


# ABORIGINAL STRATEGY ON HIV/AIDS IN CANADA II

*for First Nations,  
Inuit and Métis  
Peoples from  
2009 to 2014*

Canadian  
Aboriginal  
AIDS  
Network





## BRIEF OVERVIEW OF THE CANADIAN ABORIGINAL AIDS NETWORK (CAAN)

- Established in 1997
- Represents over 400 member organizations and individuals
- Governed by a national 13 member Board of Directors
- Has 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 Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS). CAAN faces the challenges created by HIV/AIDS in a spirit of wholeness and healing that promotes empowerment and inclusion, and honours the cultural traditions, uniqueness and diversity of all First Nations, Inuit and Métis people regardless of where they reside.

### ACKNOWLEDGEMENTS

CAAN is grateful for the participation of Aboriginal People living with HIV/AIDS, representatives from Aboriginal AIDS Service Organizations, allied community stakeholders and the Board of Directors who shared their time and wisdom.

### FUNDING ACKNOWLEDGEMENT

Production of this document has been made possible through financial contributions from the First Nations and Inuit Health Branch (FNIHB) of Health Canada. The views expressed herein do not necessarily represent the views of FNIHB.

**ISBN No.** 1-894624-77-7

Prepared by Renée Masching, Seven Directions Consulting

Canadian Aboriginal AIDS Network®

1-888-285-2226

**[www.caan.ca](http://www.caan.ca)**

March 2009





## ABORIGINAL STRATEGY ON HIV/AIDS IN CANADA II

for First Nations, Inuit and Métis Peoples  
from 2009 to 2014

### **Dedication**

This is dedicated to our Aboriginal Warriors who have gone before us and those who are living with and affected by HIV/AIDS.

### **Acknowledgement**

The Aboriginal Strategy on HIV/AIDS II was developed in direct consultation with 140 people. Each voice that has contributed towards the strategy is speaking out to stop the spread of HIV, raise awareness and advocate for compassionate care, treatment and support for Aboriginal People living with and affected by HIV/AIDS.

*All of the people who strive to make a difference in other people's lives through their involvement with HIV/AIDS are warriors who we honour for their commitment.*

### **Introduction**

The HIV/AIDS epidemic within the Aboriginal population<sup>1</sup> in Canada threatens the ongoing health and stability of our peoples. The complexity of the epidemic demands a strategic and thoughtful response grounded in meaningful and culturally relevant actions. The Aboriginal Strategy on HIV/AIDS in Canada (ASHAC) was first proposed in 2003 based upon consultation and discussion with 173 people and a literature review. The result was a strategy document with two broad goals and nine strategic areas envisioned to set a course for the next five years. As ASHAC is renewed for another five years through 2014, new ideas are presented for consideration and original strategic responses remain relevant.

ASHAC II is offered as a resource to all of the stakeholders involved in the response to HIV/AIDS within the Aboriginal community. Strategic areas and related objectives offer direction. All of us share responsibility for its implementation. It is laid out to highlight strategic areas for action with key objectives and overall outcomes. Following the outline of the strategic areas there are suggestions for how various 'sectors' can engage to move

---

<sup>1</sup> Indigenous Peoples in Canada, including Inuit, Métis and First Nations who are status or non-status, on or off-reserve.

the work of the strategy ahead. A companion document for ASHAC II includes: a glossary of terms, detailed description of the ASHAC II renewal process, further context regarding HIV/AIDS within Aboriginal populations in Canada, suggested guidelines for how to use ASHAC, a brief communication strategy, a summary of ideas for next steps, an annotated list of useful resources, a list of funders and a list of Aboriginal AIDS organizations in Canada as of March 2009.

The strategic areas for action identified are consistent with the goals guiding the overall Canadian response to HIV/AIDS as described in the Federal Initiative to Address HIV/AIDS in Canada (FI) and the call to action paper, *Leading Together: Canada Takes Action on HIV/AIDS (2005 – 2010)*. Of particular relevance, the FI identifies Aboriginal Peoples as a key population requiring support and *Leading Together* outlines areas for shared responsibility in the response to HIV/AIDS for First Nations, Métis and Inuit communities and governments as follows;

- Identify the needs of First Nations, Métis and Inuit people, on and off reserve;
- Develop policies and priorities to meet those needs;
- Develop culturally appropriate programs and services; and
- Advocate for resources to provide needed services.


In addition to the national context, the ASHAC II upholds the following recommendations put forward in the Toronto Charter – Indigenous Peoples Action Plan on HIV/AIDS 2006<sup>2</sup>:

- Ensure the central participation of Indigenous Peoples in all programs related to the prevention of HIV and programs for the care and support of Indigenous Peoples living with HIV/AIDS.
- Incorporate this Charter in its entirety in all policy pertaining to Indigenous Peoples and HIV/AIDS.
- Monitor and take action against any States whose persistent policies and activities fail to acknowledge and support the integration of this Charter into State policies relating to HIV/AIDS.

---

<sup>2</sup> The Toronto Charter is an initiative of the Planning Committee of the International Indigenous Peoples Satellite at the 16<sup>th</sup> International AIDS Conference, 2006 and has been endorsed by Indigenous Peoples around the world..





These goals and responsibilities reflect the values of social justice, human rights, diversity, participation and empowerment, global responsibility and mutual accountability. Each strategic area is also built upon an evidence base, critical at this point in the epidemic. Evidence comes in many forms including research, surveillance, literature, consultation, stories and lived experience.

Consistent with the population health approach, ASHAC II continues to include the Determinants of Health recognizing that health (and HIV/AIDS specifically) cannot be addressed in isolation from the social, political and economic environment. The determinants of health affect the resilience and ability of individuals, families and communities to make healthy choices. In the Aboriginal context it is also essential to include awareness of the Aboriginal reality when designing interventions. The ongoing legacy of colonization, devastation of the residential school system, removal of children to foster care beginning with the “60’s scoop”, silencing of the Aboriginal voice, loss of traditional roles and enduring racism all impact the present health and well being of Aboriginal peoples.

ASHAC I outlined supports for regional and local levels to organize their efforts and views towards building a Canada-wide effort in working with HIV/AIDS in Aboriginal communities. The creation of a common ground for Aboriginal peoples to develop our own ways to take control of this disease remains fundamental in this renewed strategy. Seeking out ideas for working together across our differences and our territories continues to be our greatest hope for reaching the end of this epidemic.

## **ASHAC Vision**

Aboriginal Peoples will enjoy wholistic lives unified in action to eliminate the risk of HIV infection and the negative effects of HIV for all Aboriginal People living with and affected by HIV/AIDS.

## **ASHAC Guiding Principles**

- Change is possible and must occur.
- Honour the “Statement on the Meaningful Engagement of Aboriginal People”<sup>3</sup> and the “Greater Involvement of People Living with HIV (GIPA) Principle”<sup>4</sup>.

---

3 The statement can be found in the CAAN document [Making it Our Way: A Community Mobilization Tool Kit](#).

4 Formalized at the 1994 Paris AIDS Summit and included in the 2001 United Nations Declaration of Commitment on HIV/AIDS, the GIPA Principle aims to realize the rights and responsibilities of people living with HIV, including their right to self-determination and participation in decision-making processes that affect their lives. Retrieved on February 24, 2009 from [http://data.unaids.org/pub/BriefingNote/2007/JC1299\\_Policy\\_Brief\\_GIPA.pdf](http://data.unaids.org/pub/BriefingNote/2007/JC1299_Policy_Brief_GIPA.pdf).

- Respectfully accepting that HIV/AIDS exists in the Aboriginal community will reduce stigma and discrimination.
- Act with the pride and dignity that Aboriginal heritage demands, respecting and honouring all Aboriginal beliefs, practices and customs.
- First Nation, Inuit and Métis peoples have diverse, rich histories and strong cultural foundations to ground our actions and guide our hearts.
- Demonstrate unity amongst all Aboriginal peoples regardless of where they reside and without distinctions between Status and Non-Status First Nations, Métis or Inuit peoples.
- Integrate the wholistic Aboriginal worldview engaging the mental, physical, emotional and spiritual aspects of a person.
- Honour, respect and connect with family, the community and the whole population consistent with our family-based cultures.
- Mentorship is an effective approach for demonstrating opportunities, supporting someone to invest in their life and contributing towards sustainability for the Aboriginal HIV/AIDS movement.
- Recognize we have inherent rights which guarantee good health and well-being as Aboriginal Peoples.
- The strategy supports initiatives at the national, regional, provincial and local levels.

## **ASHAC Mission**

To support culturally relevant strategies and empower existing initiatives to compassionately address the complexity of HIV/AIDS and related issues for Aboriginal Peoples.

## **ASHAC Goals**

- Ensure that the best possible efforts, in all areas, are placed to meet the needs of Aboriginal people living with HIV/AIDS.
- Prevent the further spread of HIV/AIDS among Aboriginal populations, through education, awareness, diagnosis, care, treatment and support programs for those at risk of, living with and affected by HIV/AIDS guided by research data and evidence-based decisions.



- Respond to the diversity within the Aboriginal population through culturally relevant and targeted initiatives including harm reduction approaches and group specific resources.
- Support Aboriginal People living with HIV/AIDS to improve quality of life by maintaining consistent services and promoting relational care.

## **Diverse Groups, Many Needs**

Diversity within the Aboriginal population demands creativity to respectfully engage all of our Peoples in the response to HIV/AIDS for prevention, diagnosis, care, treatment and support. An effective and creative response must take into consideration ethnicity (Inuit, Métis or First Nation), geographic location, social isolation, language, risk behaviour(s) or a combination of these. It is challenging to develop one program, one awareness campaign, or one intervention that will address all of these considerations.

ASHAC promotes targeted efforts that respond to the unique circumstances of the diverse groups within our populations. *Examples* of the diverse groups within our populations are:

- Aboriginal People Living with HIV/AIDS (APHAs)
- Aboriginal Children
- Aboriginal Men
- Aboriginal Women
- Aboriginal Youth
- Aboriginal People who have been or are in Prisons
- Aboriginal People who Inject drugs and/or use other drugs
- Aboriginal People with Development disabilities
- Transgender and Transsexual Aboriginal People
- 2-Spirit People (Gay, Lesbian, Bisexual, Inter-sexed)
- Aboriginal People who are Street-Involved
- Aboriginal People Involved in the Sex-trade
- Older Aboriginal People
- Residential School Survivors

In addition to these groups within the Aboriginal population, it is essential to recognize that one person may belong to more than one diverse group. For example, an Aboriginal woman may inject drugs and be involved in the sex trade. An Aboriginal man may be street involved and have spent time in prison. The intergenerational impact of Residential schools may have influenced the use of substances within an entire family and a baby may



be exposed to HIV when born to an HIV+ woman. An Aboriginal Person living with HIV/AIDS may be living longer and healthier than they had imagined, or been told to expect when diagnosed, and need resources to address positive prevention, sero-discordant relationships and/or employment options.

It is also crucial to consider the many needs based upon the day-to-day reality of life for Aboriginal Peoples living in different parts of the country with unique access to communications and resources, within various distances to major urban centres. Access to health staff and resources for medical transportation may be limited. Communities may have varying degrees of autonomy over health programs and services through health transfer systems. More over, isolated, northern regions in Canada face even greater challenges to overcome the hurdles created by cost and distance. Health care is limited to nursing stations that may not see a doctor for months at a time. Patients must travel to larger communities to receive specialized care such as surgery and child birth. Inuktitut translation may be necessary; costs – even to mail or courier a package – are higher. Simply delivering a workshop requires airfare. Participation in southern training is costly and may not be transferable to the northern context. Securing political support and using an integrated approach to programs and services can help create environments that will meet the challenges of HIV/AIDS work.


*The context of complexity and diverse communities flows through each of the strategic areas identified in the ASHAC II.*

An effective response to HIV/AIDS across Canada for Aboriginal Peoples must be flexible enough to ensure the many needs of diverse groups are addressed. ASHAC encourages and supports the development of programs and services (direct and non-direct) which target specific groups and specific risk activities. Unique resources such as a Leadership Strategy, and an Aboriginal Women's Action Plan; papers regarding Incarceration, the legacy of Residential School, Medical Marijuana, and Supporting Métis needs; policy development and models for Community Mobilization and Harm Reduction have been developed by the Canadian Aboriginal AIDS Network (CAAN) as examples.

## **Epidemiological Information**

In Canada, an important part of the response to HIV/AIDS is surveillance or disease monitoring through the organized collection, analysis, interpretation and dissemination of HIV/AIDS infection information based on reports from the Provinces and Territories





to the Federal government. The science of epidemiology reports cases of HIV/AIDS, how it was transmitted, and what populations are being infected through statistics. This contributes to the evidence base used to identify priority populations in Canada and those most vulnerable to infection. The Public Health Agency of Canada (PHAC) specifically identifies HIV/AIDS surveillance and epidemiological data, STI surveillance and epidemiological data, and Hepatitis C surveillance and epidemiological data as useful evidence to support the need for a project.<sup>5</sup> PHAC releases epidemiological reports in *HIV/AIDS Epi Updates* on an annual basis and the following information is taken from the *November 2007* series of reports.<sup>6</sup>

HIV/AIDS surveillance and epidemiological data is used to produce two types of reports. One type of report is developed every 3 years and **estimates** the scope of the HIV/AIDS epidemic in Canada. It was estimated in 2005 that 58,000 people in Canada were living with HIV. At that time, Aboriginal peoples made up 3.3% of the Canadian population, but estimates for 2005 suggest that Aboriginal peoples accounted for about 7.5% of all persons living with HIV in Canada and 9.0% of new infections in that year. Therefore, the overall infection rate among Aboriginal persons was about 2.8 times higher than among non-Aboriginal persons.

The second type of report offers details and analysis based upon the actual data submitted to the Federal government by the Provinces and Territories. Information about Aboriginal Peoples, as a whole and as distinct populations with an “Aboriginal unspecified” category, is based upon all of the reports that include information about a person’s ethnicity. It is very important to note that the provinces of Ontario and Quebec do not include ethnicity when they submit HIV+ results. This limits a full understanding of the current situation for Aboriginal Peoples in Canada. Based upon the data most recently available, by 2006 Aboriginal persons accounted for 24.4% of the total reported AIDS cases for which ethnicity was known that year. Of equal concern, in 2006 the proportion of positive HIV test reports attributed to Aboriginal persons was 27.3% among the provinces and territories reporting ethnicity information with their HIV reports.

---

5 Taken from PHAC’s guiding principles for the National Specific Populations HIV/AIDS Initiatives Fund. Retrieved March 20, 2009 from [http://www.phac-aspc.gc.ca/aids-sida/funding/isa/pdf/guide\\_hssp-eng.pdf](http://www.phac-aspc.gc.ca/aids-sida/funding/isa/pdf/guide_hssp-eng.pdf).

6 *HIV/AIDS Epi Updates* can be assessed electronically in either official language via the Internet at <http://www.phac-aspc.gc.ca/aids-sida/publication/index.html>.

The following specific epidemiological information was summarized as evidence of stigma and discrimination impacting Aboriginal Peoples<sup>7</sup> and expands on the examples outlined above of diverse groups, many needs:

- **People who inject drugs** – Injection drug use (IDU) is the main exposure category for HIV among Aboriginal people in Canada. In surveillance reports that note ethnicity, IDU accounted for 40% of reported AIDS cases among Aboriginal peoples from 1979 to 2006 and 58.8% of HIV-positive test reports between 1998 and 2006. In Phase 1 of I-Track, a second generation surveillance system of IDU established by PHAC in collaboration with provincial, regional and local health authorities, community stakeholders and researchers, nearly 42% of participants identified themselves as Aboriginal.
- **Women** – In contrast to HIV and AIDS cases in the non-Aboriginal population, Aboriginal women make up a comparatively large part of the Aboriginal HIV/AIDS epidemic. Women account for nearly half (48.1%) of all cumulative HIV infections among Aboriginal people. Issues surrounding sexism, racism and other forms of discrimination, poor health, [poverty] and ailing communities compound Aboriginal women's vulnerability to HIV/AIDS. Aboriginal mothers can experience additional stigma, particularly if they choose to have children after receiving an HIV diagnosis. Among Aboriginal women, HIV is mostly spread through IDU and heterosexual contact, representing 64.4% and 34.1%, respectively, of all infections from 1998 to 2006.
- **Youth** – Aboriginal persons who test positive for HIV tend to be younger than non-Aboriginal persons. Between 1998 and the end of 2006, persons aged 0 to 29 made up 32.4% of all HIV-positive Aboriginal diagnoses, compared to 21% of non-Aboriginal diagnoses. Aboriginal peoples are also over-represented among street youth. Although Aboriginal peoples represent only 3% of the Canadian population, approximately one-third of E-SYS (a national enhanced surveillance program of street involved youth) participants identified themselves in this ethnic category.

---

<sup>7</sup> Evidence of Stigma and Discrimination Impacting Priority Populations retrieved March 20, 2009 from <http://www.phac-aspc.gc.ca/aids-sida/funding/isa/cbsm-eng.php>. (Appendix 2)



- **2 Spirit(ed) people/MSM (men who have sex with men)** – Between 1998 and the end of 2006, 13% of HIV-positive test reports among Aboriginal men were attributed to MSM and an additional 6.7% to MSM/IDU. 2 Spirit(ed) people and Aboriginal MSM face unique vulnerabilities to HIV/AIDS due to the combined impacts of homophobia and racism.

**Comparison of *selected* exposure categories for reported AIDS cases and positive HIV test reports (from provinces that report data) among Aboriginal and non-Aboriginal persons**

	Aboriginal	Non-Aboriginal
	n = number of cases with available information on exposure category	
<b>AIDS (1979 – 2006)</b>	<b>n = 576</b>	<b>n = 15,275</b>
IDU	39.9%	7.0%
Heterosexual	19.4%	15.5%
MSM	30.6%	69.2%
MSM/IDU	6.9%	4.4%
<b>HIV (1998 – 2006)</b>	<b>n = 1,407</b>	<b>n = 4,633</b>
IDU	58.8%	24.8%
Heterosexual	29.4%	31.5%
MSM	6.8%	38.9%
MSM/IDU	3.6%	2.7%

The difference between routes of transmission for Aboriginal Peoples and all Canadians highlights the uniqueness of the HIV epidemic among Aboriginal persons and the complexity of the HIV epidemic in Canada.

***Aboriginal women make up almost half of all Aboriginal HIV infections to the end of December, 2006; this was predicted about 6 years ago. Now Aboriginal youth (under 30) are nearly a third of our HIV figures to the end of December, 2006. Immediate action must be taken to avoid Aboriginal youth following the same trend as Aboriginal women. We must take action to reduce the numbers now!***

## Cultural Relevance

In building an understanding of Aboriginal Peoples in Canada it is crucial to reflect on the diversity that has been illustrated through the sections about “diverse groups, many needs” and “epidemiological information”. Throughout the ASHAC document reference is made to striving for cultural relevance in the objectives and actions suggested for each strategic area. Effectively engaging in activities that are culturally relevant for the populations and communities they are meant for requires humility.

***Learning and sharing about each other’s culture is a central element of the work when Aboriginal Peoples come together in a joint initiative.***

General suggestions for a culturally relevant approach include the following:

- Be flexible, non-judgmental and use a harm reduction approach;
- Communicate using plain language, translation to the language and dialects of specific populations when possible, and using creative approaches such as arts-based methods;
- Develop knowledge about a population’s culture with humility and an open mind by respectfully seeking out Elders and knowledge keepers;
- Develop resources that respectfully and accurately incorporate cultural concepts;
- Include self-assessment of cross cultural relations – between Aboriginal and non-Aboriginal peoples and also between different Aboriginal Peoples;
- Incorporate perspectives of diverse gender roles and sexual relations;
- Learn about and from Aboriginal specific services;
- Listen carefully before you speak and express a genuine respect and trust in the people you are working with;
- Recognize that many Aboriginal people wear the legacy of colonialism;
- Remember that Aboriginal Peoples are diverse – as 3 distinct populations, within these populations and also across these populations with belief systems, values, principles, spirituality, and teachings; and
- Respect the culture of the population where work is being done.





## ASHAC Key Strategic Areas

The ASHAC II will support the following **key strategic areas**:

- A. Wholistic Care, Treatment and Support
- B. Aboriginal HIV/AIDS Research
- C. Broad-based Harm Reduction Approaches
- D. Capacity Building
- E. Legal, Ethical and Human Rights Issues
- F. Partnerships, Collaboration and Sustainability
- G. Prevention and Awareness

### **Strategic Area A: Wholistic Care, Treatment and Support**

*Primary objective:* Aboriginal People living with HIV/AIDS report increased quality of life based upon access to wholistic care, treatment and support.

Actions related to wholistic care, treatment and support include:

- To create targeted care, treatment and support resources for HIV positive Aboriginal children and for APHAs who are living longer and aging.
- To develop and share resources for health care professionals about risk activities and the context surrounding APHAs so they have the information to provide adequate, non-judgmental counseling, testing, follow-up and after-care.
- To increase access to resources for caregivers and family members where appropriate, to learn about routine and palliative care, treatment, support, self-care for caregivers and issues surrounding death and dying.
- To increase access to treatment and treatment information at various levels of literacy in partnership with CTAC and CATIE.
- To increase resources regarding issues such as positive prevention, healthy living, relationships, behaviours after diagnosis, pregnancy and fertility and emerging topics identified through research and ongoing dialogue with APHAs.
- To increase the delivery of wholistic care models that include local cultural beliefs and protocols by building capacity with health and related service workers serving Aboriginal communities and specifically APHAs.

- To increase understanding and APHAs' access to care networks that flow across a spectrum of jurisdictions (interprovincial, urban, rural and Aboriginal communities).

### **Strategic Area B: Aboriginal HIV/AIDS Research**

*Primary objective:* To increase community engagement in Aboriginal HIV/AIDS research by prioritizing relevant research that provides accurate and up-to-date data that will inform action.

Actions related to Aboriginal HIV/AIDS research include:


- To expand research capacity by recruiting new and established Aboriginal and non-Aboriginal allied researchers who will conduct culturally relevant Aboriginal HIV/AIDS research, emphasizing community-based and arts-based projects, to accurately guide action in response to the epidemic.
- To improve access to high quality peer review and ethical review by recommending Aboriginal and allied researchers to review boards and supporting the creation of an independent Aboriginal ethics review board.
- To increase knowledge translation so that research findings will be accessible to a broad audience and guide evidence based prevention initiatives, policy and effective care, treatment and support for APHAs.
- To increase the impact of national HIV/AIDS research initiatives based on issues identified at the community level with consideration for unique cultural and regional differences.
- To increase the number of research projects that engage APHAs as researchers and respect the principles of OCAP and the Canadian Institutes of Health Research (CIHR) Guidelines for Health Research Involving Aboriginal People<sup>8</sup>.

### **Strategic Area C: Broad-based Harm Reduction Approaches**

*Primary Objective:* To increase harm reduction policies and practices accessible to Aboriginal Peoples in Canada.

<sup>8</sup> Available online at <http://www.cihr.ca/e/29134.html>





Actions related to broad-based harm reduction approaches include:

- To decrease the transmission of HIV and Hep C for our brothers and sisters in prison by promoting the safe implementation of harm reduction practices by Correctional Services of Canada and Provincial/Territorial correctional institutions.
- To enhance access to ceremonies for Aboriginal People who use substances by working with Elders to balance personal choice while respecting ceremonial protocols.
- To increase culturally relevant resources regarding safer sex, information on risky behaviours and alternative choices for all groups and all ages.
- To increase the use of harm reduction messages that respect the beliefs, choices and approaches relevant to specific Aboriginal populations and groups.
- To share harm reduction strategies and tools through the Canadian Aboriginal AIDS Network mailing list to increase the availability of Aboriginal resources from sea-to-sea-to-sea.

#### **Strategic Area D: Capacity Building**

*Primary objective:* To increase the capacity for Aboriginal Peoples to develop the skills, processes and resources needed to prevent new infections and address the complex issues related to HIV/AIDS.

Actions related to capacity building include:

- To increase the capacity of APHAs to (re)enter the work force through access to job, life skills and other training identified as a need by APHAs.
- To achieve a wide base of skilled workers by recruiting, training, mentoring, supporting and retaining university, college and high school graduates in disciplines that address the complex issues related to HIV/AIDS.
- To build capacity to determine and apply accurate and up-to-date information at the regional and local levels to increase the ability to meet the changing needs of Aboriginal communities.
- To increase the implementation of wellness efforts such as family-based support models to sustain front-line workers in the HIV/AIDS field.
- To promote ongoing education/training including certification processes, in-service training and other professional development opportunities to decrease staff turnover in Aboriginal AIDS service organizations.



- To sustain cultural competency by involving Elders in HIV/AIDS programs to promote respect, nurture spiritual strengthening and reclaiming, and ground all those involved in responding to the complex issues related to HIV/AIDS and Aboriginal Peoples.

### **Strategic Area E: Legal, Ethical and Human Rights Issues**

*Primary Objective:* To increase supportive environments for APHAs by reducing stigma and discrimination and ensuring that Aboriginal Peoples’ human rights are respected regarding HIV/AIDS.


Actions related to legal, ethical and human rights issues include:

- To increase advocacy efforts to implement the “Declaration of Rights of APHAs”, “Statement on the Meaningful Engagement of Aboriginal People” and the “Greater Involvement of People Living with HIV (GIPA) Principle”.
- To increase awareness regarding disclosure and the law relating to the criminalization of HIV transmission.
- To increase capacity to apply a rights-based approach to Aboriginal HIV/AIDS initiatives by learning from and working with agencies/services that advocate on behalf of human rights (i.e. EGALE, Canadian HIV/AIDS Legal Network, Canadian/regional Human Rights Commissions, Prisoners’ HIV/AIDS Support Action Network).
- To reduce barriers to returning to work due to loss of benefits after being on government assistance.
- To reduce jurisdictional barriers and issues that are an impediment to the good health of Aboriginal Peoples by engaging Aboriginal and Canadian governments to work with us to address those barriers through policy change.

### **Strategic Area F: Partnerships, Collaboration and Sustainability**

*Primary objective:* To increase the ability to meet the pressing issues of HIV prevention and support by engaging as many stakeholders as possible emphasizing Aboriginal people who are affected by or living with HIV/AIDS.





Actions related to partnerships, collaboration and sustainability include:

- To increase long-term funding for Aboriginal HIV/AIDS organizations and programs in Canada.
- To assist, facilitate and communicate with sectors beyond health and social services to work toward a reduction in the social and economic inequalities that contribute to behaviours that place individuals at an increased risk for HIV/AIDS.
- To increase knowledge about best practices of other Indigenous nations and other Indigenous responses to HIV/AIDS regarding Indigenous healing ways, gathered wisdom and how it is being shared.
- To increase meaningful partnerships between community organizations, various levels of government, the health care community and Aboriginal leadership to co-ordinate the delivery of sustainable prevention programs, treatment and support services while addressing the challenges of geographic location.
- To increase resources where possible by working with groups responding to HIV/AIDS and related issues such as Hepatitis C, other blood borne pathogens, addictions, mental health and dual-infection with HIV.
- To provide mainstream service agencies and HIV clinics with cultural resources and cross-cultural competency training for non-Aboriginal workers that work with Aboriginal peoples appropriate to their regions.

### **Strategic Area G: Prevention and Awareness**

*Primary Objective:* To reduce the rate of HIV infection among Aboriginal Peoples in Canada through increased understanding of HIV related risks.

Actions related to strategic prevention and awareness include:

- To reduce the misconceptions/presumptions related to the transmission of HIV/AIDS and the lives of APHAs.
- To create high levels of awareness of HIV/AIDS among elected and non-elected Aboriginal leaders and influential community stakeholders in order to increase participation in policy direction/decisions and lead Aboriginal communities in responding to HIV/AIDS.

- To increase early interventions targeting school aged children before they become sexually active or involved with alcohol and drugs, so that they will know the facts about HIV/AIDS, understand the risks, and be stronger young men and women empowered to avoid risks that may lead to HIV/AIDS.
- To increase participation in annual Aboriginal AIDS Awareness Week events.
- To increase the design and delivery of programs that are culturally, age and gender relevant to address the many needs and diversity within Aboriginal populations.
- To support culturally relevant community-based social marketing approaches that present positive messaging, honour diversity and can be widely used.
- To use research findings to increase the effectiveness of prevention and education resources to meet existing gaps or unexpected needs that may arise in the future.

## Outcomes

The Aboriginal Strategy on HIV/AIDS II identifies seven core strategic areas each with a primary objective. Actions related to each area suggest secondary objectives and activities that can be undertaken at the national, regional, provincial and local levels through multiple and creative interventions. Outcomes of these activities and objectives will be relevant to the target population(s) as defined by the stakeholders implementing them. The following outcomes refer to the primary objectives and overall goals of the ASHAC:

- Aboriginal People living with HIV/AIDS will live longer with a higher quality of life and engage in community life including work if they wish.
- Harm reduction policies and practices will be implemented to meet the needs of Aboriginal Peoples in Canada without judgement.
- HIV/AIDS workers specifically, partners and collaborators will begin to build trusting relationships and have greater competence in their individual and organizational capacity to address the complex issues related to HIV/AIDS within the Aboriginal populations in Canada.
- Human rights associated both with HIV/AIDS and Indigenous Peoples will be enacted and promoted across all provinces and territories in Canada.
- More individuals and organizations will be engaged in a formal response to HIV/AIDS and related issues within the Aboriginal populations in Canada.



- Research findings, from highly relevant HIV/AIDS research projects lead by Aboriginal research teams, will inform action from the local to the national level.
- The number of new HIV infections among Aboriginal Peoples in Canada will decrease over the next five years.

## **Evaluation**

It is recommended that the Federal government support evaluation through the Canadian Aboriginal AIDS Network as the steward of the ASHAC II. Base line data should be collected in 2009 with a full follow-up evaluation in 2012 allowing time to renew the strategy in 2013. In addition, funding should be allocated each fiscal year to develop a report card to track progress in each of the strategic areas, highlight areas that may require additional attention and identify emerging issues.

## **Overall Roles and Responsibilities**

All Peoples in Canada can contribute to the Aboriginal Strategy on HIV/AIDS in Canada. The ASHAC Guiding Principles speak to the motivations that guide our actions as we move forward with this strategy. Contributions to the development of the Guiding Principles came from documents and stakeholders representative of Aboriginal peoples from sea-to-sea-to-sea. These form the basis of our shared roles and responsibilities as we collectively work towards implementing the strategy as a whole.

A wholistic response to HIV/AIDS within the Aboriginal population in Canada includes four stakeholder groups with clear responsibility for addressing each of the strategic areas. These four stakeholder groups are: the Canadian Aboriginal AIDS Network; Aboriginal AIDS service organizations; Aboriginal communities and partner/collaborating organizations (from the local to the national level); and government (both Aboriginal and Canadian from municipal to Federal). As the national organization for Aboriginal Peoples regarding HIV/AIDS, CAAN naturally takes on a stewardship role for the ASHAC II. This role includes seeking funds for overall evaluation and leading the effort to collect information for the development of an annual report card to be released during Aboriginal AIDS Awareness Week.

*The ASHAC is not intended to replace the strategic or operational plans of individual organizations or programs, but rather, to compliment and contribute towards aligning these plans with a broad national vision.*

At different times each of these groups of stakeholders will take a leadership role, participate in an initiative, act as a mentor or support the work others are doing. Examples of the shared roles and responsibilities each of the stakeholder groups is uniquely positioned to contribute to the Aboriginal Strategy on HIV/AIDS in Canada are:


### CAAN

- Stewardship of ASHAC
  - Coordinate evaluation of ASHAC II as outlined
  - Develop an annual report card for Aboriginal AIDS Awareness Week;
- Advocate for Aboriginal funds for Aboriginal people managed by Aboriginal people;
- HIV/AIDS and Aboriginal Peoples resource development and distribution;
- Lead by example and assist member organizations i.e. effective evaluation processes and practices, capacity building for research;
- Link and network different communities within Canada and internationally;
- Promote harm reduction, OCAP principles and CIHR Guidelines, GIPA, meaningful involvement and the rights of APHAs;
- Provide a voice to political leaders at a high level of advocacy; and
- Research and lobby for more openness from government agencies (e.g. Correctional Service Canada, etc.).

### Aboriginal AIDS Service Organizations

- Contribute to the development of National/Provincial/Territorial policy related to HIV/AIDS;
- Contribute towards the evaluation and monitoring of ASHAC II;
- Disseminate ASHAC II as a resource for colleagues, government representatives, students and organizational stakeholders i.e. Board members, APHA members;



- 
- Implement prevention and education efforts that will engage hard-to-reach target groups who need a special focus;
  - Involve people from target populations in interventions from conception to project/program conclusion;
  - Produce resources for raising awareness about HIV/AIDS and Aboriginal Peoples;
  - Review ASHAC II and identify strategic areas, objectives and actions that could be incorporated in organizational work plans; and
  - Sustain Peer Support initiatives as an effective strategy for reaching diverse groups and responding to the many needs of Aboriginal Peoples in Canada.

### **Aboriginal community members and partner/collaborating organizations**

(from the local to the national level)

- Community health staff will seek out and use Aboriginal HIV/AIDS resources available to them from national, regional and provincial sources;
- Create supportive and open environments in the home communities of APHAs so they feel welcome and without fear of discrimination or isolation;
- Learn about Aboriginal Peoples and HIV/AIDS by reviewing ASHAC II;
- Parents have responsibility to educate and be educated;
- Partner and/or collaborate with Aboriginal AIDS Service organizations and programs to unite in the response to HIV/AIDS;
- Promote healthy lifestyles from a young age and onwards;
- Reaching out to those who do not access Aboriginal AIDS Service Organizations services; and
- Recognize the importance of community-based efforts and their staff who have awareness of local issues and approaches, including community values and ways of sharing information.

### **Governments**

(both Aboriginal and Canadian from local to national/municipal to Federal)

- Contribute to wise practices, including funding for a minimum of two-years to facilitate the testing of new projects/initiatives to make sure resources, materials and focus are working;

- Develop and enforce non-discrimination policy and legislation to contribute to supportive and open environments in all communities so that APHAs feel welcome;
- Governments should seek out and employ Aboriginal input to inform policy and program development related to HIV/AIDS and related issues affecting the health of Aboriginal peoples;
- Invest in long-term actions based on the understanding that projects are responding to needs that do not disappear when project funding ends;
- Leaders can contribute to prevention and awareness and remove barriers to capacity building by sharing in the ownership and responsibility of responding to HIV/AIDS;
- Leverage funding and time for chiefs/tribal councils/mayors/Members of the Legislative Assembly/ Members of Provincial Parliament and Members of Parliament to learn about HIV/AIDS; and
- Ongoing review and revision of policies and practices that affect Aboriginal peoples.

## Conclusion

The Aboriginal Strategy on HIV/AIDS in Canada is an important document. It offers a unifying approach for Aboriginal Peoples across the country to confront HIV. For those outside the Aboriginal community it offers insight regarding pressing needs, core principles of engagement and guidance for how to contribute. Funders have relied upon the ASHAC to guide decision making for limited resources. ASHAC I was developed with extensive community consultation and ASHAC II has been renewed with ongoing consultation and document review. Ultimately, the success of the strategy requires the willingness and commitment of all partners to identify their individual roles and work together in a coordinated approach. HIV has taken a great deal from our communities, it has been a teacher of harsh lessons and reminds us of our resilience. This strategy proposes steps to continue on a journey to take action and eliminate the risk of HIV infection for Aboriginal Peoples in Canada. United we can respond to the negative effects experienced by all Aboriginal People living with and affected by HIV/AIDS with a strong vision for the time when HIV/AIDS no longer threatens our communities.









