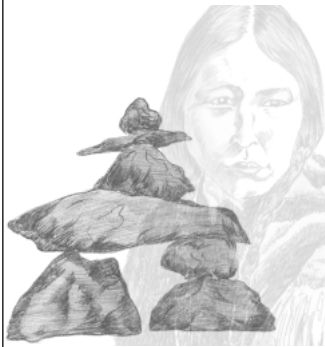




Strengthening Ties - Strengthening Communities



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An Aboriginal Strategy on HIV/AIDS in Canada

*For First Nations, Inuit and Métis People
July 2003*



Overview of the Canadian Aboriginal AIDS Network

- Established in 1997
- National and not-for-profit
- Represents over 160 member organizations and individuals
- Governed by a National twelve member Board of Directors
- A four member Executive
- Provides a National forum for members to express needs and concerns
- Ensures access to HIV/AIDS-related services regardless of where one resides
- Provides relevant, accurate and up-to-date information.

Mission Statement

The mission of the Canadian Aboriginal AIDS Network (CAAN) is to provide leadership, support and advocacy for Aboriginal people living with and affected by HIV/AIDS regardless of where they reside.

Disclaimer

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Acknowledgements

The Canadian Aboriginal AIDS Network would like to express deep appreciation to all 173 Aboriginal and non-Aboriginal people who took the time to contribute to this document. In addition, all members of the two Working Groups who first prepared a framework and later this document, are hereby recognized. Without them, the process would not have been a success.

Cover Art

Artist is Tom Cheyenne, Lakota. Chosen to reflect that this strategy is about people - Aboriginal people, in particular. CAAN and this strategy recognize the importance of Elders and culture in the struggle to overcome HIV/AIDS and all related issues.

Researched and developed by

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A Vision

Aboriginal People in Canada will achieve and maintain strong, healthy, and fulfilling lives, free of HIV/AIDS and related issues.

Our Mission

To support meaningful, lasting efforts for Aboriginal communities to address HIV/AIDS and related issues in a culturally relevant manner.



Glossary of Terms

AASO/ASO	Aboriginal AIDS Service Organization / AIDS Service Organization
Aboriginal	Indigenous peoples in Canada, including Inuit, Métis, and First Nations who are Status or Non-Status, On or Off-reserve.
AIDS	Acquired Immune Deficiency Syndrome
ADD/ADHD	Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
ASHAC	Aboriginal Strategy on HIV/AIDS in Canada
ANAC	Aboriginal Nurses Association of Canada
APHA	Aboriginal Person living with HIV/AIDS
CAAN	Canadian Aboriginal AIDS Network
CAS	Canadian AIDS Society
CATIE	Canadian AIDS Treatment Information Exchange
Circles of Knowledge Keepers	A Peer Education and Counselling Training manual recently developed for Aboriginal Offenders around HIV, Tuberculosis and Hepatitis available through CAAN.
CSC	Correctional Service Canada
CSHA	Canadian Strategy on HIV/AIDS
CHALN	Canadian HIV/AIDS Legal Network
CIHAN	Canadian Inuit HIV/AIDS Network
CTAC	Canadian Treatment Action Council
EGALE	Equality for Gays and Lesbians Everywhere
EIC	Emerging Issues Committee of the ASHAC Working Group
FASD	Fetal Alcohol Spectrum Disorder formally known as FAS/FAE
Harm Reduction	A social policy approach, initially applied to injection drug use, yet can be adapted to respond to other drug use including alcohol, whose first priority is to decrease negative consequences from drug use.
HAV/HBV/HCV	Hepatitis A, B or C Virus, respectively
HIV	Human Immunodeficiency Virus
Inter-sexed	Another term for hermaphrodite, a person born with genitals that show characteristics of both sexes.
Methadone Maintenance	A medication used to support addicts to stop using injection drugs, more commonly heroin.

NACHA	National Aboriginal Council on HIV/AIDS
National Partners	A group of national organizations that play key roles in the HIV/AIDS health field and collectively provide advice to the federal government.
Needle Exchanges	Street-outreach service agencies that distribute clean, unused needles in exchange for the used ones as part of harm reduction. Education, counselling, condoms and other types of support are also provided.
NIICHRO	National Indian and Inuit Community Health Representatives Organization
NNADAP	National Native Alcohol and Drug Abuse Prevention
OCAP	Ownership, Control, Access and Possession. Refers to the status information and programs intended to benefit Aboriginal people in Canada and that these programs should be run under the principles of OCAP, meaning that they are owned, controlled, accessed and possessed by Aboriginal people for Aboriginal people. The ASHAC is committed to the principles of OCAP.
Stakeholder	An organization identified in one or more of the groups listed Appendix C. Any group or individual who can affect or is affected by this Strategy.
Social Marketing	Use of resources with targeted methods to market social change.
Transgendered	People who feel they are members of the opposite sex with which they were born. This exists with or without the need/desire to change their bodies. Transgendered people may or may not take hormones and may or may not have genital surgery.
Two-Spirited	A generic term used mostly by some First Nations and Métis people to describe from a cultural perspective, people who are known in mainstream as either gay, lesbian, bisexual or inter-sexed/transgendered. It is used in place of words which may exist in Indigenous languages, such as the Winkte in Lakota culture.
WG	Working Group of the ASHAC.
WG 2	Phase 2 members of the Working Group of the ASHAC.
WG 2 Secretariat	A committee that works within the Working Group to support the Strategy Coordinator and help plan and guide all meetings.

Guiding Principles

- First and foremost, show respect and honour for all Aboriginal beliefs, practices and customs, acting with pride and dignity that Aboriginal heritage demands.
- Remember who we are, as Inuit, Métis and First Nations People while keeping a community-based approach.
- Recognize the importance and contributions of those living with HIV in developing the strategy and in all its phases and implementation.
- Strive to ensure that Aboriginal people will be afforded the best possible access, to an improved and equitable quality of health, life and wellness.
- Support and demonstrate unity amongst all Aboriginal people regardless of where they reside and without distinctions which may be drawn between Status and Non- Status First Nations, or amongst Métis and Inuit people.
- Support and uphold the principles of OCAP (Ownership, Control, Access and Possession) of information and programs by Aboriginal People.
- Honour and respect the commitments to all Aboriginal People living with and affected by HIV/AIDS in Canada.
- Honour and respect the commitments to the stakeholders.



1.0 Executive Summary

HIV/AIDS among Aboriginal people in Canada, is a serious health issue with an ever increasing need for action and strategic planning. As infection rates continue to rise, more and more Aboriginal people, their families and communities are faced with the many and complex challenges that go with this disease. Although new medications are helping people live longer - there remains no cure. Aboriginal Leaders are called upon to speak publicly about this serious health issue. There is an urgency that requires political support, so that HIV/AIDS among Aboriginal people is properly addressed. Further examples of how Aboriginal Leaders can support this cause, is found at the beginning of the nine strategic areas, which could include council resolutions ensuring respect for individual human rights, lobbying for increased funding, etc.

Access to adequate care, treatment and support can be a huge task when many Aboriginal people live below the poverty line: some are incarcerated, while others yet are dealing with issues that complicate prevention methods, such as injection drug use or the Residential School Legacy. Northern communities also face sub-standard health with little access to healthcare because of their isolation. As well, different health care coverage exists within Aboriginal populations depending on the status of individuals including residency and system involvement.

From what is known through epidemiological evidence, between 1996-1999 both cumulative (91%) and new (19%) HIV infections con-

tinue to be quite high. Although infection rates vary among Inuit, Métis, and First Nations people, there is an over-representation for Aboriginal people in terms of HIV/AIDS, who make up approximately 4.4% of the Canadian population, yet are seeing HIV/AIDS figures continue to rise. There are wide gaps in the data, and more research with the full involvement of Aboriginal people, is needed to accurately reveal how this disease is impacting Inuit, Métis, and First Nations people.

This strategy will offer a vision for Inuit, Métis and First Nations¹ (status or non-status, on or off-reserve) people to respond to HIV/AIDS. It will outline and describe key issues and nine strategic areas which can be taken to ensure that a range of programs and services are in place to meet the needs of Aboriginal People Living with and affected by HIV/AIDS. The following nine strategic areas were selected after researching all Provincial/Territorial Aboriginal HIV/AIDS strategies, some mainstream HIV/AIDS strategies in Canada, and the National Australian HIV/AIDS Strategy. Common ground made its way into this document, as each strategy reviewed essentially were stating the same issues, just in different language and formats.



¹ This document will use the term "Aboriginal", which is meant to include Inuit, Métis and First Nations (On or Off-reserve, Status or Non-Status) people.

These nine key strategic areas are:

- Coordination and Technical Support
- Community Development, Capacity Building and Training
- Prevention and Education
- Sustainability, Partnerships and Collaboration
- Legal, Ethical, and Human Rights Issues
- Engaging Aboriginal Groups with Specific Needs
- Supporting Broad-based Harm Reduction Approaches
- Holistic Care, Treatment and Support
- Research and Evaluation

The title was chosen to reflect the need to create stronger ties, at any level. By doing so, HIV/AIDS work will not operate in isolation of other health and social issues. Whether it is creating a Community Wellness Team, a Regional Network, or bringing together groups on a national level - the potential exists to strengthen the response to HIV/AIDS among Aboriginal communities. The Aboriginal Strategy on HIV/AIDS in Canada (ASHAC) is not about competing with regional and local efforts - it is more about offering support and national coordination that can strengthen ties and strengthen Aboriginal communities. By doing so, it will identify and support measures which can take Aboriginal people that much closer to meeting and overcoming the many challenges related to HIV/AIDS.

In some parts of Canada, Provincial/Territorial Aboriginal HIV/AIDS Strategies are in existence. The ASHAC will build upon these regional strengths to support and encourage other regions to develop strategies, create and maintain effective networks, and where

needed, assist in the development of frameworks, action plans, protocols and other tools. Much of the early advocacy and prevention efforts around HIV/AIDS started in urban areas. However, there have also been good examples from on-reserve and isolated populations. One example was the establishment of the Atlantic First Nations AIDS Task Force (now Healing our Nations), which mobilized from a regional perspective. Another is the Canadian Inuit HIV/AIDS Network, which has actively engaged its members to raise the profile of HIV/AIDS among Inuit. Numerous other resources have been developed in other regions, for First Nations on and off-reserve, as well as with Inuit and Métis rural HIV/AIDS response teams exist in some regions.

It is with these in mind that the ASHAC will seek to provide broad strokes that will bring together current efforts and resources. This Strategy is not about prescribing a vision. It is about building common ground that can enhance, guide, support and complement work in all regions so that Aboriginal people can continue to find innovative ways of taking control of a disease that has taken far too many lives. Aboriginal people are not a special interest group, and have been impacted differently by HIV/AIDS, resulting in varied responses based on a number of reasons. The last section will offer glimpses into issues and factors that may be affecting a diverse listing of groups, such as injection drug users, women, men, etc. There is also an appendix D, which is the Consultation process used which reached 173 Aboriginal and non-Aboriginal people across the country.

2.0 Background: Why an Aboriginal Strategy Now?

The ASHAC comes at a time when we are several years past the first and second phases of the National AIDS Strategy (NAS), now known as the Canadian Strategy on HIV/AIDS (CSHA). It has only been in recent years that the Canadian Aboriginal AIDS Network (CAAN) had secured resources to build and maintain a national coalition which is determined to respond to this health issue. The key advantage of having an organization like CAAN is that it has a single health issue as its sole mandate - which is HIV/AIDS.

As stated earlier, HIV/AIDS among Aboriginal communities has seen a steady increase in the numbers of infections. As Aboriginal people are largely family-based cultures, this means that for every Aboriginal person that is living with HIV or AIDS, an entire immediate and extended family system is being affected. In a country such as Canada, with all its resources and expertise, it is simply unacceptable how Aboriginal communities continue to be infected and affected by a preventable disease.

A strategy can be defined as “a careful plan or method.”² The ASHAC will be plan out areas to reach certain goals. Some people may understand strategy and strategic planning differently. This strategy is about setting future directions, and does not deal with day to day operations, which is otherwise known as operational plans.

²Webster's Ninth New Collegiate Dictionary, Merriam-Webster Inc. 1989



Two broad goals will be supported by the ASHAC, which are:

- **ensure the best possible efforts, in all areas, are placed to meet the needs of Aboriginal People living with HIV/AIDS; and**
- **prevent the further spread of HIV/AIDS among Aboriginal populations, through education, awareness, and whatever means available and necessary.**

Underlying these broad goals, is the recognition that because Aboriginal people are family-based, support is also needed for those affected by this disease, such as family members, partners, and HIV/AIDS workers to name a few. These two goals will be realized through the nine key strategic areas which have specific objectives and expected outcomes attached to direct the work. These are found later in this document under section 5. The Canadian Strategy on HIV/AIDS has six goals (see page 9) that the ASHAC supports, yet some of those goals are beyond the direct scope of the Aboriginal community. For instance, it is unlikely Aboriginal HIV/AIDS dollars will be doing medical research to find a cure, yet ASHAC supports continued efforts to find a cure, so that ALL people living with HIV/AIDS can rid this disease from their bodies and lives. This can also include reducing the factors that place individuals at risk for HIV.

A key advantage regarding the ASHAC, is the potential exists to use resources more wisely, rather than rushing into areas which have

not been properly planned out. What this means is that without a plan, whatever actions that are taken stand the risk of not being effective. Some of the earlier efforts in the Aboriginal AIDS movement can now be reviewed with more objectivity. In essence, the lessons learned from a few fledgling Aboriginal AIDS Service organizations, can now be said to be the normal growing pains of groups who knew there was a serious issue facing Aboriginal people, but struggled with creating an effective organization to meet the challenges.

Thus, the absence of an Aboriginal HIV/AIDS Strategy has been felt for sometime. In its place the federal strategy guided actions, but several factors complicated efforts to effectively reach Aboriginal populations. Some were systematic weaknesses found in the federal funding, as many Aboriginal AIDS Service organizations were quite late in getting started. In the first and second phases of the federal strategy, the main source of funds that could be accessed by Aboriginal groups were known as "special projects", which meant they were time-limited.

Medical Services Branch (now called First Nations & Inuit Health Branch) also offered funding for On-reserve and Inuit communities, but again, these funds did not support organizational structures. Other factors experienced, included the fact that, as with mainstream populations, HIV/AIDS first began affecting Two-Spirited (gay) males, and also occurred mostly in larger urban centers. Thus, many Aboriginal political leaders, and even health portfolios did not heed the warnings being raised. Today, we know that HIV/AIDS is being spread through unprotected sex and injection drug use among all people,

irregardless if they are heterosexual, homosexual, bisexual, women, babies develop HIV from HIV+ mothers, youth, or older individuals.

Yet some groundwork within the Aboriginal community was being laid to support the eventual realization of a national Aboriginal AIDS network, as well as this strategy. As HIV/AIDS is growing significantly among Aboriginal populations and within most groups in Aboriginal societies, this strategy is built upon the lessons learned from years of advocacy and hard work. It is also built on hope, that as Aboriginal People who have endured so much, our spirit and determination remains strong. It is this fact that will allow Aboriginal Cultures and Traditions to meet the challenges head on.

Achieving Holistic Health

Determinants of health which are factors known to affect or influence a persons health, can be either negative or positive. Negative determinants can be such things as living in poverty, having inadequate or no housing, as well as childhood traumas that remain unresolved. Positive determinants can be getting higher education, having stable home environments, or strong cultural connections. Generally, the main factor affecting the health of Aboriginal people is socio-economic status, in addition to environmental factors. Many Aboriginal people experience higher rates of disease and extensive health issues, mainly because these social determinants of health are much lower for far too many Aboriginal people.

When there are too many negative determinants in a person's life, the risks for HIV/AIDS and other diseases increase. Aboriginal communities have experienced major negative forces, like the Residential School Legacy. While Aboriginal people's experiences are not all the same, there are some common issues, such as: a loss of language, culture, and traditional use of land. As well, systemic discrimination; gender inequality and displaced roles; are just some of the other forces that have shook the foundations that Aboriginal cultures once thrived upon. It is easy to see how many of these underlying issues can complicate intervention strategies. For many Aboriginal people, achieving holistic health after generations of trauma and losses, is necessary to rebuilding our societies and in order for our health conditions to improve, including removing much of the risk for HIV and AIDS. Holistic health is about finding balance emotionally, physically, spiritually, and mentally.

Northern and isolated communities face challenges brought on simply by their geographic location, such as access to adequate resources and health systems. Language can also be a factor when an indigenous language is mostly spoken such as Inuktitut, Slavey, or Cree, while many of the resources are printed in English and/or French. Few hospitals or clinics offer services in indigenous languages, or provide interpreters who can. The ASHAC recognizes that HIV/AIDS is one of the many health and social challenges facing Aboriginal people today. The need for an Aboriginal Strategy is largely based on the information in the next section, as well as what has been echoed by Aboriginal HIV/AIDS advocates in the last ten years or so.

3.0 HIV/AIDS Among the Aboriginal Populations

Although there are numerous gaps in research and surveillance data, there have been improvements in trying to gauge more accurately how HIV/AIDS is truly impacting the Aboriginal populations. One reason for the inaccurate picture is that some provinces, like Ontario, do not collect ethnic identifiers making it hard to determine how many new infections and cumulative cases exist. In other areas, the physician or testing site may not ask or accurately determine if a patient is Aboriginal, simply because they may be fair-skinned or could resemble another ethnic group. Although the statistics presented here are significant, HIV trends may differ from region to region and community to community, as well as between Inuit, Métis and First Nations. In fact, some groups have different risk factors as the main methods of HIV transmission for them.

While some people feel statistics soon become outdated, or can present an inaccurate picture of how HIV/AIDS is affecting specific groups, there is value to seeing how figures have been increasing. It is important to locate information that is more relevant to one's own community or region. This disease continues to infect and affect high numbers of Aboriginal people.

The figures below come from a number of studies, and may not best describe regional variations, or those between Inuit, Métis, and the various First Nations. However, as many Aboriginal people experience similar socio-economic issues, some of what is stated below may

describe the potential behind how this disease may continue to unfold. In essence, these figures describe only part of the situation, and not the whole picture.

HIV Figures:

From **1996 to 1999**, there was:

- an estimated 91% (ninety-one) increase (from 1,430 to **2,740**) in the number of Aboriginal people living with HIV;
- an estimated 19% (nineteen) increase (from 310 to **370** infections) in the number of Aboriginal people newly infected with HIV.

Of the estimated **2,740** Aboriginal people living with HIV infection at the end of 1999, their risk factors for HIV infection were:

- 54% through injection drug use;
- 15% through heterosexual sex;
- 23% through male-to-male sexual activity;
- 6% through male-to-male sexual activity and injection drug use.

Among this estimate of **370** Aboriginal people newly infected with HIV, their risk factors



for HIV infection were:

- 64% through injection drug use;
- 17% through heterosexual sex;
- 11% through male-to-male sexual activity;
- 8% through male-to-male sexual activity and injection drug use.³

AIDS Figures:

“As of December 31, 2001, there has been 18,026 AIDS cases reported to the Centre for Infectious Disease Prevention and Control in Canada. Of that total, 437 were reported as Aboriginal persons (17 Inuit, 34 Métis, 354 Native Indians (i.e. First Nations) and 32 Aboriginal unspecified).”⁴

As can be seen, unprotected sex and injection drug use are playing key roles in the transmission of HIV/AIDS among many Aboriginal people - regardless of residency, ethnicity, or sexual orientation. It is no longer just a gay disease.

³Centre for Infectious Disease Prevention and Control, Health Canada, HIV and Aboriginal People in Canada: A Report on the Estimated Number of HIV Infections Among Aboriginal People in Canada. Prepared by the Focus Group on Aboriginal HIV Estimates and Bureau of HIV/AIDS, STD and TB, May 2001.

⁴HIV/AIDS Epi Update, Centre for Infectious Disease Prevention and Control, Health Canada. April 2002

4.0 Canada's Strategy on HIV/AIDS (CSHA)

The Canadian Strategy on HIV/AIDS (CSHA) has been designed to continue efforts on this serious health issue. The CSHA has six goals and the ASHAC will work within these through the measurable objectives and expected outcomes later presented under nine key areas. Obviously, some of the following CSHA goals will not be the primary responsibility of the ASHAC, such as finding a cure or finding effective vaccines, drugs and therapies. Certainly Aboriginal people can participate in medical research, including clinical trials, however it is unlikely that Aboriginal HIV/AIDS resources would be devoted to these areas. Traditional medicines also require recognition, since some people choose to pursue this approach to treating their illness.

The six goals of the CSHA are:

- to prevent the spread of HIV infection in Canada;
- to find a cure;
- to find effective vaccines, drugs and therapies;
- to ensure effective care, treatment and support for Canadians living with HIV/AIDS, and for their families, friends and caregivers;
- to minimize the impact of HIV/AIDS on individuals and communities; and
- to counter the social and economic factors that increase individual and collective risk of HIV infection.

Within the CSHA, and in light of more than two decades that this disease has been in North America, a lot of work has been done. How-

ever, much more needs to be done among the Aboriginal populations to prevent the needless loss of lives, to properly care and support those now living with the disease and to meet the prevention challenges related to HIV/AIDS and other illnesses like Hepatitis C.

In order for this to happen, Aboriginal and non-Aboriginal stakeholders and governments must take collaborative efforts that will ensure this health issue is met with all the resources it requires so that Aboriginal people living with and affected by HIV/AIDS are not alone.



5.0 Nine Key Strategic Areas

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

- 1 Coordination and Technical Support;
- 2 Community Development, Capacity Building and Training;
- 3 Prevention and Education;
- 4 Sustainability, Partnerships and Collaboration;
- 5 Legal, Ethical and Human Rights Issues;
- 6 Engaging Aboriginal Groups with Specific Needs;
- 7 Supporting Broad-based Harm Reduction Approaches;
- 8 Holistic Care, Treatment and Support; and
- 9 Research and Evaluation.

Each of these strategic areas will be introduced, and described more fully with a rationale, objectives and expected outcomes. Before doing so, a message to Aboriginal Leaders is provided.

ABORIGINAL LEADERSHIP

Elected Aboriginal Leaders as a group, are no more at risk than whatever their sexual orientation, gender, or risk behaviors may be. They are listed here as a group that requires education about all the aspects involved in HIV and AIDS. Whether at the community level, through regional bodies or the national scene, greater work is required to ensure that HIV/AIDS stays on the agenda of political organizations. These types of partnerships can lead to a stronger voice. Likewise, engaging Aboriginal Leaders so that community-



based staff get the direction and support they need to develop programs and services is critical to fighting this battle.

There is a critical role that Aboriginal Leaders can play in each of these strategic areas and in the overall struggle to overcome all the challenges that come with HIV/AIDS. Aboriginal Leaders need to speak publicly about HIV/AIDS so that Aboriginal communities hear their Leaders talking about these issues and begin to take it more seriously. A few examples for Aboriginal Leaders can be: negotiating Health Transfer agreements which include adequate HIV/AIDS programming needs; passing Band/Hamlet/Settlement Council Resolutions to ensure that Aboriginal People living with HIV/AIDS in their communities are not discriminated against; supporting lobbying efforts to ensure that adequate funding is available to combat this health concern; and simply learning enough about this disease so that it gets the proper attention and any misconceptions can be removed.

COORDINATION AND TECHNICAL SUPPORT

Coordination and technical support will be carried out by the Strategy Coordinator and will focus on linking Provincial/Territorial/Local levels up to the national level. As the HIV/AIDS epidemic changes, coordination and technical support will respond accordingly. Understanding the Canadian and Provincial/Ter-

territorial Aboriginal HIV/AIDS strategies is key to the success of the ASHAC and is the basis for forming partnerships and supporting local initiatives.

The ASHAC is viewed as a parallel approach within the CSHA. The process will be dynamic with information coordinated at the national level, and local experiences relayed up to the national level. This creates an "Information Clearinghouse" for which coordinated efforts can support regional funding initiatives and program development needs.

This process will also result in the development of new materials, up to date data reflecting the health needs of Aboriginal People, and a leadership role for the strategy to be a supportive document that will tie in to the NACHA and other key stakeholders. There can also be a role for ASHAC and CAAN to lobby for increased attention to Aboriginal HIV/AIDS issues, or to advocate on certain issues that APHAs may be experiencing, such as those with Child Tax Credits, or treatment issues.

Rationale:

Central coordination and ongoing technical and human support are available to support regional/local HIV/AIDS efforts, while influencing related agencies/governments/funding sources to be responsive in various areas listed throughout this document.

Objectives:

- to ensure central coordination is available to Aboriginal People so that regional/local trends and issues are known at the national level

- to utilize various communication methods to ensure timely and accurate information flow to/from national level
- to identify and provide advocacy, which is to represent issues and influence outcomes, and support regional/local levels in order to share information and learn from varied experiences
- to provide technical support to assist, when requested, in the development of regional strategies, networks, protocols, frameworks, proposal writing, etc.
- to engage mechanisms for effective collaboration and partnership development to support regional and local efforts, including advocating for appropriate Federal/Provincial/Territorial responses in critical areas
- to create and/or update a directory of Aboriginal-specific HIV/AIDS resources and services
- to conduct ongoing evaluation of the ASHAC.

Expected Outcomes:

- strengthened network
- increased awareness among Aboriginal Communities of existing resources
- effective communication system
- increased recognition of barriers to overcome regarding mainstream communication systems, including internet
- increased advocacy effectiveness
- improved communication and dialogue
- increased response time for appropriate actions
- enhanced organization at various levels
- shared expertise

- newly developed initiatives at the regional/local levels
- improved cross-jurisdictional communication/action
- improved knowledge of resources and services
- increased accountability
- efficient local and regional input into national efforts

COMMUNITY DEVELOPMENT, CAPACITY BUILDING AND TRAINING

Community development, capacity building and training are key to the success of the ASHAC, as well as the Aboriginal HIV/AIDS movement in Canada. Capacity building can include informal learning, whereas training generally (not always) involves more formal learning environments. In large part, Aboriginal communities are doubly burdened, both with the challenge of playing catch up to the rest of Canada in regard to HIV/AIDS, but also because significant social, economic and other health issues continue to exhaust resources.

Greater efforts are required to plan, design, create and support implementation and/or adoption of preferred practices to ensure the best possible use of both human and financial resources. It is also critical to understand that Aboriginal communities have generations of negative impacts from failed government policy such as Residential Schools and assimilation in general. These have contributed directly and indirectly, to the multitude of underlying issues that Aboriginal people experience.

Rationale:

Resources, including human, financial, informational and others, are available to Aboriginal communities for capacity building and sustained effective responses to HIV/AIDS.

Objectives:

- to provide accurate and timely information which can increase capacity to respond
- to collaborate where possible and necessary to ensure human and financial resources are obtained
- to recruit, retain, support and enhance more human resources by working through Universities and Colleges, high school graduates, etc
- to support the creation and adoption of preferred practices, including minimal two-year project initiatives as the optimal length for resource development and focus testing
- to secure resources and support the design and delivery of training packages to gain more qualified human resources to work in this health field, including certification processes, in-service training opportunities and other professional development
- to encourage the establishment of inter-agency, rural and system response teams or community wellness teams
- to assist in development of policy, through meaningful public participation.

Expected Outcomes:

- skilled, knowledgeable workers
- accurately informed workers
- mobilized communities
- cross-jurisdictional support

- matured and nurtured workforce with expanded expertise
- expanded workforce opportunities gained through individuals in advanced learning environments
- appropriate, culturally designed resources
- increased effectiveness in design and implementation
- enhanced staff and agencies
- expanded workforce
- appropriately delivered staff/board orientation
- effective mechanisms at the local level
- cross-jurisdictional collaboration
- strengthened ties and communities
- increased understanding and community support
- effective public policy

PREVENTION AND EDUCATION

Because HIV/AIDS is a preventable disease, significant energy and resources are required to ensure that accurate and timely information is being delivered. There is also a need to ensure that targeted messages are designed, created and implemented which look at specific high-risk activities, such as injection drug use or unprotected sex. All this must be done within the context of the community and environment where prevention and education are being delivered and in proactive ways. The use of Aboriginal languages and other culturally appropriate means, are also needed and necessary. Inmate populations, street-involved people, youth, and others all require appropriate interventions. More information is available in the section on Diverse Groups - Many Needs, on some of the key issues facing specific groups.

Rationale:

Increased focus is directed toward prevention and education efforts, especially targeted prevention messages to curb increases in HIV/AIDS.

Objectives:

- to examine and enhance current prevention efforts by convening a national meeting of Aboriginal HIV/AIDS educators to review and revise current tools and methods being utilized, and recommend new approaches
- to create implementation strategies for hard-to-reach target groups which require a specialized focus
- to proclaim and promote adoption by Aboriginal communities for a national Aboriginal HIV/AIDS Awareness Week with new promotional methods and resources to be developed
- to assist in the development and utilization of evaluation tools and methods
- to collaborate with related agencies and services to ensure appropriate means and efforts are secured
- to design and deliver age appropriate prevention messages starting at minimum, grade 5.
- to develop, where appropriate, additional prevention and education resources to respond to any existing gaps or future needs.
- to examine and develop appropriate initiatives to address mother-to-child HIV transmission.

Expected Outcomes:

- enhanced prevention and education messages/approaches

- expanded, working knowledge of broad and targeted deliveries
- increased and updated resources
- formalized, appropriate and current education messages
- increased awareness of issues facing hard-to-reach groups
- increased collaboration with shared expertise
- shared knowledge of current trends and emerging issues
- enhanced awareness campaigns
- mobilized regions and communities
- broadened support through more knowledgeable communities
- effective delivery and refined approaches
- appropriately developed and maintained programs
- broadened awareness and support
- cross-jurisdictional approaches
- better informed children and youth
- healthier life approaches to sex and sexuality, alcohol and drug use, and other related issues
- enhanced and relevant educational delivery
- up-to-date information delivery
- enhanced and relevant educational delivery

informed and appropriate treatment choices

SUSTAINABILITY, PARTNERSHIPS AND COLLABORATION

Sustainability is about designing comprehensive efforts that can ensure HIV/AIDS work gets incorporated into all relevant services and agencies. In this way, the necessary response can be formed and maintained because clearly, HIV/AIDS is affecting Aborigi-

nal People at alarming rates. People who work in the HIV/AIDS field are required to be knowledgeable of numerous areas and issues. Sexual health, sex education, addictions, opportunistic infections, medications including drug resistance and negative interactions, psycho-social issues including home or palliative care and holistic support, are all issues that come to play. There is greater need to broaden our reach, so that related issues and initiatives can partner and collaborate so that this work is sustainable or lasting. Sustainability rests on how well efforts can influence and create positive outcomes. It is important to avoid a competition mind set between groups doing HIV/AIDS work. This is especially true since there are few human and financial resources available. Also, some people do not see government staff as partners, yet there is value for both stakeholders to find mutual ways of furthering the HIV/AIDS agenda.

Rationale:

Broader partnerships and collaborative efforts are created and maintained to widen the reach of interventions around HIV/AIDS and related issues.

Objectives:

- to identify, consult and develop effective partnerships and collaboration (Alternative Justice, NNADAPP, Education, Health, Homecare, CATIE, CAS, CSC, ANAC, etc.)
- to engage in an annual Stakeholders* Consultation process to present and review progress and set upcoming and ongoing targets
- to identify and survey key stakeholders on needs, issues and barriers encountered in the design and implementa-

* see definition and list of stakeholders in Appendix C

- tion of HIV/AIDS programs and services within their structures
- to support and utilize where appropriate, cross-cultural sensitivity training for non-Aboriginal workers/agencies who work with Aboriginal people
- to identify and support means to collaborate with Hepatitis C groups who address similar issues, which can include dual-infection with HIV
- to advocate for greater transparency with governmental stakeholders, (e.g. Correctional Service Canada, etc.)
- to insist government departments engage Aboriginal input regarding decisions affecting policy and programs related to HIV/AIDS and determinants of health.

Expected Outcomes:

- strengthened ties
- increased effective programs and services
- shared expertise accessed in an ongoing manner
- collaboratively designed initiatives and integrated services
- increased accountability and effective mechanisms to evaluate the ASHAC collective response processes
- effective mechanisms to collect and analyze regional/local trends, issues and priorities
- increased and coordinated support and technical services
- increased awareness, shared information and broadened reach
- increased access to current and relevant resources
- shared best practices and lessons learned

- improved and maintained communication
- increased understanding of Aboriginal cultural norms
- enhanced service delivery
- increased effectiveness behind partnerships
- shared partnership roles
- improved governmental/community relationship
- accountability

LEGAL, ETHICAL, AND HUMAN RIGHTS ISSUES

HIV/AIDS is still largely misunderstood which often results in fear and other reactions which contribute to the alienation felt by those living with and affected by this disease. In some cases, people living with this illness are wrongly discriminated against, such as not having their confidentiality respected or not being offered employment, just because they have HIV. Fear is a powerful obstacle, yet the key behind ensuring individual human rights are respected, is to remove fear by education and awareness. It is also important to recognize that Aboriginal People living with HIV/AIDS are our relatives. They can be our brother, sister, uncle, aunt, mother, father, child, or cousin.

Reports exist from HIV/AIDS advocates that tell of HIV positive individuals not being welcomed in their community. Likewise, non-Aboriginal service providers may also overlook basic client rights, either through ignorance or indifference. Specific work must be done to ensure less of these types of violations occur. Tools need to be developed and supported, so that Aboriginal communities can

better understand and be trained in what is involved when respecting and protecting individual rights, including such things as Labor Codes, and various resolution processes.

Rationale:

Address discrimination and ensure human rights and other legal, ethical issues are respected and adopted within Aboriginal communities and by non-Aboriginal service providers.

Objectives:

- to inform, educate, promote and support the rights of Aboriginal People living with HIV/AIDS within existing local/regional structures, both Aboriginal and non-Aboriginal
- to discuss stigma and other types of discrimination at all levels
- to collaborate with related agencies/services (EGALE, CHALN, Canadian/regional Human Rights Commissions, etc.) to create more supportive, knowledgeable and caring environments for Aboriginal People living with HIV/AIDS based upon Traditional & Cultural practices/teachings
- to plan, design, create and strengthen advocacy efforts by collaborating with currently funded initiatives, agencies and services, which can support and educate communities to resolve and avoid human rights violations and ensure confidentiality
- to support, via policy templates Band/Hamlet/Settlement Council resolutions of respect
- to define areas of concern and systemic discrimination, and to meaningfully engage Aboriginal people in removing

or minimizing impacts felt from policy and program guidelines which differentiate groups based on ethnicity or risk behaviors

Expected Outcomes:

- increased knowledge and respect for individual rights and responsibilities
- informed APHAs of their rights, including avenues and tools to handle grievances
- better informed communities, agencies/services for APHAs
- adopted and implemented protocols
- increased awareness, sensitivity and response to APHA needs, issues and concerns
- more informed and culturally sensitive non-Aboriginal operated services/agencies
- increased action to protect and respect the rights of APHAs, including family members and partners needs
- increased knowledge and capacity to intervene in human rights violations, and other legal, ethical issues
- increased support and protection of human rights and other legal, ethical issues
- increased understanding of concepts and impacts of stigma and various forms of discrimination
- removed and/or minimized impacts felt from such occurrences

ENGAGING ABORIGINAL GROUPS WITH SPECIFIC NEEDS

HIV/AIDS affects just about every group in Canada and it matters little what your ethnic roots are, how much money you have, or where

you live. Although Inuit, Métis and First Nations people have things in common, such as assimilation, there are significant differences as well. A wide range of languages, values, customs and beliefs exist, not to mention hundreds of years of disruptive influences. Numerous illnesses are among these influences, starting with measles and tuberculosis to now HIV/AIDS.

Even within Aboriginal populations there are certain risk activities and issues that can contribute to how wide HIV/AIDS can impact a group. Injection drug use is one, unprotected sex is another, and for some people who find themselves marginalized, or feel apart or isolated from their community - their circumstances can mean the difference between knowing and understanding the risks they may face. The purpose here is when working with specific groups, it is best to meaningfully engage members from these groups in all aspects of how a program or service can best meet their needs. Cross-cultural training, increasing awareness among service providers, and respecting individual choices are some examples where work is needed. As well, increasing Aboriginal participation in HIV/AIDS program planning, implementation and evaluation is another area.

The issues around mental health and disabilities can also be an important issue to address. Various players, such as Fetal Alcohol programs, Public Health and other agencies can be brought in to build effective approaches. Community Health Workers are also a target group to assist in this approach. **Please review the section, "Diverse Groups - Many Needs" for more specific information regarding various issues.**

Rationale:

Aboriginal people who come from groups with specific needs are engaged and supported to help design appropriate and relevant initiatives that will target these needs (i.e. injection drug users, inmate populations, two-spirited people, women, HIV+ children, families, etc.)

Objectives:

- to examine and enhance current prevention efforts by convening a meeting of Correctional Elders, Halfway Houses, Alternative Justice, Healing Lodges, etc. to discuss and develop an action plan and increase advocacy role
- to support implementation and timely follow-up on the Circles of Knowledge Keepers manual, and expand training and delivery to include Halfway Houses, Healing Lodges, etc. in an effort to create a solid base of prevention and support workers
- to recruit Knowledge Keepers where possible and when willing, to deliver prevention efforts for hard-to-reach populations at the local level
- to create a National Aboriginal Task Force on Substance Use (Treatment Centers, Prevention Workers, Harm Reduction programs, Street-Outreach services, HIV/AIDS Organizations, APHAs, etc.)
- to encourage and support development of appropriate programs and services (direct and non-direct) for specific groups (e.g. two-spirited people, women, men, children, youth, family members, partners, etc.) on specific risk activities
- to ensure Aboriginal women are provided access to current and accurate

information and support regarding testing, prevention, sexual assault issues, choices and treatment options around pregnancy and HIV/AIDS to address peri-natal HIV and HCV transmission, as well as female-specific research on care and treatment issues, which is both culture and gender specific

- to continue to examine and respond to specific issues related to the role of unprotected sex in the spread of HIV/AIDS within all groups
- to ensure an increase in youth-specific efforts are designed to provide access to current and accurate information and support regarding testing and prevention, as well as care and treatment needs
- to increase knowledge and education on Inter-sexed and transgendered issues/needs regarding HIV/AIDS and related issues
- to expand efforts that respond to issues facing Aboriginal men in regards to HIV/AIDS and related issues
- to continue and expand efforts that respond to issues facing Two-Spirited people in regards to HIV/AIDS and related issues
- to recognize, design and implement efforts that address needs and issues, within a "family-based" cultural context, and in consideration of impacts on Support and Prevention Workers in the HIV/AIDS field
- to recognize unique and special needs and challenges in terms of mental health issues, and developmental learning issues, including Fetal Alco-

hol Spectrum Disorder, Attention Deficit Disorder, among others.

Expected Outcomes:

- collaboratively developed action plan
- increased knowledge and awareness
- enhanced prevention and support efforts
- increased number of human resources
- enhanced programs and services
- mobilized efforts
- collaboratively developed initiatives
- focused efforts and interventions
- updated responses to new trends and issues facing Aboriginal women
- effectively planned initiatives
- updated responses to new trends and issues
- updated responses to new trends and issues facing Aboriginal youth
- increased understanding
- improved support
- increased effectiveness behind targeted messages
- improved interventions
- increased understanding and respect for family-based concept
- effective targeted prevention
- improved interventions

SUPPORTING BROAD-BASED HARM REDUCTION APPROACHES

Harm reduction can also be known as risk management, risk reduction, and harm minimization. Harm reduction is based largely in recognizing that some individuals, for whatever reason, may not be ready, willing or able to completely change behaviors which may pose risks to their health. The clearest example in regards to HIV comes from the risks associated with sharing injection needles.

Responses to reduce the risk have included needle exchanges, condoms, education, and methadone to name a few. In this way, a person is not required to abstain from drug use, and the focus becomes one of educating and supporting this person to make changes to reduce risks for HIV or Hepatitis C for example.

The term "broad-based" is meant to respect communities where they are at, for example, needle exchanges or methadone maintenance programs may not be what the community wants to implement. Broad-based implies that as a principle, most communities likely support reducing harm, yet require the autonomy to develop approaches that fit their needs and circumstances.

The challenge is that for many Aboriginal Customs and Traditions generally require abstinence or freedom from mind and mood altering drugs. Likewise, almost all Aboriginal addictions programs and treatment centers operate under abstinence philosophies. There is room for educating relevant agencies, and better defining harm reduction so that greater efforts are placed to overcome how addictions or substance use relate to HIV/AIDS, including offering sensitized treatment services for HIV positive clients, including those who may be on methadone maintenance.

Harm reduction and abstinence based philosophies are not in conflict with each other - they both support similar goals for the individual while using different ways to reach that goal - which is no harm, and when that is not possible, reducing the harm. Harm reduction efforts ought to also include efforts to support individuals to realize a different lifestyle. In

many cases, basic life skills and issues around healthy sexuality need to be taught and important to consider for all strategic areas. Aboriginal people who have been caught up in the world of injection drug use need support, not only in terms of treatment options, but also training to pursue other life opportunities such as employment, and to have access to Traditional Elders and spiritual support, when requested.

In addition to injectable drugs, are other substances and alcohol. The role of addictions in many Aboriginal communities is a serious one. The byproduct is social isolation, which can lead to increase risk taking. Issues of self-esteem and self-image can also contribute to why some individuals engage in risk behaviors, even when they may know the risks for such things as HIV and Hepatitis.

Rationale:

Health promotion and harm reduction models can assist in the prevention of HIV/AIDS and Hepatitis C and must be better defined and encouraged as one means to reach specific groups/risk activities.

Objectives:

- to define, educate and support implementation of harm reduction messages which acknowledge and respect regional/local beliefs and choices, as well as varieties of methods that can be used and is based on what will work in any given locale
- to collaborate with existing harm reduction agencies and services
- to examine, define, design and support greater use of social marketing ap-

proaches which acknowledges diversity and need to be culturally appropriate

- to recognize the link between achieving holistic health, as it relates to intervening in the spread of HIV/AIDS
- to support and recognize the importance of community-based efforts and staff who are aware of local issues and approaches, including community norms and methods for information sharing

Expected Outcomes:

- enhanced prevention efforts
- increased awareness, knowledge and use of harm reduction messages that fit the community
- increased understanding (not just receiving) of messages being delivered
- shared expertise
- improved cross-cultural relations and culturally sensitive programs and services
- increased, targeted messages
- increased planning and design of prevention and education
- increased understanding for the role of personal histories and unresolved trauma in interventions
- increased understanding of multi-risk groups
- increased understanding for the role of local dynamics, belief systems, and practices

HOLISTIC CARE, TREATMENT AND SUPPORT

Each of these three areas require more examination. Care issues can range from homecare to palliative care. Treatment may

involve a persons choice to not take anti-retroviral medications to combining Traditional medicine with Western. Support can start with a parent showing love to their Two-Spirited child or from a friend talking with someone about when and why they may want to be tested for HIV. As this illness continues to show itself, Aboriginal communities are also becoming more and more affected.

For each Aboriginal person living with HIV/AIDS, there is a whole family and community that is affected. Partners, children, parents, and even those who work in this health field have grief and loss issues that require support. From HIV positive mothers who need to plan for who will take care of their children when they go to the next world, or for same-sex partners who have to fight for surviving spousal benefits, there is a wide range of needs that require continued efforts that are culturally appropriate. Funding sources are an issue in terms of ensuring appropriate programs, services and training is available. Remote or isolated communities also are faced with access, medical staffing issues, and the added burden of medical transportation costs to urban facilities.

There are also issues around mental health, disabilities such as deafness, or a wide range of developmental learning issues, such as with Fetal Alcohol Spectrum Disorder (FASD), Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD). New policies need to be developed, and in some cases, support to implement them properly is also important. Efforts to support compassionate leave so a caregiver can support an ailing partner or family member is also needed. Creating more supportive environ-

ments is key. Co-infections with either hepatitis or tuberculosis are also areas that need attention. For some, reductions in Non-Insured Health Benefits are creating hardships and require advocacy work.

Rationale:

Holistic Care, Treatment and Support options are available to address issues facing Aboriginal People living with HIV/AIDS and their support systems, through culturally appropriate means. Access and availability are linked to related efforts, such as the Homecare initiative and others.

Objectives:

- to expand knowledge and capacity to related services to increase trained workers who can provide culturally appropriate services and utilize holistic approaches
- to collaborate with existing agencies (CTAC, etc.) using existing or newly designed care models to develop culturally sensitive approaches
- to support initiatives for Aboriginal women or families who have HIV positive children
- to examine issues related to treatment in terms adherence to drug protocols, and faster access to improved and new medications
- to support creation of more supportive and responsive environments to ensure Aboriginal People living with HIV/AIDS are welcomed into their home communities without fear of discrimination or isolation
- to support and train caregivers and where appropriate, family members in understanding all aspects of care,

treatment and support, including palliative care needs

- to design or create, encourage and support adoption of appropriate preferred practices within a cultural and local context
- to examine and design responses to privacy issues, confidentiality, access, transportation costs, community planning needs, etc. in order to define preferred practices

Expected Outcomes:

- expanded knowledge and capacity to provide culturally appropriate services
- increased number of trained, skilled workers
- shared expertise
- enhanced initiatives
- improved and/or introduced appropriate care and support
- improved knowledge and skills among APHAs and Treatment Workers
- increased access to clinical trials
- increased education and policy development on treatment issues
- enhanced knowledge and capacity to provide culturally appropriate support services
- increased understanding of the role of personal histories and unresolved trauma in support services
- increased understanding of the various stages of HIV infection
- decreased isolation for caregivers and APHAs
- improved care, treatment and support developed and adopted/recognized preferred practices
- skilled, trained caregivers

- enhanced knowledge and capacity to provide culturally appropriate support services

RESEARCH AND EVALUATION

It has been often said that Aboriginal people have been researched to death and the time is here to research us back to life. The time is long overdue for Aboriginal people themselves to use research as a tool for designing efforts that can support greater opportunities to collect and analyze data, so as to respond appropriately and effectively. There remains a need to train and increase the number of Aboriginal researchers.

For those who now are working in this field, there is room for expanding their knowledge of HIV/AIDS. A number of efforts are now being placed, and the ASHAC can be a tool to engage these efforts so that more research is undertaken within the OCAP (ownership, control, access and possession) philosophy. There are issues around intellectual property rights, as pharmaceutical companies are claiming ownership of many Traditional Aboriginal medicines. There is opportunity to partner with newly formed Aboriginal research entities, such as the Institute of Aboriginal Peoples Health, National Aboriginal Health Organization, and the ACADRE (Aboriginal Capacity and Developmental Research Environments) Centers being funded across the country. The Regional First Nations and Inuit Health Surveys is another resource.

Rationale:

Expand capacity and build coalitions to create a solid base of Aboriginal researchers who can examine critical areas in terms of preven-

tion and medical advancements as they relate to Aboriginal populations.

Objectives:

- to promote and expand the Aboriginal Capacity Building project on Community Based Research to train more Aboriginal students
- to collaborate with existing Aboriginal researchers to collect accurate data on HIV/AIDS and related issues respecting an OCAP philosophy in all areas
- to support the creation of Aboriginal Ethics Review Boards
- to recruit Aboriginal researchers and expand existing Ethics Review Boards to include Aboriginal people in the peer review process, respecting an OCAP philosophy
- to set targets of specific research initiatives that can increase the availability of accurate data which can reveal current trends, in relation to prevention efforts
- to support national research initiatives, which can reflect and respond to regional disparities
- to support research and evaluation which can be better used to address issues raised at the community level
- to implement and support use of various evaluation techniques to ensure efficient use of resources

Expected Outcomes:

- more trained, experienced Aboriginal research students
- increased knowledge and understanding of HIV/AIDS and related issues
- enhanced interventions

- enhanced, appropriate peer review systems
- expanded efforts to conduct OCAP Aboriginal research initiatives
- collected and analyzed current data to better identify issues and trends
- improved program design and accountability outcomes

6.0 Diverse Groups, Many Needs

While all Aboriginal populations may be deemed "vulnerable", there are diverse groups within our populations with different needs. This section is not about isolating any one group and leaving out others. It is more about educating what some of these needs or issues may be. Whether based on ethnicity (Inuit, Métis or First Nations), geographic location, social isolation, language, risk behavior(s) or a combination of these, the purpose here is to provide a general understanding of some of the issues. We know that certain behaviors have higher risks than others - injection drug use, specifically sharing used needles is one in particular.

First Nations, Inuit and Métis People have long histories on this continent, as well as vibrant cultures. Many of the traditional teachings, however unique to each group, can be the basis to recover the strengths once common in Aboriginal communities. These strengths and values, included a respect for the land and for all life. Aboriginal people can be called family-based cultures, because of the role and importance of extended family systems. Diversity among many groups, was also seen as having purpose and place, generally speaking. If a child was born different, many Aboriginal cultures saw that as happening for a reason. Spirituality, was a central approach largely based on respecting life and demonstrating thankfulness for what blessings the Creator provided. These same cultural values can be the basis for responding to HIV and AIDS, in ways that utilize traditional teachings.



In terms of HIV/AIDS, two key barriers continue in varying degrees, to hinder prevention efforts. These barriers are that HIV/AIDS is seen by some as: 1) a gay disease; and, 2) HIV/AIDS is only in the cities. However, the evidence provided in section three disputes these myths. There is also a "perceived" responsibility or blame assignment suggesting fault for people who become HIV positive, whereas there may be sympathy for those who did nothing to become HIV positive, such as children.

This section is about introducing the diversity that exists among Aboriginal populations. It will describe some key risk behaviors within certain key groups or provide specific needs where risk behaviors are not the issue (as with children). As stated earlier, the determinants of health for Aboriginal people are much lower than the rest of Canada. One needs only to visit Statistics Canada's website to determine socio-economic status facing Aboriginal people. Issues like poverty, lower education levels for some, and personal histories all contribute to how we address HIV and AIDS. Again, some Aboriginal people may need basic life skills, because they have missed out on many essential learning experiences vital to achieving and maintaining strong, healthy and fulfilling lives.

The reality is that HIV/AIDS can and does infect and affect Aboriginal people\from all walks of life, all ages, regardless of whether they are Inuit, Métis or First Nations or where they reside.

Aboriginal Women

The role of Aboriginal women as caregivers and lifegivers is common among all Aboriginal cultures. As was noted in section 3, there is also a significant number of HIV infections occurring for women. There are more Aboriginal women becoming infected, especially when compared to infection rates for non-Aboriginal women, which is a cause for great concern. Family violence may be one factor, but unprotected sex and having a partner who is an injection drug user plays a greater role. More Aboriginal women also engage in injection drug use as well.

The result is both partners may become HIV positive and if a pregnancy occurs, then there have also been cases where the child too became HIV positive. Aboriginal women who are HIV positive and choose to give birth to children can experience reactions that are often discriminatory and offensive. Family planning, may become more of a focus on condom use or birth control, instead of the present child care needs or those that arise when one or both partners loses their battle with AIDS. Poverty and discrimination can also factor in, making the delivery of sexual health messages much harder to have impact that translates into behavior change. Many Aboriginal women place other peoples needs first, as part of their caregiver role, but also for unhealthy reasons, such as low self-esteem. The Residential School Legacy (outlined later on), is being seen more as a significant negative force that has battered a persons psyche, spirit, and making them exposed to sexual assault and other acts of violence, because of feelings of low self-worth.

Aboriginal women have yet to be more widely encouraged for voluntary HIV testing during prenatal visits. In Alberta for instance, since May 1998, all pregnant women are tested for HIV during prenatal screening unless they opt out. In these cases, improved pre and post test counseling must occur as some women do not understand they are being tested or that they can opt out. There are HIV positive women who want to have children, yet it is still largely unknown what effect medications have when taken during pregnancy. While it is believed to greatly reduce risks for the infant to become HIV positive, issues of access to medications, prenatal care, and compliance become factors. Many people think the fetus is more important than the woman, while others see both fetus and woman as being equally important. It is important to see both the woman's choice over what they ingest, and their choice over what happens to their body. The need is one of building up respect and honor for women, and supporting them in whatever decision they make, including pregnancy terminations if that is their informed choice. Empowerment to help make difficult life decisions is a key requirement.

Ongoing attention needs to be given to prevent mother-to-child transmission of HIV. Working with health professionals and Aboriginal Women's groups, efforts need to take place to examine this area more closely and identify multi-pronged approaches to educate around mother-to-child HIV transmission, and prevent future infections. There are also issues for breast-feeding when a woman is HIV positive, which needs to have proper attention.

Aboriginal Children

Some children born to HIV positive Moms also become HIV positive. For those who live in poor and unstable homes, finding the proper support is a difficult task whether the child is HIV positive or not. Other parents may react with fear and not want children to be in the same daycare or school with an HIV positive child.

Healthy sexuality education and the prevention of sexual abuse, nutrition and stable environments are key areas to help raise healthy children and to increase their chances of living a full and happy life. It is also useful to look at games that some children play, such as "bloody knuckles" or similar games where blood and broken skin are key parts of the game. There is a need to begin HIV/AIDS education as early as grade 5. Hopefully, this long-term preventative approach can assist Aboriginal children to understand the disease and make healthier choices about when and how to become sexually active, and to understand the risks behind alcohol and substance abuse.

Where dysfunctional issues, such as family violence, addictions, mental health issues, etc. are present with the parent(s), then children too may experience difficulty in understanding boundaries and/or need behavior management. Lack of environmental stimulation at home may also be a concern and impact future learning for these children. Early interventions and understanding developmental milestones is critical to alleviating the affects of developmental delays, Attention Deficit Hyperactivity Disorder (ADHD), Fetal Alcohol Spectrum Disorder (FASD formally known as FAS/E) and other learning disabili-

ties and developmental disorders pose challenges for life success.

Students with learning disabilities and developmental disorders need a wide range of teaching methods in order to learn the need to use safer sex or to practice other personal safety behaviors. Headstart, Brighter Futures and Building Healthy Communities are some of the partnerships that can be developed to ensure our children have the best chances possible. There can also be Provincial resources such as NB's Chit Chat Program and Ontario's Preschool Initiative that can be accessed to support children and families with developmental issues. Some parent support programs also provide developmental support in a culturally meaningful context, for example, the Hanen Center in Toronto also offers parenting training from a First Nations perspective. Early intervention and a family centered approach leads to healthy development of all children.

There is also the issue of orphaned children, who lose their parent(s) to AIDS. The added burden and concern of preparing for your children, after a parent(s) loses the battle with AIDS is a difficult one. The emotional, spiritual and psychological issues can be especially hard, when the family may also be experiencing poverty or feel socially isolated because of the illness. Add to this the possibility of more than one family member being HIV positive and the challenges become that much greater.

Special attention must be given to children who are system involved (e.g. child welfare, group homes, etc.) or who have been taken into care by Provincial/Territorial authorities.

In some cases, when a parent is HIV positive, children are apprehended and subjected to screening processes which may not be necessary. The issue of child welfare and adoption is a factor facing all too many Aboriginal people. For some time, Aboriginal communities did not have meaningful say in this area, and there was even mass adoptions of Aboriginal children into non-Aboriginal homes including the United States. These are further examples of historical wrongs by a dominant society which can affect how Aboriginal people trust and relate to systems in place today.

Aboriginal Youth

With over half the Aboriginal population being youth, the need to design and deliver youth-specific interventions is of utmost necessity. Aboriginal Youth need to be full participants in determining priority actions which address their needs. Some who may drop out of school, lose opportunity to advance themselves in life. They may also miss the opportunity to learn about HIV/AIDS when it education is being delivered in high school. There are also those who may have learning disabilities and developmental disorders, which make it harder to instill messages that can help protect them. Some move to urban centers, unprepared for the harsh realities that can come with unfamiliar territory. Without adequate knowledge of the need for safer sex, or the introduction to alcohol and drugs, many youth become at risk for HIV. In fact, Aboriginal people who are becoming infected are younger than their non-Aboriginal counterparts. The issue of teen pregnancies indicates to some extent the frequency of unprotected sex. There is also the prevalence of sexually transmitted diseases, which supports the concern around HIV.

Peer pressure also is a deciding factor, and some end up homeless because they do not have the necessary skills to secure a job and home or prefer to be outside the home and their immediate family due to abuse issues. The lack of family support in some cases, can also send the message to a youth that nobody wants or understands where they are coming from. Some end up sexually exploited or become involved in the sex-trade to survive financially or feel welcomed in a community. Others may be sexually assaulted, especially female youth who engage in alcohol and drug use and experience blackouts because of excess consumption. There may even be value to establishing youth detoxification units and treatment programs, as youth may have different issues than older individuals. Regional directories listing Aboriginal Social Service Agencies and increased efforts within the educational system can prepare Aboriginal youth with the adequate knowledge and support if and when they move to a new community.

Aboriginal youth face a number of challenges that were not present even a decade ago. Some become parents to their parents and this may be a reason that they are not in school. It is a role reversal, oftentimes because of the presence of alcohol, other substance use, or dysfunction in the home. Other homes may disown or reject a child because they are Two-Spirited or Inter-sexed.

Two-Spirited People⁵ (Gay, Lesbian, Bisexual, Inter-sexed)

While many Two-Spirited males have been significantly affected by HIV/AIDS, there are several issues that continue to play out. Unprotected sex, more recently called bare back-ing and injection drug use are key ways that

HIV is being spread within this group. Homophobia and discrimination contribute to social alienation or isolation that many Two-Spirited people experience.

Another new phenomenon is the active pursuit by some people to become infected with HIV. Bareback parties sometimes actively promote the "gift" givers and seekers, referring to HIV as the gift. To what extent this is occurring among the Aboriginal Two-Spirit population is unclear and requires further study. Another issue is regarding young Two-Spirited males who move to urban areas, without adequate knowledge of HIV/AIDS and risk behaviors.

Two-Spirited females can also be faced with risks for HIV, even though there may be fewer women becoming HIV positive than males. There are also grief and loss issues, such as when friends who are HIV positive become more ill or experience many ups and downs. An important issue appears to be presence or absence of spirituality in relation to susceptibility to HIV infection. Love or perception of love, may also be a factor if a partner says "don't use a condom." When HIV is present in a relationship and there are subsequent issues for that relationship because of HIV,

⁵Note: **Inuit do not use the term "Two-Spirited". Likewise, some Aboriginal people and communities do not use this term at all, as traditionally they did not assign labels or speak publicly in terms of sexual orientation. The term itself is a generic term to fill the place of words in various Indigenous languages which include Traditional roles not based solely on sexual orientation, such as the Winkte in Lakota culture. It is important to point out that this section is about risks and issues facing men who have sex with other men. This can and does include married men.**

these dynamics need to be examined and better understood. As well, some people confuse love and sex, which is especially true when sexual abuse histories are present.

Injection Drug Use and other Substance Abuse

Increasingly, injection drug use and sharing unclean needles are creating very significant rates of infection for both HIV and Hepatitis C. Depending on the type of drug being injected, an injection drug user may inject several times a day, and often much more. Needle Exchange Programs and Harm Reduction approaches have been used to reduce the adverse affects or harm, associated with this very high-risk behavior. Methadone maintenance is another method used to get addicts off of injection drugs, but access can be an issue.

The challenge remains that many of the Aboriginal Addiction Treatment centers are using abstinence-based models and are not prepared to deal with injection drug use. Elder support and training is also key to broadening our reach. As with all areas, there are underlying issues that can increase chances that an Aboriginal person would turn to alcohol and/or drugs to negatively cope with life circumstances. These issues can include growing up in a violent home, sexual abuse, poverty, and loss of loved ones to suicide or other violent deaths, and more. All of these personal histories need to be dealt with, if a person is to overcome negative experiences, which are often multiple losses.

The creation of a National Aboriginal Task Force on Substance Use may begin to examine more closely, ways of intervening. Bringing together Elders, including those working

in Correctional facilities, injection drug users themselves, and other interested and related stakeholders may help to take control of this key area. Sexual partners (including female spouses) have been known to become HIV positive by having sex with their husbands or by sharing needles with them. As can be seen, men and women face equal risks when injection drug use, more so sharing uncleaned needles, as well as other substances that are at play.

Recent notice in Eastern Canada along the US border, are certain prescription drugs being used more frequently referred to as "cheap man's cocaine and hillbilly heroin". They are percoset which is snorted up the nose, and dilaudid, which is melted down and injected, like cocaine. Both prescription drugs and solvent abuse needs to be acknowledged. Even for methadone maintenance treatment programs, these are very limited, and there is a need for more programs across the country

Aboriginal Inmate Populations

Aboriginal inmates are over-represented in many Provincial/Territorial/Federal correctional institutions. Injection drug use within Correctional Institutions is one environment where the opportunity is great for the spread of HIV and Hepatitis C. Regulations that prohibit the use or possession of drugs or paraphernalia (needles) make the sharing of needles much more likely and greatly increases risk for both HIV and Hep C. Upon eventual re-integration into the community, there remains a need to provide adequate education and counseling which can start at intake, throughout their sentence and upon release. The Circles of Knowledge Keepers Peer Education manual developed by CAAN needs to

be implemented and supported. Although few efforts have seen this manual implemented or tested, the issue is that increased attention must be placed to address this area of concern. Training must be expanded to include Correctional Elders and other people who work in this area, to receive the training and properly support inmates. There are also issues for young offenders and some variations of issues within provincial/territorial institutions from federal institutions which can affect what approaches are needed.

The creation of a National Aboriginal Task Force on Substance Use must include Correctional Elders and former inmates. Needle exchange programs are being considered within Institutions but it is unclear whether these would be established. Methadone maintenance is also another area that creates difficulty when trying to provide it to inmates. Inmates generally need to be on the program before incarceration in order to qualify for it on the inside.

Harm reduction, and effective safer sex messages for sexual practices both inside Correctional Centers and during private family visits are key to the prevention of HIV and Hepatitis C. Alternative Justice Initiatives and Correctional Healing Lodges need to be partnered with, to reach those on conditional releases or to divert people away before entry into the penal system. As both Aboriginal men and women are incarcerated, there are equal risks and challenges for responding to HIV and Hepatitis C within institutions. Training around harm reduction for Correctional staff, parole and probation officers is also necessary in order to recognize drug abuse issues and

support diversion programs away from incarceration.

Correctional Institutions may provide bleach to clean needles, however there is recent evidence that suggests bleach may not be an effective measure against HIV, as well as Hep C. Most inmates may not use it properly or have old, overused, and even homemade syringes/rigs, and there is no evidence that bleach kills Hep C. Advocates and health workers need to revisit whether they should still be advocating bleach kits as a harm reduction practice, given the barriers and unclear effectiveness. Although bleach is likely better than nothing, the message may need changing, since it may be setting people up for false hope. Caution ought to be used, since some may interpret the message to mean bleach does not work in all cases, and thus not use anything. For some inmates, such as with Inuit Offenders, it may not be so much the injection drug use but the tattooing which can also pose risks for HIV transmission, when the tools are not properly cleaned. Tattooing and use of unsterilized equipment is an issue for all offenders.

Sex-trade Workers

The term "sex-trade workers" replaced prostitutes, largely because some of those involved in this area see it as a profession, complete with occupational hazards such as assault, and health risks. Sadly, some Aboriginal people including children as young as twelve, become involved with the sex-trade, more so to survive rather than it being a profession. In other words, there are likely more Aboriginal people involved in sex-trade as a means of survival or when a person is in need of a place to stay. Sadly, another reason is to feel needed

and in some ways, money represents your self worth.

There are also a lot of emotional issues as well. When mental illness is present, these can be factors that contribute to social isolation. The isolation that sex-trade workers feel, needs to be addressed when providing services and support. Some Aboriginal people in the sex-trade do so to feed their habit to alcohol and/or drugs. Addiction treatment services and programs aimed at supporting individuals to find other means of income, can assist in reducing risks found in the sex-trade, including violence. Development of support programs to assist individuals to leave the sex-trade are linked to housing availability, labor market, and skills development including life skills training, etc.

Street-Involved

Aboriginal people can also become street-involved perhaps running from a bad home situation. Injection drug use, isolation from community, mental illnesses can all pose risks to a persons health and safety, if they engage in risk behaviors. Some leave their home communities for the city, to find jobs or pursue their education, but are ill-prepared for city life. In some cases, they end up homeless, experience poverty, addictions, unemployment, all which can create a vicious cycle and dependency that is difficult to break. Another consideration is a need for belonging. Many Aboriginal people become street-involved and find a community there, including support, information and other needs.

Abuse, sexual exploitation, especially for youth, discrimination, and racism - are all aspects of street life that eat away at a persons

social standing. Aboriginal people are more mobile or migratory and may do so for various reasons. As stated, some are escaping bad situations at home or feel unsafe in their home communities, possibly because they are Two-Spirited. Others simply travel from coast to coast and couch to couch. Even in On-reserve environments, there can be street-kids when their home situation is not a safe place or a parent(s) are not able to provide the proper guidance. Access to affordable housing or shortages of adequate housing in some communities are also factors for why some people end up on the streets. Mental health issues can also factor in to the marginalization that some people experience when street-involved. The level of support, complexity behind interventions, and the diversity and transiency behind this aspect of society all are issues that affect how HIV/AIDS is a reality for many street-involved people.

The Community level

At the community level, a lot can be done to begin or further efforts on HIV/AIDS and related issues. The establishment of Community Wellness or Inter-agency Teams can be a solid first step because it allows broader input from all agencies and services who can play a role. Community-based health workers need ongoing support and training to assist them in delivering HIV/AIDS related work. It is difficult to do community development from a national level, but support can be given to build the capacity of communities.

An example can be studies that look at knowledge, attitudes and beliefs. These can be useful in offering insight into how communities view this health issue. The influence of reli-

gion in some cases is a factor in many communities on how best to deliver safer sex messages, deal with Two-Spirited issues, and even how to approach addictions. The difference between rigid interpretation of church teachings and having an openness toward working within today's environment can mean the difference between reaching people before they engage in risks.

The health transfer system, access to adequate health care or even medical staff in remote communities, are some issues that need to be considered when designing community approaches. Isolated communities have additional costs for transporting people to medical facilities. Resource development guides, action plans, and implementation frameworks are available to help support community action. 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. Transfer negotiations can also affect the availability and access to harm reduction supplies, such as condoms.

Northern Issues

It is important to understand that isolated regions of Canada, face unique challenges. The first, is access to health care, which is generally not available. Likewise, there are also different cultures, from the Inuit to a number of First Nations and Métis. Language is often a barrier, for example it has only been more recently that some resources have been available in Inuktitut. Costs are also higher up north, even to mail or courier a package. To do HIV/AIDS education essentially means airfare, even within a territory. Conferences and training in southern Canada for northern

residents is also a barrier, because of costs. Some northern communities experience difficulty in delivering HIV/AIDS education. For example, how does HIV/AIDS rate when there may be high suicides, or violence and addictions in a community? Although these social issues are not unique to just northern communities, they can be issues to contend with. The geographic isolation can also lead to more youth engaging in gas sniffing or solvent abuse. It is important for initiatives developed in southern Canada to recognize the additional costs and burdens that northern, isolated communities face.

Adults and Older Aboriginal People

Although there are fewer Aboriginal Seniors or elderly people becoming diagnosed with HIV, there can still be risk behaviors for these groups. It is a false perception that elderly people don't have sex or all of them are in stable relationships/marriages. Some elderly people find themselves single for several reasons. Perhaps a partner has died, or in some cases, a couple may have married straight out of high school, only to find the marriage failed after a lengthy period. These are some of the ways heterosexual people may face risks for HIV infection.

Conceivably, someone in their mid-forties or older could find themselves dating again only to find out that there are much more serious health risks today, than when they were a youth. These are some of the ways that heterosexual individuals may face risks for HIV. Without proper guidance and education, a person may find themselves out of touch and feeling awkward about how to use protection or knowing what is risky or not. Elders can

play an important role in that they are keepers of the culture and teachers for youth. They need education around HIV/AIDS to assist them in being more knowledgeable in their role to help address this disease and related issues. The influence of older adults and Elders on younger generations requires recognition. People in management and leadership positions, or heads of large families, can impact prevention and education messages and influence environments.

Residential School Survivors

Aboriginal communities have experienced generations of what is becoming more widely known as a significantly disruptive force, (less so for Inuit communities) and that is the Residential School system, including Boarding and Mission Schools. Not all experiences were negative, and not all groups had Residential Schools. Depending on the generation that went and what was occurring at home, many people who did attend found themselves being abused and traumatized in several ways. Even those who were not sexually abused, may have witnessed it. Sexual and physical abuse, forbidden to speak their languages, disconnected from Elders and their traditional societies because when they returned they could not communicate in their mother tongue. All of these are factors in how many Aboriginal communities, families, and individuals who attended, have been struggling to overcome major traumas and life changing experiences.

Parents who went, those in foster care, and others involved in the child welfare system, especially in the fifties and early sixties have been deeply wounded. The result, now called the Residential School Legacy because many

social issues are linked to it, is that many Survivors have turned to alcohol and drugs to numb the pain. Others have used physical violence as ways of lashing out, seemingly without the ability to stop the cycle of abuse. Emotionally and spiritually shut down, many have difficulties in intimate relationships or showing affection to their own children. With such deep wounds, some ending up incarcerated, several factors exist that can lead or contribute to whether a person can practice personal safety or even if they care enough about themselves to want to. Self-destructive patterns are common until the pain and hurt is dealt with. Some Residential School Survivors did not learn proper parenting skills. Others may have difficulty talking about sex and sexuality to their children, because they had such negative experiences themselves.

Aboriginal Men

In Traditional societies, men were often seen as protectors and providers. For some of the reasons mentioned under Residential Schools, roles have changed, and not always for the better. Even for Aboriginal men who did not go to a Residential School, they can experience what is called inter-generational impacts. In some cases, Aboriginal men have become the abusers, acting out unresolved trauma or repeating learned behaviors such as growing up in a violent home. Aboriginal men are not always as willing to participate in healing type activities, until the consequences become too great or they are unable to ignore the realities facing them.

Again, patterns of self-destructive behavior can become major challenges. In terms of HIV/AIDS, substance use and injection drug use can create major risks for HIV infection,

as well as Hepatitis C. Unprotected sex can lead to partners becoming infected as well. Thus, injection drug use and/or unprotected sex means heterosexual transmission rates are also increasing. Aboriginal men who become incarcerated also face greater risks because the environment is a closed one where HIV and Hepatitis C exist. All it takes is one try of sharing a needle with HIV or Hepatitis C, and the result is very likely to be infection. Until Aboriginal communities find balance in addressing the healing needs of men and women, there likely will be continued disharmony which can lead to more HIV infections.

The traditional roles of men as protectors needs to be regained, and Aboriginal men need to use this role effectively. Young men need to see and hear adult men show them how to be respectful of their partners, how to respect the gift of their sexuality, and to be responsible in how this gift is used. Issues of fatherhood can support prevention and education goals around HIV/AIDS and related issues, when adult and young men set aside being macho and false pride, to learn exactly what their role involves.

Transgendered, Inter-sexed and Transsexual People

Transgendered, inter-sexed, and transsexual people have been largely misunderstood by society and often even within their families. Living conflict between mind and body creates a lifelong journey - and lengthy process - for some who are undergoing a transitioning (the process of changing from one state to another, formerly called a sex change operation by some). Others undergo just the hormonal procedures. Yet still, some may dress in what may be termed "opposite-sex" cloth-

ing. There is evidence that many people who call themselves transgendered, inter-sexed, or transsexual are living with HIV. Some turn to the sex-trade to survive, many out of negative experiences with societal barriers and discrimination. For those incarcerated, significant risks exist, as with all inmates for HIV and Hepatitis, as well as for physical safety. Transphobia, like homophobia is when people have unfounded fear oftentimes resulting in physical assault or threats toward safety.

Medical procedures for post-operative transsexuals, can also factor into risks with reconstructed vaginas that cannot lubricate. Therefore, abrasions or tearing can provide opportunity for infection. Not only is there a need for comprehensive HIV education and prevention strategies for members in these groups, but much work is needed to educate about specific medical and social needs as well.

7.0 Implementation

As stated earlier, the advantage of having CAAN is that it is a national organization dedicated to Aboriginal HIV/AIDS issues. The ASHAC recognizes that implementation of the strategic areas in this document can occur at various levels. For example, any group or region can design efforts under prevention and education, or any of the other strategic areas. In support of this, the Strategy Coordinator, the Working Group, its committees and the Canadian Aboriginal AIDS Network will support and guide implementation issues related to the ASHAC.

It is important to also recognize, that in getting organized, each region or group needs to manage and design their own developmental process. As stated earlier, the ASHAC is not about prescribing what or how a community or region should implement HIV/AIDS initiatives. This strategy is a key resource and describes nine strategic areas with numerous objectives that can be used in the fight against HIV/AIDS. It is a very useful exercise for a community or region to set its own priorities based on information relevant to their own needs. The Strategy Coordinator can be a support in related efforts under the ASHAC, by fulfilling the role outlined under Coordination and Technical Support, as well as other CAAN staff. Ongoing communication and tools will be developed and shared.

For communities or regions without Aboriginal HIV/AIDS strategies, this document can begin the developmental process that is needed to design an approach that works within your community or region. Some provinces or territories may not fund a regional strategy or the process may be long to lobby for such a resource. When funding is not available for a provincial/territorial strategy, the coordination role is notably absent. It becomes much more difficult to have an effective network and flow of information. It is not enough for a community to be given a resource manual, and reasonably expect that community to implement all the necessary aspects to an effective HIV/AIDS program. Support is needed, which is a key role that a Strategy can provide. The ASHAC supports the development of provincial/territorial Aboriginal HIV/AIDS strategies in those regions where none currently exist. Communities can begin by starting a Community Health and Wellness Team, made up of various community-based health workers, such as Alcohol and Drug Workers, Community Health Representatives, Nurses, Public Health, volunteers, etc. Going through this document as a team, can assist in identifying areas where your community wants to focus its energy. The Assembly of First Nations has also developed an Implementation Framework, and some regions with Aboriginal HIV/AIDS



Strategies have similar resources. All of these can assist your own developmental needs.

In addition, the working group (see appendix B) is comprised of a variety of individuals and organizations committed to this health issue who will continue in their role. Two phases of the working group were held, the first kick started the process by developing guidelines that would outline how the ASHAC would be developed. These guidelines included terms of reference, composition, and guiding principles. The following guiding principles apply to the Working group and its committees. Also, there are two committees: Emerging Issues Committee and Working Group Secretariat. 1) The Emerging Issues examines new trends that are being noticed and raises these with the larger working group. 2) The Secretariat supports the Strategy Coordinator in planning out processes, especially agendas for all meetings.

Working Group Guiding Principles

- We will endeavour to work in a cooperative manner with other groups and organizations, be they Aboriginal or non-Aboriginal, in order to develop a society of equal opportunity for all people and respect for all living things.
- We will support and work towards achieving the stated aims and objectives of the Strategy.
- We honour diversity, will be forthright in expressing our views on particular issues and respectful of the opinions of other Working group members, stakeholders and all Aboriginal groups.
- We encourage people to bring grievances, comments, or complaints relating to the Working Group to the attention of the Working Group Secretariat.
- We endeavour to work in a cooperative manner with working group colleagues, strategy partners, stakeholders and individuals to solve issues of mutual concern.

APPENDIX A: CSHA FUNDING ALLOCATIONS

CSHA COMPONENT	FUNDING AMOUNT
Prevention	\$3.9 Million
Community Development/NGO Support	\$10.0 Million
Care, Treatment and Support	\$4.75 Million
Research	\$13.15 Million **
Surveillance	\$4.3 Million
International Collaboration	\$0.3 Million
Legal, Ethical and Human Rights	\$0.7 Million
Aboriginal Communities	\$2.6 Million *
Consultation, Evaluation, Monitoring and Reporting	\$1.9 Million
Correctional Service Canada	\$0.6 Million
TOTAL	\$42.2 Million

Aboriginal HIV/AIDS Funding Allocations

HPPB Aboriginal Allocation	FNIHB Allocation (On Reserve/Inuit)
\$100 K Prevention and Education	\$300 K Prevention and Education
\$1.2 Million Community Development	\$300 K Community Development
\$100 K Care, Treatment and Support	\$300 K Care, Treatment and Support
\$100 K Coordination	\$200 K Coordination
Sub-total = \$1.5 Million	Sub-total = \$1.1 Million
\$800 K Research	\$2.5 Million A-Based Funding ***
TOTAL = \$2.3 Million	TOTAL = \$3.6 Million

* The \$1.1 Million requires regional workplans to guide how dollars will be spent.

** \$800,000 is the Aboriginal allocation under research for both On & Off-reserve.

*** First Nations & Inuit Health Branch (FNIHB) has an additional \$2.5 million in A-Based funding dedicated to the First Nations & Inuit HIV/AIDS Program. What is meant by A-Based funding is this amount comes out of the overall budget for this Branch, and not from the CSHA. FNIHB uses a funding formula with a base amount, then factors in geographic location, remoteness, population size, etc. to determine what a region or a First Nation would get as their share of this funding allotment. Some dollars also stay at national level for coordination.

APPENDIX B: CURRENT ASHAC WORKING GROUP MEMBERS

Following is a list of organizations and individuals who reside in various regions of Canada. Members were selected based on various criteria, including: Aboriginal People living with HIV/AIDS, relationship to the Aboriginal HIV/AIDS movement in Canada, organizational political mandates, and representation of current regional Aboriginal HIV/AIDS Strategies. Regions were not a deciding factor, although current membership represents almost all regions in Canada, with CIHAN and other national organizations providing access to wider networks. All three Aboriginal groups are represented, namely Inuit, Métis and First Nations.

- Métis Nation of Canada, Mr. Duane G. Morrisseau-Beck
- Assembly of First Nations, Ms. Anita Stevens
- Canadian Inuit HIV/AIDS Network, (CIHAN), Mr. Todd Armstrong
- Ontario Aboriginal HIV/AIDS Strategy, Ms. LaVerne Monette
- Healing Our Spirit, BC First Nations AIDS Prevention Society, Mr. Ken Clement
- Kimamow Atoskanow Foundation, Alberta Aboriginal HIV Strategy, 2001-2004, Ms. Denise Lambert
- The Circle of Hope: The First Nations and Inuit of Quebec HIV and AIDS Strategy, Ms. Guylaine Chastroux
- Ms. Jonelle Garriock, YK
- Ms. Lillian George, BC (Co-Chair)
- Ms. Margaret Akan, SK
- Ms. Donna Everette, MB
- Mr. Trevor Stratton, ON
- Mr. Ashley Dedam, NB/Atlantic (Co-Chair)
- Mr. Fred Anderson, NF/Labrador
- Mr. Quinn Wade, NS/Atlantic
- Two Health Canada seats: Ms. Anita Tuharsky-Ross and Mr. Alain Houde
- CAAN Staff: Mr. Art Zoccole, Ms. Kim Thomas and Ms. Eve Louttit
- Strategy Consultant: Mr. Kevin Barlow

APPENDIX C: LIST OF KEY ABORIGINAL STAKEHOLDERS

Note: The process of involving stakeholders in the process is on-going and part of the mandate of the working group. Below are listed the categories for inclusion as a stakeholder.

NATIONAL/REGIONAL ABORIGINAL POLITICAL ORGANIZATIONS

Groups that advocate for Aboriginal people on a national level (E.g. Assembly Of First Nations, The Métis National Council, Inuit Tapirisat of Kanata, Tribal Councils, Friendship Center Collectives, etc..)

NATIONAL/REGIONAL ABORIGINAL ORGANIZATIONS

Service-delivery type organizations, with health portfolios and are committed to advocating on various health issues for Aboriginal people, including general health mandates and specific HIV/AIDS related issues. (E.g. Friendship Centers, Métis coalitions, Inuit Health Boards, etc.)

COMMUNITY GROUPS

Organizations and individuals that advocate and set policies for Aboriginal people on a community level, such as specific urban friendship centers and Inuit and Métis community centers.

NATIONAL ABORIGINAL HEALTH ADVOCACY ORGANIZATIONS

Aboriginal Health Advocacy organizations that have a national mandate, such as Aboriginal Nurses Association of Canada, Native Physicians in Canada, the Canadian Aboriginal AIDS Network, National Indian/Inuit Community Health Representatives Organization, etc.

ABORIGINAL PROVINCIAL/TERRITORIAL HIV/AIDS STRATEGIES

Aboriginal HIV/AIDS Networks and Strategies, such as: The Red Road in BC, The Circle Of Hope HIV/AIDS Strategy in Quebec, Alberta Aboriginal HIV/AIDS Strategy, and the Ontario Aboriginal HIV/AIDS Strategy.

ABORIGINAL COMMUNITY-BASED ORGANIZATIONS

Aboriginal community-specific health and/or HIV/AIDS organizations, such as Healing Our Nations in Atlantic, 2-Spirited People of the 1st Nations in Toronto, Healing Our Spirit in BC, etc..

NATIONAL HIV/AIDS PARTNERS AND FEDERAL/PROVINCIAL/TERRITORIAL GOVERNMENTS

National partners or those groups such as the Canadian AIDS Society, Canadian AIDS Treatment Information Exchange, etc. who are mainly non-Aboriginal but have mandates to work within the HIV/AIDS health field.

APPENDIX D: DESCRIPTION OF CONSULTATION PROCESS

The consultation version of the ASHAC was released June 2002, which led into summer, normally a slow time of year and very little activity took place until September. Time and budget did not allow for a different approach because of when funding was released. The second expanded working group brought additional knowledge, support and well needed expertise to the process which helped prepare the consultation version. The process was left open - depending on needs and requests of any region or group - a Focus Group or Presentation could be held or individual input could occur.

The budget for this project simply did not allow for travel to bring participants in to consult, which also limited the Strategy Coordinator's travel. Some Working Group members delivered Focus Groups or Presentations, and some were done by teleconference. A mass mail out also occurred, inviting individual feedback. In the end, 173 Aboriginal and non-Aboriginal people took time to read and comment on this document. Much of the feedback made its way into the document. Some did not, because issues were already included in the first draft or were more of an implementation issue. Many questions were around the consultation process and implementation. CAAN hopes to eventually release two additional resources: 1) Summary Consultation Report; and 2) Condensed version of the ASHAC. The Canadian Aboriginal AIDS Network wishes to thank each person who contributed.

Location	Attendance
Yukon Community Groups	11
APHA Consult	15
Quebec	8
Assembly of First Nations	6
AIDS Calgary	2
Saskatchewan Conference	12
NWT Healing Connections	2
Ontario First Nations HIV/AIDS Education Circle	8
Alberta Consult	38
Métis Addictions Council SK Inc.	1
Canadian Inuit HIV/AIDS Network (4 + 11)	15
Labrador Aboriginal HIV/AIDS Circle	5
Atlantic Aboriginal HIV/AIDS Circle	10
Ontario Federation of Friendship Centers	5
Manitoba (3 + 8)	11
BC (Healing Our Spirit/Red Road)	7
2-Spirited People of the 1st Nations	7
Ontario Aboriginal HIV/AIDS Strategy	10
TOTAL	173

Note: Some meetings had multiple interests involved, including Métis, Inuit and First Nations, as well as APHAs. Efforts were made to reach each Province/Territory, all three major Aboriginal groups, and National Aboriginal Organizations, but not always possible. For example, Métis National Council affiliates were approached, but unable to participate in a teleconference, however fully support the ASHAC. Likewise, no Newfoundland or PEI representatives were available, yet all were provided opportunity.