS - Care, Treatment and Support Issues Study, a Questionnaire for Organizations and a small APHA Medicinal Marijuana Focus Group.

This document does not examine the issue of misuse or addiction. It will provide background on the subject which will inform the reader of what marijuana is, its uses, and its relevance to HIV/AIDS disease and symptom management. A collection of opinions and experiences of APHAs and Aboriginal Community Service Organizations on the issue is synthesized here to give further depth and relevance to the needs of CAAN and its membership.

3. What is Marijuana?

Marijuana (also spelled marihuana) and referred to by a number of street names, including weed, reefer, pot, among others, is a natural plant that can be inhaled when dried and smoked or ingested, such as in tea, baked goods or other food products. There are also other less common forms of consuming marijuana such as in concentrates (oils, hashish, "budder"), oral sprays, tinctures and edible oils.

> Cannabis indica, cannabis sativa, cannabis americanus, Indian hemp and marijuana (or marihuana) all refer to the same plant. Cannabis is used throughout the world for diverse purposes and has a long history characterized by usefulness, euphoria or evil depending on one's point of view. Medical professionals in the western world have forgotten almost all they once knew about the therapeutic properties of marijuana, or cannabis. (Retrieved January 27, 2006. http://www.medicalmarihuana.ca/health.html)

The many active ingredients in marijuana are called "cannabinoids". The main cannabinoid widely known to be the most active is "THC" or delta-9-tetrahydrocannabinol. There are literally hundreds of strains of the marijuana plant containing differing levels of different kinds of cannabinoids. Medicinal users of marijuana report that different strains of marijuana provide varying levels of benefit for different symptoms. Two synthetic forms of the active ingredient in marijuana are available in the form of Cesamet™ (nabilone) and Marinol™ (dronabinol) available by prescription through pharmacies.

Marijuana has been around for a long time, and there is evidence it has been used as a medical treatment in many diverse ways. It has been illegal to possess or use in Canada since 1923, after which its medicinal properties were no longer employed by the health care system. Today in Canada, marijuana is again being used legally as a medicine in the health care system, especially by those living with HIV/AIDS. The next section will explore some of the ways medical marijuana is used.

4. Medical Marijuana: Its uses and relevance to HIV/AIDS

Consumers of medicinal marijuana report many benefits to its use, but especially appetite enhancement. Other reported uses include pain management, mood enhancement, as a sleep aid, helping adhere to complicated drug regimens, helping with depression, helping with anxiety and managing weight.

People living with HIV/AIDS often experience loss of appetite, nausea and vomiting which can lead to involuntary weight loss. The loss of more than 10% of a PHA's weight where no other reason can be found is called "wasting syndrome" and usually suggests that the HIV disease is progressing. Marijuana also has elements which create a mind and mood altering state. It is this effect which some first time users report as unwanted, unhelpful or somewhat disorienting.

Pain management is also an important function of smoking Cannabis reported by medicinal consumers. Some Persons Living With HIV/AIDS (PHA) have reported that they have benefitted from smoking medicinal marijuana as it provides temporary relief and elimination of some of their chronic neuropathic pain. Most APHAs who have compared the medicinal use of Cesamet™ (nabilone) and Marinol™ (dronabinol) report that they prefer smoked marijuana over the pills.

> A native of central Asia, cannabis may have been cultivated as long as ten thousand years ago. It was certainly cultivated in China by 4000 B.C. and in Turkestan by 3000 B.C. It has long been used as a medicine in India, China, the Middle East, Southeast Asia, South Africa, and South America. Today, people all over the world are beginning to use the cannabis plant for its unique medicinal properties. (Retrieved January 27, 2006. http://www.medicalmarihuana.ca/health.html.)

What follows is some analysis from care, treatment and support research undertaken by CAAN on the subject of medical marijuana.

5. Canadian Aboriginal People Living with HIV/AIDS Care, Treatment and Support Issues Study - CAAN 2005

In the summer of 2004, CAAN conducted a nation-wide survey of 195 APHAs in Canada. The primary goal of this study was to document the extent to which service needs of APHAs were being met, and to identify deficiencies in the provision of those services. The survey elicited closed and open-ended responses to 38 types of care, treatment and support services used or needed by APHAs. One of these types of care was the use of medical marijuana. The findings on medical marijuana by this study served as a starting point for creating a background this document.

HIGHLIGHTS

The following are six points of analysis taken directly from CAAN's APHA CTS Report:

- Marijuana is the most commonly used alternative or complementary therapy (35.9%). Almost a third (31.7%) of APHAs who use marijuana indicate their needs are sometimes or never met.

- The use of marijuana differs significantly by region: 45 – 50% of APHAs in Manitoba, Ontario and British Columbia use/need marijuana for medical purposes; in the Quebec Atlantic region, the need/use rate is 36.8%; elsewhere the use/need rates are between 12% and 22%.

- Marijuana for medical use also differs significantly by gender: Male APHAs indicate a need/use rate of 41.6%; female APHAs indicate a rate of 27%. Interestingly, it appears that female APHAs are more satisfied that marijuana meets their needs (88.2%); among male APHAs who use marijuana, 39% indicate it only sometimes or did not meet their needs.

- Results are also significant with regard to health status: 60.9% of APHAs with serious viral loads (over 10, 000) use marijuana compared with 35.1% of APHAs whose viral loads are not serious. However, data on self reported CD4 T-cell counts indicates that APHAs with serious health problems (count under 200) are less satisfied with the extent to which marijuana meets their needs (47.8%), than APHAs whose counts are not serious (20%).

- Illegal access is the most frequently identified barrier specific to marijuana for medical use. APHA's also identified logistical barriers related to illegal access, such as unpredictable availability or not knowing where or how to obtain marijuana. Together these types of barriers specific to marijuana for medical use account for 33.3% of cases.

- Marijuana for medical use received a relatively high rate of unsolicited positive comments (60% of cases). APHAs report benefits for appetite, sleep, pain relief, spiritual and mental effects.

Keeping in mind this valuable data, CAAN desired to know more about the experience of Aboriginal community service organizations in regards to medical marijuana. Next, this paper will focus on their responses to some targeted questions posed to Aboriginal organizations.

6. Questionnaire for Organizations

CAAN asked 4 basic questions to twenty-two Aboriginal community service organizations across Canada. CAAN wanted to find out how it could create a background paper on medicinal marijuana that is actually useful to our Aboriginal APHAs, communities and/or organizations. Half (11 of 22 questionnaires emailed received responses) of the recipients responded to the following emailed questions:

THE QUESTIONS

1. Is medicinal marijuana on your organization's or community's radar screen?
2. What is the number one issue that has arisen regarding medicinal marijuana?
3. What kind of information does your organization require about medicinal marijuana?
4. If an APHA wants to know more about marijuana, do you know where to refer her/him?

THE ANSWERS

> "When the government rolls joints for people who are living with HIV/AIDS they contain a lot of seeds, stems, leaves and not much bud." - Toronto Aboriginal AIDS Service Organization





1. Five out of eleven of those who responded said that medicinal marijuana is a big issue for them. Ontario and BC organizations (2 in Ontario and 3 in BC) seemed to have a lot of experience with the issue. Four organizations however (2 in the Arctic, 1 Saskatchewan, 1 prevention organization in BC) answered that medical marijuana has not appeared on their radar screen. In Saskatchewan, although no APHA has ever asked about marijuana, it is known that some do use it medicinally. One respondent noted that although they have many clients who need/use marijuana medicinally, the organization has no policy around the issue. One organization in Saskatchewan observed that it has not come up. In the Arctic region, there are a few people who use medicinal marijuana however, it has not become a big issue up north as of yet. It was also an issue at an organization providing HIV/AIDS and Sexually Transmitted Infection (STI) education and training. Unfortunately, no responses were forthcoming from Alberta or Manitoba.
2. Three organizations reported that access to good marijuana without fear of police involvement is a big issue for APHAs. One urban Aboriginal AIDS service organization is already stocked up with the federal government license application forms and does referrals to medicinal marijuana buyers clubs. This same organization reports that their APHAs clients who use the government supply of medical marijuana say that the government product is inferior to medical marijuana buyers club supplies that offer multiple strains. Another organization that sees a lot of medical marijuana use says that it would be better if there was an Aboriginal medical marijuana buyer's club. Another

respondent with experience mentioned that the high cost of poor grade government marijuana is a problem. Many communities do not have a safe, reliable source of medical marijuana (i.e. buyer's clubs). Medical Marijuana buyers clubs are illegal distribution centres, tolerated by police, which compassionately supply a variety of marijuana products to customers with a membership.

Two organizations mentioned that in some cases where an APHA wants access to medicinal marijuana, the doctor refuses to sign the application form. Under the present system, doctors are the gatekeepers and can actually be a barrier to access for APHAs. First Nations PHAs with treaty cards want to know why Non-Insured Health Benefits (NIHB) is not covering the expenses of medicinal marijuana.

> "Many APHAs in the region are still struggling with addictions which may make the medical marijuana option less desirable. Some APHAs here may be using other illicit drugs to maintain their addiction. Of course, not all APHAs who are struggling with addictions are in recovery. Basically, we don't see licenses around here." - Saskatchewan AIDS Service Organization

For many Aboriginal organizations, medical marijuana is not an issue that has ever come up. Again, the answers to this question pointed to regional differences in medical marijuana use. From Saskatchewan, it was reported that little or no issues have surfaced. In the Atlantic, no issues have come to light because no one has been talking about it. In the Arctic there seem to be some obvious theoretical barriers to access but no examples to note.

3. When asked what kind of information would be helpful to their community/organization, respondents most often cited that there was a need for an easy-to-understand, basic information document on how to work with doctors, information and a list of medicinal marijuana buyers clubs across Canada or step by step directions on how to get a card to be able to legally obtain and/or grow marijuana.

   There was interest also in how medical marijuana might fit with addictions treatment and harm reduction approaches. For example, if APHAs are seeking residential or out patient treatment for crack addiction would medicinal marijuana be an option for them? Medical marijuana resources that appear at Harm Reduction conferences would be good to have in Aboriginal AIDS Service Organizations (AASO). One organization disclosed that it would write about the issue more if they knew more about it as a harm reduction tool.

   One person suggested that in regions where there is opposition or lack of support for APHAs who wish to use medical marijuana we could provide information on its benefits. This transfer of knowledge should relate to our traditional beliefs and in the process could promote the understanding of Elders. For example, parts of plants such as leaves and roots have been used medicinally by Aboriginal people for thousands of years. As one AASO staffer said, "We would benefit from someone coming in and doing a culturally competent workshop about medical marijuana."

4 Respondents generally indicated that the best way to refer an APHA somewhere when they ask about medicinal marijuana is to another APHA. Referrals by Aboriginal organizations are limited to government web sites or buyers clubs where they're available. In one case, an organization said





they would refer APHAs to the Canadian AIDS Treatment Information Exchange (CATIE). Mostly though, Aboriginal organizations report that they need a lot more information before they'll know where to refer APHAs or others who ask questions about medicinal marijuana. Half of respondents said that they did not know where to refer people.

One organization said that it would be helpful if one of their staff knew a lot about the issue to suggest referrals and to provide guidance. Some organizations do have some information from medicinal marijuana advocacy groups. Another respondent replied that they don't have enough information to give an accurate referral.

HIGHLIGHTS

While this data was not collected scientifically, it does help to shed more light on the Aboriginal communities experience and informational needs around the subject of medicinal marijuana. One noticeable trend was that differences in experience and attitudes seem to vary somewhat by region. This trend seems to backup and support the regional differences pointed out and discussed in the CAAN CTS Issues Study.

Organizations almost uniformly said that they require more information about medical marijuana. Practical information that would be helpful included description of the medical benefits, how to apply for a license, where to get a safe supply and how to work with doctors who are sometimes resistant to prescribe a substance that still has a lingering stigma attached to it. Some organizations said they were unsure where to refer APHAs who wanted to know more about medical marijuana.

Many organizations said that the best referral for more information of medical marijuana is to another APHA. In order to give a more personal context to the background data collected in this medical marijuana paper, CAAN felt that it was necessary to bring together a group of APHAs to discuss the topic. The following section deals with APHA's feedback to 5 ad-hoc questions.





7. APHA Medicinal Marijuana Focus Group

On September 28, 2006 in Ottawa CAAN held a small focus group with four APHAs. Two of them had federal licenses to legally grow and possess medicinal marijuana. The third APHA was an occasional smoker while the fourth had never used medicinal marijuana. Over dinner, five questions were posed to the APHAs to provoke vigorous dialogue among the focus group participants. The questions were developed on the spot in consideration of the dialogue preceding each. The five final questions were:

THE QUESTIONS

1. Do you feel that there is enough information out there for APHA's who do want to access medicinal marijuana?

2. What focus would you like to see for this document?

3. If you feel that there is stigma associated with marijuana, what can be done about it?

4. What do you recommend for those APHAs who don't use marijuana and/or are in recovery from addictions and who get triggered by medicinal marijuana use?

5. What are some other questions we should be asking?

THE DIALOGUE

1. The four participants agreed that there is not enough information for APHAs. One of the APHAs did not even realize that there was a legal source of medicinal marijuana for licensed users.

2. Group participants thought that it was primarily people living with HIV/AIDS who were moving this issue forward politically. They said that the people who are accessing medicinal marijuana now no longer have to take risks on the streets. They felt like they were being viewed as criminals when they were only trying to get their medicine. Some felt that this stigma added to the stigma that already exists around HIV/AIDS. They thought this background paper might begin to focus on breaking down the stigma around the issue.

3. Applying for and receiving a license to possess and/or grow medicinal marijuana can, in itself, be something that can be done about the stigma associated with medicinal marijuana. Even when trying to be discreet while smoking marijuana, licensed APHAs say they attract unwanted attention from authority figures such as security and police. Once a license to possess is shown, there is usually, but not always, less discrimination around the issue. Strong advocacy around the issue of the benefits of medicinal marijuana would help more APHAs to access medicinal marijuana legally through applying for and receiving a license. "We should also educate public and service providers so they understand that this exists and that we have the right," explained one card-carrying APHA in the focus group.





Aboriginal people's history with substance use and its destructive legacy may contribute to difficulty for our people to see that marijuana can be a good thing. APHAs in the focus group agreed that being discreet with medicinal marijuana is the smartest way to behave. Because of stigma attached to any marijuana use, some people have strong reactions when they see marijuana being smoked, legally or not. Focus group participants agreed that continued dialogue aimed at striking a balance between APHAs who smoke medical marijuana and people with concerns about how marijuana is used is important.

4. During some HIV/AIDS conferences or meetings, it is known that some APHAs choose to use medicinal marijuana. Not all people at these meetings are comfortable with this behaviour. For example, there are some people who have been involved in substance use in the past and/or who are currently in recovery. Some of these people have reported that they cannot tolerate any mind or mood altering substance, such as marijuana, being used in their presence.

   It was agreed in the focus group that APHAs who smoke medicinal marijuana don't want to offend or hurt anyone by doing so. The wishes of APHAs who are not using medicinal marijuana and/or are currently in recovery from addictions deserve to be respected. Vigorous discussion ensued and many possible recommendations were discussed. Below is a list of the suggested actions that could be undertaken by CAAN.

   Suggestions for CAAN re: Those who are uncomfortable being around medicinal marijuana

   It should be noted that these are individual suggestions (not by consensus) on what CAAN could do to accommodate APHAs who smoke Medical Marijuana and also those who do not wish to be unnecessarily exposed to its consumption.

   - provide separate rooms for smoking APHAs and those just looking for a place to relax
   - create guidelines on a smoking room, such as time limit to room use and a maximum capacity
   - inform everyone that a room is going to be used for marijuana
   - have counselors available
   - create a harm reduction policy
   - let people know that these are some of the things that one can expect
   - post rules about excessive substance use but who determines the lines between substance use and substance abuse or misuse?
   - code of conduct
   - explore marijuana as harm reduction tool for those recovering from harder substance use

   The following suggestion for a beginning of a Harm Reduction policy was given by those APHAs in the focus group: "If your substance use becomes a barrier or a disruption to participation in the event or CAAN's ability to function, steps should be taken to correct this violation of the CODE OF CONDUCT".

   In some cases, where individuals have developed a dependency on hard drugs, there are some people who suggest using marijuana can help alleviate withdrawals. Caution is urged here, as there may be some people who cannot tolerate any mind or mood altering substance, when they have





become dependent on others. Also, so far there has been no research to support this idea. More research is needed.

5. APHAs in the focus group gave the following examples of questions CAAN should be asking about medicinal marijuana:

    - What are APHA's experiences with alternatives such as THC derivatives or other pharmaceuticals?
    - What is the organization's role in all of this?
    - What kind of supports are APHA's going to have?
    - What about liability issues such as insurance or HIV/AIDS institutions
    - What about exploring marijuana as a harm reduction tool for those getting off harder substances?
    - What about addictions treatment centres who do not accept medicinal marijuana users into their programs?

HIGHLIGHTS

The focus group revealed some things we already suspected but also some ideas and suggestions that had not been heard previously. All four APHAs in the group agreed that there is not enough information out there on the subject. They said that this medical marijuana background paper could start to break down the stigma around the issue. Three of the group said that in some cases they were made to feel as though their medical marijuana use made them look like criminals in other peoples' eyes.

Two participants said that applying for and receiving a license to possess and/or grow medical marijuana is a stressful process but helps to reduce the stigma around smoking it. Three of them said that smoking almost always attracts attention no matter how discreet one tries to be. They said that there needs to be some public tolerance for smoking medical marijuana because it is their right. Legal or not, witnessing APHA's smoking marijuana can invoke strong emotions in our Aboriginal communities. The negative effects of the historical Aboriginal experience with chaotic substance use surely adds to the stigma and the cautious approach that most Aboriginal people take when trying to understand the issues around medical marijuana. To add more complexity to the topic, one idea mentioned was that there could be some value in exploring marijuana as harm reduction tool for those recovering from harder substance use.

It was discussed that no APHA wants to upset anyone or make anyone uncomfortable by smoking their medical marijuana. It is also known that some people DO react negatively to witnessing the smoking of marijuana by APHAs. Many ideas were discussed on how to avoid these types of occurrences at events where APHAs gather such as providing one APHA lounge for smoking and one for non-smoking, educate and inform participants at events, create a policy, post rules, etc. It was agreed that CAAN should facilitate a dialogue to determine how best to deal with this issue of triggering people when APHAs smoke medicinal marijuana.

Focus group members firmly stated that it was mainly HIV/AIDS activists and people living with HIV/AIDS who have become politically active in advocating for the issue. What follows is a short overview of the government of Canada's response to the public's demand for access to medical marijuana.





8. Health Canada and the federal government response

Health Canada grants access to marijuana for medical use to those who are suffering from grave and debilitating illnesses. It is important to note that the Marihuana Medical Access Regulations deal exclusively with the medical use of marihuana. They do not address the issue of legalizing or decriminalizing marijuana for general consumption.

To learn more about the Regulations and any recent changes, please view the page devoted exclusively to Acts and Regulations. This information can be found on Health Canada's website www.hc-sc.gc.ca, Drugs and Health Products, Medical Use of Marijuana http://www.hc-sc.gc.ca/dhp-mps/marihuana/index_e.html.

There are two categories under which people can apply to access legal medical marijuana. For the purposes of this paper, CAAN will focus primarily on Category 1 as this is the category most relevant to APHAs applying for authorization. An applicant can obtain marijuana from the government, they can produce their own or they can designate someone else to grow it for them. This must be indicated in the application.

Category 1: This category is comprised of any symptoms treated within the context of providing compassionate end-of-life care; or the symptoms associated with the specified medical conditions listed in the schedule to the Regulations, namely:

- Severe pain and/or persistent muscle spasms from multiple sclerosis;
- Severe pain and/or persistent muscle spasms from a spinal cord injury;
- Severe pain and/or persistent muscle spasms from spinal cord disease;
- Severe pain, cachexia, anorexia, weight loss, and/or severe nausea from cancer;
- Severe pain, cachexia, anorexia, weight loss, and/or severe nausea from HIV/AIDS infection;
- Severe pain from severe forms of arthritis; or
- Seizures from epilepsy.

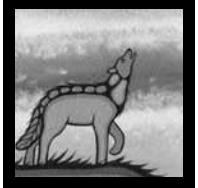
Applicants must provide a declaration from a medical practitioner to support their application.

Category 2: This category is for applicants who have debilitating symptom (s) of medical condition (s), other than those described in Category 1. Under Category 2, persons with debilitating symptoms can apply to obtain an Authorization to Possess dried marihuana for medical purposes, if a specialist confirms the diagnosis and that conventional treatments have failed or judged inappropriate to relieve symptoms of the medical condition. While an assessment of the applicant's case by a specialist is required, the treating physician, whether or not a specialist, can sign the medical declaration."
(Retrieved January 27, 2006. http://www.hc-sc.gc.ca/dhp-mps/marihuana/index_e.html)

There are different application forms, depending on the type of access for which APHAs are applying. It may seem confusing at first. If applying, one must read the guidelines carefully and ensure they have assembled all necessary support materials for their application. A properly completed application will encourage prompt processing. For any questions about the application process or medical marijuana







access in general, call toll-free at 1-866-337-7705 or fax: (613) 952-2196.

Completed applications should be mailed to:

Marihuana Medical Access Division
Drug Strategy and Controlled Substances Programme
Address Locator #3503B
Ottawa ON
K1A 1B9





9. Conclusions

> "We're not trying to promote drug addiction. We're trying to expand the compassion of the people. This medicine helps me live with HIV." APHA Respondent

Aboriginal People living with HIV/AIDS report benefits from smoking medical marijuana for appetite, sleep, pain relief, spiritual and mental effects. The Canadian government has provided regulations and a process under which people can apply to access legal medical marijuana. This Medical Marijuana Background Paper should shed some light on the subject so that CAAN's Board of Directors can more fully understand this issue, through the cultural lens of the Aboriginal community.

Data herein was collected from CAAN's Care, Treatment and Support Issues Study, a small APHA focus group and a questionnaire distributed to 22 Aboriginal Community Service Organizations who serve APHAs. Through a brief analysis of these 3 sources of information, this Background Paper has revealed a high rate of use of Medicinal Marijuana (nearly a third of APHAs according to the CAAN CTS Study).

While the data was not collected scientifically, the responses to CAAN's organizational questionnaire and small focus group seemed to support much of the analysis in CAAN's CTS Study. From the study, male APHAs tend to use/need Medical Marijuana at higher rates than female APHAs and those with higher viral loads show higher rates of use. APHAs also reported many logistical barriers to access to Medical Marijuana. Regional trends were also noted with stronger support for APHAs who use medical marijuana in larger urban centers where (illegal but tolerated by police) marijuana buyers clubs are present.

During the CAAN APHA focus group it was discussed that not all people at Aboriginal meetings are comfortable with APHAs openly smoking medical marijuana, perhaps due to stigma attached to its use. Aboriginal people's history with substance use and its destructive legacy may contribute to this stigma. But in general, APHAs who are smoking medicinal marijuana do not want to offend or hurt anyone by doing so. It has been recommended that CAAN facilitate more dialogue to come up with a policy or to incorporate the issue within another larger policy document such as one on Harm Reduction.

Aboriginal Service Organizations identified a number of issues through CAAN's short questionnaire. All expressed a need for more information on the subject of Medical Marijuana especially practical information. Some organizations are completely in the dark on the issue and do not know where to refer someone who wants more information. While some others are fully versed in the issues offering help filling out the government forms and advocating for their APHA clients who use medical marijuana. Some of the urgan AASOs have disclosed that many clients who use the federal government's legal supply of only one strain of medical marijuana is low quality and does not meet their needs. This facilitates the need for license-holding APHAs to frequent medical marijuana buyers clubs which are illegal yet tolerated by police.

Balancing the needs and rights of APHAs to choose medical marijuana and the needs and rights of those who may still be uncomfortable with the concept may be advisable here. It is the hope of APHAs who use Medical Marijuana that this background paper might begin to focus on breaking down the stigma around the issue. This paper is an important step in understanding the issues before taking a firm position on the subject at hand.





10. Links

www.caan.ca

www.cdnaids.ca/web/casmisc.nsf/pages/cas-gen-0112

Medical Use of Marijuana
http://www.hc-sc.gc.ca/dhp-mps/marihuana/index_e.html

Health Canada grants access to marihuana for medical use to those who are suffering from grave and debilitating illnesses. It is important to note that the Marihuana Medical Access Regulations deal exclusively with the medical use of marihuana. They do not address the issue of legalizing marihuana for general consumption. To learn more about the Regulations and any recent changes, please view the page devoted exclusively to Acts and Regulations.

The following information is pertinent to applicants and stakeholders, such as health professionals and law enforcement agencies:

About Medical Marihuana
Expert Advisory Committee on Marihuana for Medical Purposes (EAC-MMP)
Health Canada's Marihuana Supply
How to Apply
Law Enforcement Issues
Medical Marihuana Research Strategy
Stakeholder Statistics

The access to marihuana legislation and regulation is handled within Health Canada by the Marihuana Medical Access Division. If you require more information regarding medical use of marihuana, please contact the Marihuana Medical Access Division.





11. References

Canadian Aboriginal AIDS Network, 2005 - "Canadian Aboriginal People Living With HIV/AIDS Care, Treatment and Support Issues" research study report

Canadian AIDS Society (CAS)
www.cdnaids.ca

Report - Cannabis as Therapy for People Living with HIV/AIDS: "Our Right, Our Choice" 2006

To address some of the practical information needs identified regarding the use of cannabis for medicinal purposes, CAS produced a series of fact sheets on Cannabis and HIV/AIDS which include:

Fact sheet # 1 - The Medicinal Use of Cannabis
Fact sheet # 2 - How to Apply to Use Medicinal Cannabis Legally
Fact sheet # 3 - How to Speak to your Doctor about Medicinal Cannabis
Fact sheet # 4 - Information Sheet for Physicians
Fact sheet # 5 - Where to Find Cannabis for Medicinal Purposes
Fact sheet # 6 - A Few Tips for Safer Use and Better Health
Fact sheet # 7 - Cooking with Cannabis
Fact sheet # 8 - Tips for Growing Cannabis Safely
Fact sheet # 9 - How to Deal with the Stigma and Discrimination of Cannabis Use