# Peer-to-Peer Program

## Programming Connection

### Case Study

**Organization:** Regina Qu'Appelle Health Region  
**Region:** Saskatchewan  
**Prepared:** 2014

### Quick Facts

<table>
<thead>
<tr>
<th>Goal (immediate)</th>
<th>To support people newly diagnosed with HIV, those who have been lost to care or those needing tailored support to re-engage in care</th>
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</thead>
<tbody>
<tr>
<td>Goal (ultimate)</td>
<td>To improve linkage to, engagement in and retention in healthcare for people living with HIV to improve client health outcomes and reduce onward transmission of HIV</td>
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<tr>
<td>Population</td>
<td>People living with HIV</td>
</tr>
<tr>
<td>Participants</td>
<td>People living with HIV/AIDS needing extra support to engage in and remain in care</td>
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<tr>
<td>Type of Program</td>
<td>Support</td>
</tr>
<tr>
<td>Setting</td>
<td>Community</td>
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</table>
| Required Resources | 1. Program coordinator  
                    | 2. One peer mentor for every one to five mentees                                                               |
| Scope and Duration | Seven mentors, 20 mentees. Ongoing.                                                                           |
| Date Started     | 2012                                                                                                          |
| Region           | Saskatchewan                                                                                                  |
| Recruitment      | Referrals from Infectious Diseases Clinic, public health nurses, social workers and community-based organizations. |
| Challenges | 1. **Ongoing funding.** Short-term funding contracts for the Peer-to-Peer Program make it difficult to plan for the long term, including finding a permanent space and conducting a program evaluation.  
2. **Space.** While the flexibility of the program is one of its strengths, having a dedicated space would allow mentors to expand their services to meet mentees on a drop-in basis. This would improve access for clients who may not be able to keep appointments or need crisis support.  
3. **Mentor capacity.** The Peer-to-Peer Program is in its infancy, and mentors continue to need a lot of training and support. This limits the number of mentor/mentee matches the program can facilitate. However, significant growth has been observed, however, with mentors learning to support each other and take on more planning responsibility.  
4. **Building trust.** It takes time to build trust between mentors and mentees because many mentees come to the program with previous experiences of trauma and abuse. Mentors and the program coordinator work diligently with mentees to build trust by following up and offering non-judgemental support.  
5. **Mentor-clinician relationship.** The dual role of patient and mentor that some mentors play can be a challenge for both mentors and clinicians. One strategy to overcome this challenge has been for the program coordinator to build lines of communication between the Peer-to-Peer Program and clinicians so that concerns on both sides are addressed. It is also hoped that the ongoing presence of mentors at the Four Directions Primary Health Care Clinic will help both mentors and clinicians to view mentors as professionals.  
6. **Communications limitations.** Mentors may have limited talk and text functions on their personal cellphone plans. This may limit mentor and mentee contact. One solution being explored is to cover the cost of limited talk and unlimited text functions on mentor cellphone plans. |

| Evaluation | The Peer-to-Peer Program has not been formally evaluated. However, anecdotal evidence suggests that the program is having an impact. Most mentees paired with a mentor are engaged in care and regularly attend their appointments. In addition, the program has observed an increased number of referrals for new mentors and mentees and an increased number of new matches and has expanded services to the Four Directions Primary Health Care Clinic. A logic model has been drafted and the future evaluation of the program will be based on this framework. |

**What is the program?**

The Peer-to-Peer Program is a crucial way that the Regina Qu’Appelle Health Region is trying to improve health outcomes for people living with HIV. The program pairs people living with HIV who have trouble remaining engaged in care with peer mentors who also live with HIV. The goal of the program is to use the lived experience of peers to increase the engagement and retention in healthcare of people living with HIV.

Since the program was established in May 2012, the focus has been to build the capacity of mentors, to determine how best to serve the needs of clients (known as mentees) and to provide tailored support to people in need. During the first 15 months of its existence, the program engaged nine peer mentors, received 29 referrals and made 21 peer matches.

Mentors provide many of the same services as other support workers, with the added benefit that they have lived experience of being diagnosed with HIV, accessing healthcare and starting treatment. Mentors provide non-judgemental phone and in-person support, referrals, peer counselling, accompaniment services and advocacy as needed. The program’s strength is its flexibility, which allows peer mentors and their mentees to meet as frequently or infrequently as required to provide the type of support mentees need most.

As of January 2014, the Peer-to-Peer Program uses an approach that allows mentors and mentees to meet when and where it is convenient and comfortable for them to do so, from Monday to Friday between 8 am and 4:30 pm. In November 2013, the program started offering drop-in services at the Four Directions Primary Health Care Clinic.
Why Was the Program Developed?

In 2010, the Government of Saskatchewan released a comprehensive strategy to tackle Saskatchewan’s HIV epidemic. The province (as of 2012) has the highest rate of HIV infection in Canada (17 infections per 100,000 people, more than double the national average).

The provincial strategy calls for the establishment of HIV-positive peer-to-peer networks to provide “knowledgeable and acceptable” supports to people living with HIV. It goes on to describe how a peer-to-peer model of mentorship for people living with HIV should provide support across the continuum of care.

Evidence gathered from healthcare providers in Saskatchewan during the development of the strategy suggested that many people were being diagnosed late with HIV; others, who were diagnosed soon after their exposure, experienced rapid disease progression. Both late diagnosis and rapid disease progression point to an increased need for early and continuous client engagement in HIV treatment and care.

How Does the Program Work?

The Peer-to-Peer Program is coordinated by the Regina Qu’Appelle Health Region as a way to improve engagement in care for people living with HIV in the health region. Vancouver’s Peer Navigation Services, one of Canada’s most established peer navigation programs, has been a reference program in the development of the Peer-to-Peer Program in Regina. The programs have been in close contact, with coordinators and peers meeting in December 2012 and September 2013 to share knowledge, experiences and best practices.

The program pairs a mentor—someone who has lived experience with HIV and has undertaken training offered by the Regina Qu’Appelle Health Region—with mentees. Mentors provide tailored support to engage and retain their clients in healthcare. Mentors’ objectives are to provide the best support and guidance they can, to act as an advocate and educator and to understand when to refer mentees to outside services. Mentors play a key role in identifying mentee challenges and obstacles and then providing appropriate referrals to additional support.

Typically, mentors and mentees meet in public places, over the phone, or in healthcare and social service settings. Most meetings are arranged by appointment, although the mentors are available for drop-in support one afternoon each week at the Four Directions Primary Health Care Clinic.

Promotion

In the early months of the Peer-to-Peer Program, the program’s champions (the program coordinator, the HIV strategy coordinator for Regina and an infectious diseases specialist) recruited both mentors and mentees by promoting the program to healthcare providers at the Infectious Diseases Clinic at Regina General Hospital and to people living with HIV. This promotion was done informally, when the champions deemed it to be appropriate. This personal approach to promotion worked well when the program was new and had not yet built up a reputation.

Once the program’s reputation was established in the HIV community, the program coordinator visited community-based organizations with whom the program already had a relationship, such as the All Nations Hope Network, Carmichael Outreach, Street Worker’s Advocacy Project and AIDS Programs South Saskatchewan. The Peer-to-Peer Program has also been promoted through presentations at the Wise Practices Gathering and at one of the HIV stakeholders meetings, which brings together healthcare providers and community-based organizations working in HIV in Regina.

Referrals for both mentors and mentees have increased as healthcare providers and staff at community-based organizations have met the program coordinator and some of the mentors and begun to understand the benefits of the service they offer.

Referrals

Mentors
Most referrals for potential mentors come from the Infectious Diseases Clinic at Regina General Hospital, where most people in the Regina area receive their HIV care. Referrals also come from public health nurses, social workers and staff at community-based organizations and community clinics.

Mentors are typically people with strong self-management skills, who have demonstrated good spiritual, emotional and physical health. People with positive attitudes and who make connections easily with other people also tend to be referred for an assessment by the program coordinator of their potential to be a mentor.

Some mentors have lived experience of drug use and recovery. Such experience is valuable because it allows mentors to draw on their own history of drug use to help mentees who may be going through similar struggles. The value of this lived experience must, however, be balanced with the need to provide relatively stable support to mentees, and thus the program coordinator prefers to engage mentors who have used drugs only after they have demonstrated at least a year’s sobriety.

**Mentees**

New clients are referred to the program using a referral form (see the Program Materials section of this case study). Mentees must be living with HIV to be referred to the program. More than half of mentees are referred to the program by healthcare providers at the Infectious Diseases Clinic. Additional referrals also come from mentors, who use their networks to find out who in the community is in need of extra support.

Many mentees are referred to the program because they have been lost to care in the past, or because they have been admitted to the hospital with complications from HIV. About 40 percent of mentees are newly diagnosed.

**Mentee intake**

The program coordinator is responsible for following up on new client referrals and usually sets up an initial meeting with a potential mentee wherever they feel most comfortable. Meeting informally on the potential mentee’s terms demonstrates to potential participants that the program will meet them where they are on their journey toward health. During this meeting, the program coordinator listens to clients and tries to gauge the type of support they might want from the program.

The mentee and the program coordinator also go over the peer intake form (see Program Materials section of the case study), which helps the mentee outline what they hope to gain from the program and how they think a mentor could best support them. The program coordinator also completes the peer assessment form for each individual (see Program Materials section of the case study).

If the potential mentee is interested in participating in the program, they complete the consent to participate agreement (see Program Materials section of the case study), which explains the purpose of the program and describes what information will be shared with mentors. The program coordinator stresses to the mentee that any information they share with the coordinator and with the mentors is treated as confidential.

At the end of the first meeting, mentees are invited to complete three surveys. Completion of these surveys—one on chronic disease, one on stigma and one on medication adherence—is not mandatory, and applicants will not be excluded from participating in the program if they choose not to fill them out. The forms are used to establish baseline data about mentees before their engagement with the program. Mentees who complete and return all three surveys receive a $20 honorarium. Participants who completed the forms during their intake meeting will be asked to complete the forms again periodically or when they exit the program.

**Mentor recruitment**

Mentor recruitment is an ongoing process rather than a periodic effort. The program coordinator processes mentor referrals as they are received.

**Application form and informal interview**

Once a potential mentor has been referred to the Peer-to-Peer Program, the program coordinator sets up an informal interview with the individual. During this meeting, the potential mentor fills out an application form, either
The application gives the mentor the opportunity to describe their knowledge of subjects that will be crucial to connecting with mentees. In Regina, where the populations most affected by HIV include Aboriginal people and people who use injection drugs, mentors should have knowledge of harm reduction and Aboriginal culture and should understand the dynamics of a neighbourhood in Regina called North Central, where many clients live or have lived.

Many potential mentors do not have experience with job interviews, but the informality of the interview with the program coordinator puts them at ease. During the interview, the program coordinator asks mentors questions about their lived and work experience, especially as it may relate to providing support and guidance to others and what they feel they could contribute to the program.

These types of questions allow mentors to speak about their strengths and consider what they might be able to offer to the program. The program coordinator also asks specific questions about the amount of time mentors can spend on mentoring and whether they are able to commit to attending frequent training sessions.

**Criminal records check**

Each mentor must undergo a criminal records check (including a vulnerable persons check) to work in the Peer-to-Peer Program. Regina Qu’Appelle Health Region wants to ensure that mentors do not pose a risk to their clients. The program coordinator uses the criminal records check only to ensure that mentors do not have a history of violence. Records associated with street involvement such as drug offenses and petty crimes are not a barrier to participation in the program.

**Peer mentor agreement**

The relationship between Regina Qu’Appelle Health Region and the mentor is outlined in the peer mentor agreement (see the Program Materials section of this case study). During the initial interview, the program coordinator usually goes over the agreement with the potential mentor because it outlines their rights and responsibilities. The agreement also gives potential mentors an idea of the commitment they are making, which includes a significant time commitment to attend training sessions and meetings and to provide support to mentees. The agreement also indicates that mentors can resign from the program at any time with two weeks’ notice.

**Hiring mentors**

After the interview, individuals whom the program coordinator identifies as good candidates for the mentorship program and who are interested in participating attend an orientation session.

During this session, the program coordinator gives new mentors a binder that includes all essential documents: the peer mentor agreement, the Health Information Protection Act form, the public health confidentiality form, the peer mentor contact form and the Regina Qu’Appelle Health Region’s safer home visiting procedure (see the Program Materials section of the case study for some of these forms). The mentor job description, important program information and a listing of community resources are also included in the binder.

**Applicants who are not ready to be mentors**

If, after the interview, the program coordinator believes a potential mentor is not ready for this role, that person will be matched, with their permission, to a mentor and become a mentee. Potential mentors who are new to the community, who might need more knowledge and training or who have not been sober for at least a year may be referred to a mentor in this way.

When potential mentors are kept engaged with the program, they are able to improve their knowledge and receive extra support from mentors, and the program coordinator is able to observe their growth. In the past, some mentees have become mentors, although this transition is not one of the central goals of the program.

**Payment**
Mentors are paid (in the form of honoraria) for all support, training and staff meetings they attend as part of the Peer-to-Peer Program at the same rate at which they are paid for their meetings with mentees. Mentors are reimbursed for the child care and transportation costs they incur during their work.

**Mentor training**

Once a mentor has been recruited and attended the orientation session with the program coordinator, they will start to attend staff meetings and training sessions. Mentor training is ongoing and mentors are expected to attend as many sessions as they can. Ongoing training allows mentors to continue to build on their knowledge and skills, improving their ability to offer support to mentees. It also offers mentors the opportunity to build marketable employment skills, some of them for the first time.

Sessions on confidentiality, HIV basics, nutrition, working with vulnerable clients, communication skills, facilitation, boundaries, active listening, being assertive and self-care have all been offered to mentors in the past. Additional training opportunities—attendance at conferences, webinars and workshops—are offered regularly. Mentors must have a basic knowledge and lived experience of HIV and must understand how to work with people who experience barriers to care and support before they are matched with mentees. This knowledge and capacity to offer support is assessed on a case-by-case basis.

**Staff meetings**

Once a month, the program coordinator and the mentors meet for a half day. During this session, the program coordinator alerts mentors to upcoming events, meetings or training sessions and goes over any administrative information mentors might need. The program coordinator also chooses a topic to discuss with peers that helps them build their capacity to offer support to mentees.

Staff meetings are an opportunity for mentors to brainstorm plans for the future direction of the program. They are also a time for mentors to share recent achievements or challenges they have had with mentees. These meetings have been critical to creating peer support for mentors where none previously existed. Since the program’s inception, mentors have got to know one another, learned one another’s strengths and challenges and created a supportive community. A deep level of trust has been reached within the mentor team, which has improved mentors’ confidence in their ability to support other people living with HIV.

**Mentor/mentee matching**

The program coordinator matches mentors and mentees on the basis of mentee preference, mentor availability, the issues the mentee wants to address and the program coordinator’s assessment of who would be a good match. The matching process is not a hard science and the program coordinator admits that they never know if the match is the best one possible. Since the program’s inception, only one match has ended (because of a situation that had nothing to do with the mentor’s and mentee’s relationship).

The numbers of mentors, mentees and matches are always in flux. As of January 2014, seven peer mentors and 20 mentees are participating in the program, and 29 mentees have been matched with a mentor. Some mentors continue to build their skills and have not yet been matched with a mentee; other mentors have taken on multiple mentees. The program remains small because Regina is a medium-sized centre with a smaller population than other provincial capitals, and consequently it has fewer people living with HIV. The number of mentees accepted into the program has also been kept small so that mentors can build their skills before they take on more mentees.

As the program grows, however, and more mentors are recruited and trained, the capacity of the program will increase. While waiting for matches, mentees are invited to attend monthly support groups as well as some training sessions and workshops and to seek support from the program coordinator.

**First mentee/mentor meeting**

When a mentor and mentee are matched, the program coordinator schedules a meeting for all three of them. The program coordinator attends this meeting to provide some structure and to go over the confidentiality agreement (see Program Materials section of the case study). The experience so far has been that mentors prefer this arrangement to setting up and leading their own initial meetings with their new mentee. However, as the program
evolves, the goal is to have mentors schedule and lead these meetings.

After the meeting, the program coordinator follows up with the mentee over the phone to make sure they are comfortable continuing with the mentor with whom they have been matched. The program coordinator also debriefs with the mentor. This allows the program coordinator to answer any questions and make changes to mentor/mentee matches and increases the likelihood that mentors and mentees will establish a connection.

Services

Mentors do not offer a set type of service to each mentee; instead, the mentor and mentee work to set tailored goals and the steps to achieve them. As advertisements for the program state, mentors offer to listen, answer questions, serve as positive role models, connect mentees with community resources, help navigate the healthcare system, share their experience with HIV and help mentees cope with daily struggles in a healthy way. When mentors feel that mentees could use additional supports, mentors facilitate referrals to other services as appropriate.

Mentors support their mentees by meeting or communicating with them regularly, accompanying them to appointments and helping them to set goals. Some mentors and mentees meet frequently; others meet when the mentee feels they need extra support. Mentors try to connect with mentees, even just over the phone, every couple of weeks. The informal quality of the relationship has been one of the program’s strengths early in its implementation; mentors and mentees build a relationship that allows clients to seek the support they need when they need it.

Reporting

Mentors and mentees set goals for their relationship, and one tool they can use to document how they meet those goals is the peer mentor contact form (see the Program Materials section of the case study). The form helps mentors track the type of contact (face to face, telephone or internet), the primary purpose of the interaction (i.e., appointment support, education, accompaniment services, referrals to services and relationship building) and the duration of the contact with their mentees. The form also has space for mentors to record any notes about the mentee.

These forms are collected once a month and reviewed by the program coordinator. They allow mentors and the program coordinator to follow the progression of the relationship between the mentor and mentee. They also provide the program coordinator with confirmation that meetings between mentor and mentee have taken place, insight into how the relationship is evolving and an opportunity to review any challenges or issues faced by mentors and mentees. In addition, the program coordinator uses the forms to compile statistics on the types of supports mentees receive.

Although the forms are stored, for a limited time, in the houses of mentors, a review by the privacy coordinator for Regina Qu’Appelle Health Region concluded that this process does not represent a breach of privacy because no identifying information is recorded on the contact forms.

Peer-to-Peer Support Group
In September 2013, the Peer-to-Peer Program established the Peer-to-Peer Support Group, a monthly drop-in support group for people living with HIV in Regina that is led by peer mentors. Mentors choose the discussion topics and a different mentor facilitates the discussion every month.

The group is open to anyone in Regina living with HIV. Attendance at the support group is a good way for people who are not yet engaged in the Peer-to-Peer Program to meet mentors and other people living with HIV in the city. People do not need to join the Peer-to-Peer Program to attend the group, but mentors do encourage group members to join if they feel it would be beneficial.

**Next steps**

The Peer-to-Peer Program is a recent development in Regina and there are plans to expand the program's capacity. As of November 2013, mentors are on-site one afternoon a week at the Four Directions Primary Health Care Clinic, which is located in North Central Regina. This allows mentors to offer support to people living with HIV on a drop-in basis. Once a month, this weekly presence of the mentors coincides with the clinic of an infectious diseases specialist who offers HIV care.

There is also a plan, in its preliminary stages, to have mentors accompany infectious diseases specialists to a rural area outside Regina on a monthly basis. The presence of mentors at these monthly clinics may provide community members one of their few opportunities to talk openly with other people living with HIV about their experience.

Finally, there are also plans to provide permanent office space for the mentors. The program coordinator is working with the mentors to determine where in the community this space should be located. Office space will allow the mentors to provide additional drop-in services to mentees who do not like scheduled appointments.

**Required Resources**

1. **Program coordinator**: Provides administrative support, recruits mentors and mentees, supervises mentors and organizes and facilitates mentor training.
2. **Peer mentors**: In the early stages of a program of this type, one peer mentor for every one to five mentees, depending on mentor readiness, availability, stability and needs.

**Barriers to Implementation**

1. **Ongoing funding**: Short-term funding contracts for the Peer-to-Peer Program make it difficult to plan for the long term, including finding a permanent space and conducting a program evaluation.
2. **Space**: While the flexibility of the program is one of its strengths, having a dedicated space would allow mentors to expand their services to meet mentees on a drop-in basis. This would improve access for clients who may not be able to keep appointments or need crisis support.
3. **Mentor capacity**: The Peer-to-Peer Program is in its infancy, and mentors continue to need a lot of training and support. This limits the number of mentor/mentee matches the program can facilitate. However, significant growth has been observed, however, with mentors learning to support each other and take on more planning responsibility.
4. **Building trust**: It takes time to build trust between mentors and mentees because many mentees come to the program with previous experiences of trauma and abuse. Mentors and the program coordinator work diligently with mentees to build trust by following up and offering non-judgemental support.
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6. **Communications limitations**: Mentors may have limited talk and text functions on their personal cellphone plans. This may limit mentor and mentee contact. One solution being explored is to cover the cost of limited talk and unlimited text functions on mentor cellphone plans.

**Evaluation**

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mentees and an increased number of new matches and has expanded services to the Four Directions Primary Health Care Clinic. A logic model has been drafted and the future evaluation of the program will be based on this framework.

For more information on the evidence that supports health navigation in HIV care more broadly, please consult Health Navigation: A Review of the Evidence.

**Learned and Confirmed**

1. **Offer support based on lived experience.** People who live with HIV every day have a critical vantage point from which to help other people living with HIV. Mentors connect with mentees in a way that service providers may not be able to do. This shared experience increases the likelihood that mentees will seek support when they need it.

2. **Offer flexible and responsive support.** Mentors and mentees are free to define the limits of their relationship. Interaction can be as frequent or infrequent as they like, and the types of support offered vary. For mentees, this means that they can receive the support they need when they need it.

3. **Offer opportunities for mentors to connect with each other.** The Peer-to-Peer Program has provided a strong framework for mentors to provide support to each other. This is done through training, workshops and staff meetings. This community provides mentors a space to talk about challenges, achievements and ongoing issues they are experiencing with mentees.

**Program Materials**

- [Consent to Participate and Confidentiality Agreement](https://www.catie.ca/sites/default/files/Consent to Participate and Confidentiality Agreement.pdf)
- [Mentor Application](https://www.catie.ca/sites/default/files/Mentor Application.pdf)
- [Peer Intake and Peer Assessment Form](https://www.catie.ca/sites/default/files/Peer Intake and Peer Assessment Form.pdf)
- [Peer Mentor Agreement](https://www.catie.ca/sites/default/files/Peer Mentor Agreement.pdf)
- [Peer Mentor Contact Form](https://www.catie.ca/sites/default/files/Peer Mentor Contact Form.pdf)
- [Peer-to-Peer Mentee Referral Form](https://www.catie.ca/sites/default/files/Peer-to-Peer Mentee Referral Form.pdf)
- [Peer-to-Peer Program Poster](https://www.catie.ca/sites/default/files/Peer-to-Peer Program Poster.pdf)
- [Support Group Poster](https://www.catie.ca/sites/default/files/Support Group Poster.pdf)

**Other Useful Materials**

- [Treatment](http://www.catie.ca/en/treatment)
- [Healthy Living](http://www.catie.ca/en/healthy-living)

**Resources**

*Optimizing Entry Into and Retention in HIV Care and ART Adherence for PLWHA: A Train-the-Trainer Manual for Extending Peer Educators' Role to Patient Navigation*

2012, International Association of Providers of AIDS Care (IAPAC), National Minority AIDS Council

Guidelines and manuals

English

[More information](#)
Building Blocks to Peer Program Success: A toolkit for developing HIV peer programs
2009, Peer Education and Evaluation Resource (PEER) Center
Guidelines and manuals
English
More information

Contact Information
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