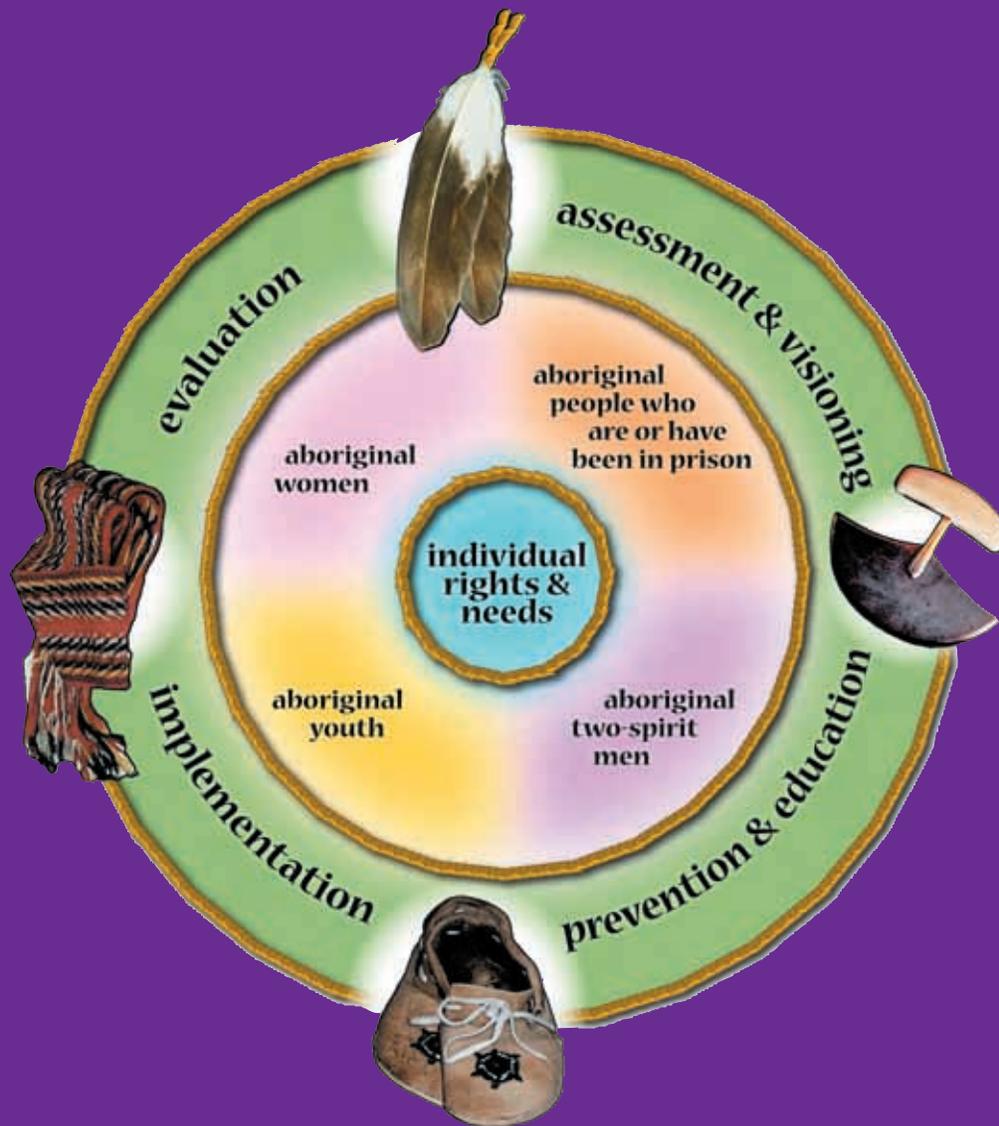




Walk With Me Pathways to Health Harm Reduction Service Delivery Model



For Aboriginal Women, Aboriginal Youth, Aboriginal People who are or have been in Prison and Aboriginal Two-Spirit Men



THE CANADIAN ABORIGINAL AIDS NETWORK

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Brief Overview of the Canadian Aboriginal AIDS Network (CAAN)

- Established in 1997
- National, not-for-profit organization
- Represents over 340 member organizations and individuals
- Provides a national forum for members to express needs and concerns
- Provides relevant, accurate and up-to-date information on issues facing Aboriginal people living with and affected by HIV/AIDS in Canada
- Is governed by a thirteen member National Board of Directors and operated by a four member Executive

CAAN Mission Statement

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

CAAN Vision Statement

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

Acknowledgements

A special note of appreciation, to all participants of the focus groups, who have demonstrated courage and resiliency, as a model for living, and for the wisdom of the experiences they have shared from their daily lives. CAAN would like to give a special thank you to Bernice Downey for developing the original work used to frame this service delivery model.

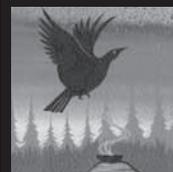
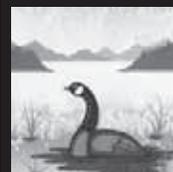
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Section One – Introduction

1.1 Introduction

The overall goal of this Harm Reduction project is to advance CAAN's previous work towards refining a culturally safe Harm Reduction service delivery model. The model is comprehensive, holistic and inclusive of the components of assessment, prevention, implementation and evaluation. This model has been designed to be diverse, and meets the needs of four target groups: Aboriginal Women, Aboriginal Youth, Aboriginal People who are or have been in Prison, and Aboriginal Two-Spirit men.

This culturally appropriate Harm Reduction model serves as a resource guide for service providers, communities, policy makers, and leaders. Groups may use the model to enhance their existing services or to learn more about Harm Reduction for Aboriginal people with respect to vulnerability to acquiring Human Immuno-Deficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS). Four training modules have been developed to address the needs of each of the four target groups. The strategies used may be evaluated on a regular basis to ensure that client's needs are being met as the needs of the community/clients change. This document works together with the four training modules which provide a more practical hands-on version of information.

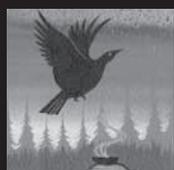
The development of this model has been conducted through focus groups that have provided the voice of experience. The work completed has been guided by a Harm Reduction National Steering Committee comprised of experts in HIV/AIDS and addictions.

1.2 About this Model

This model respects that all individuals reserve the right to be educated and receive health care services. They have the right to receive culturally appropriate services within the community designed for their basic needs. This project focuses on the needs of four target groups, Aboriginal Women, Aboriginal Youth, Aboriginal people who are or have been in Prison and Aboriginal Two-Spirit Men, while building on previous CAAN Harm Reduction initiatives such as Joining the Circle I and II, and the Circles of Knowledge Keepers Peer Education Module.

The targeted outcome is to improve and increase the Harm Reduction activities and policies within organizations and communities which provide culturally appropriate services to the Aboriginal target groups. This Harm Reduction service delivery model includes four comprehensive, flexible, holistic and culturally appropriate components that will meet the unique needs of the target groups. It is hoped that the work will influence the rapidly increasing rates of HIV/AIDS within the Aboriginal population and inform others about culturally appropriate Harm Reduction approaches.

Finally, this model will assist the spectrum of service providers including, community health representatives (CHR), addiction workers, mental health workers, nurses, doctors, and others in their day to day work with clients. This resource will provide First Nations, Inuit and Métis peoples who are or may be faced with the complex challenges related to chaotic substance use and issues related to HIV/AIDS.^A



Guiding Values

Wisdom, respect, humility, honesty, love, bravery and truth are the guiding values to this Harm Reduction strategy. These teachings provide this Model the basic values to associate with in order to provide a balanced and holistic approach to addressing Harm Reduction.

Wisdom

Traditional teachings, indigenous education, awareness sessions, use of Elders, generations of experience, and history combine to provide the capability of teaching others how to live a healthy balanced life.

Respect

This includes viewing people as equals, with their own gifts to share, practicing kindness towards others, regardless of their health status, sexual orientation, race, etc., while being appreciative of and caring for each other.

Humility

Recognizing that leadership, para-professionals, community, service organizations and clients understand and realize that all people have their own journey to follow in life.

Honesty

Providing a trusting environment for clients, with accurate, informative materials to advance the Harm Reduction approaches in Canada. It includes providing an atmosphere for clients where they may receive assistance regardless of risky behaviors that they may engage in, without judgement.

Bravery

Honouring the bravery of clients who come forward to mobilize against the continued spread of the HIV/AIDS and Hepatitis C (HCV) virus, by engaging in Harm Reduction initiatives. Promoting the bravery that is required for HIV and HCV testing. To have the courage and strength to make healthy choices that will influence your life, and the life of your family.

Love

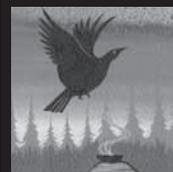
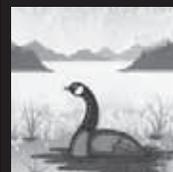
Using positive energy to provide a loving environment to help people who may not have been shown love in their lives. Showing affection, kindness, and caring to everyone that you greet throughout your day.

Truth

To be sincere, and to speak your truth, be who you are and be proud.

1.3 Development of Model

A culturally appropriate model is proposed as a way to frame a Harm Reduction approach to care, support and treatment. A number of information gathering activities contributed to informing the development of the model. A literature review to prepare for this project was undertaken by CAAN^B to synthesize information related to HIV/AIDS, Harm Reduction and Aboriginal populations; *Literature Review and Model Building in Harm Reduction for Selected Populations*.



A Harm Reduction National Steering Committee (HRNSC) was established and was representative of Aboriginal People Living with HIV/AIDS (APHA), various partner organizations, CAAN staff and CAAN Board of Directors (See Appendix I – Harm Reduction National Steering Committee) The HRNSC’s primary purpose was to guide the development of this service delivery model.

A focused review of other CAAN documents has been undertaken, including Aboriginal and non-Aboriginal AIDS service organizations (ASO) documents, select government sources, and other articles and documents. Internet searches included Pub Med Central, Google Scholar, CINAHL, with search words of Harm Reduction, service delivery models, best practices, HIV/AIDS, Aboriginal, models of intervention and culture assessment. Various HIV/AIDS related databases were also searched. Focus groups with target population representatives were held which further informed the development of the service delivery model and the development of the training modules.^C

Four specific training modules have been developed that use the ‘Walk with Me Pathways to Health’ model as the framework for training various service providers involved in HIV/AIDS work for First Nations, Inuit and Métis.

1.4 Who can use this resource and how will it help?

This document is targeted for use by a range of health care workers. These include community leaders, health directors, band councils and policy makers such as government representatives or AIDS service organizations.

Health care service providers

Through the development of policies, training, counseling with clients, community events, and collaborating with partners, the health care service providers may normalize, and incorporate this model into their programs and services.

Addiction Treatment Centres

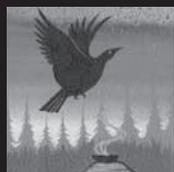
May utilize this Harm Reduction approach when addressing the needs of the communities that they are serving. Treatment Centres may educate the public on Harm Reduction approaches and are encouraged to produce new provisions for Harm Reduction services within the Centres.

Community members and leaders

Community members, families and leadership are also in need of support as they face this serious health issue. While there are community initiatives making headway in creating awareness about the HIV/AIDS epidemic, there are still others who don’t understand the vulnerability of their community members to this disease. There is often confusion or misinformation related to stigma and discrimination about the issue. There is also fear and anxiety and a sense of being overwhelmed as to how to address it. Community members and leaders need to understand what a Harm Reduction approach means. Often supportive approaches and programs are difficult to implement because of a lack of understanding, discrimination towards injection drug users, or a difference in values and beliefs.

Policy makers

Policy informs decision makers and provides a consistent structure within the organization, which



further provides a foundation for the management process of that organization. Policy makers at all levels of government and throughout the levels of organizations, both Aboriginal and non-Aboriginal, need to be informed of policies to ensure their influence will effectively achieve the goal of removing barriers, and of improving their organization's services.

AIDS service organizations (ASO) – are instrumental in the work they accomplish in addressing HIV/AIDS. Depending on their mandate, most are leaders in the fields of advocacy, policy development and research of HIV/AIDS and related issues. Aboriginal people need the expertise and leadership of these organizations to support their voices and convey the key message for change required.

1.5 Service Delivery Model

This service delivery model is comprehensive, holistic and inclusive of the components of Assessment and Vision, Prevention and Education, Implementation, and Evaluation.

Harm Reduction is an approach which focuses on the reality that an individual's readiness to change varies, and that individuals may not be ready, willing or able to completely change risk behaviors. Harm Reduction awareness sessions can be provided to educate the public on accepting Harm Reduction initiatives, to reduce the incidence of HIV/AIDS. Currently, Harm Reduction approaches are not fully accepted within communities. This is primarily because there is a discrimination against chaotic substance use and service providers believe that an abstinence approach is more effective in dealing with chaotic substance use. Applying a Harm Reduction approach within the community will ensure safe, holistic practices for all people, and will meet the differences in people's beliefs and values.

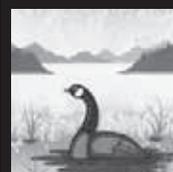
This model allows for flexibility and provides the tools necessary to provide for the implementation of Harm Reduction practices which are assessed by all partners within a community according to the needs, cultural requirements and level of community awareness of HIV/AIDS.

Many Aboriginal people who are or have been in prison are being diagnosed with HIV/AIDS and Hepatitis C (HCV). It is important that these individuals receive the appropriate health care, education and resources necessary to live as HIV/AIDS and HCV positive persons.

Tattooing, injection drug use (IDU), and unsafe sexual practices are some of the activities that are taking place within the prison system. One of the difficulties associated with introducing Harm Reduction initiatives within correctional facilities is the belief that providing clean needles and condoms means condoning or promoting injection drug use and inmate sexual intercourse.

Aboriginal Two-Spirit Men historically held a respected place within society where they were valued for the gifts which they possessed. Increasing services, support, care and treatment for Two-Spirit Men within communities/organizations, through the implementation of the Harm Reduction Model, will help to improve and address the individual rights and needs of this target group.

Strategies for Aboriginal Youth which keep their development in mind will assist Youth in being more accepting of Harm Reduction approaches later in life. As Aboriginal youth grow and experiment and learn their own ways, they will do so armed with the tools that will offer protection and wisdom that will reduce the chances of transmission of HIV/AIDS.



Aboriginal Women have HIV/AIDS at very high rates and a strategy must be put in place to reduce the incidence immediately. Communities, shelters, programs and services must provide these mothers, and daughters the tools necessary to have the strength to speak up, act and protect in order to reduce the incidence of HIV/AIDS and HCV within this target group. As with the other target groups, many women are engaging in risky behaviours. Through education and resources, and the acceptance of an effective Harm Reduction approach, more appropriate steps can be taken to address women's needs.

1.6 Barriers in Developing Harm Reduction Approaches

Critics of Harm Reduction believe this approach condones and even encourages behaviors they consider to be dangerous, socially de-stabilizing, and immoral. CAAN reports that the most common argument against needle exchange is that it will encourage drug use, even though this is not supported by scientific evidence.¹

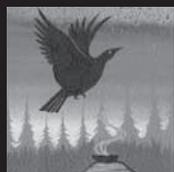
Today, while there are some encouraging examples of Harm Reduction initiatives emerging, overall there remains many challenges to implementing effective Harm Reduction programs and services in communities. Abstinence-based addiction treatment philosophies, limited access to services, and confidentiality concerns are a few of the barriers that individuals and communities are currently experiencing. Others may include (but are not limited to):

- Youth not attending school, and not participating in prevention and education activities.
- Women becoming too isolated within their homes to attend awareness activities about the high risk activities that they may be practicing.
- Two Spirit men may be within a community which is not accepting the existence of problems (i.e. high risk activities) occurring in the communities.
- Communication problems within a community, such as members not attending community meetings;
- Aboriginal people who are or have been in prison are faced with outdated policies that do not support Harm Reduction.
- Lack of Harm Reduction initiatives.
- Fear of providing Harm Reduction activities because it will be viewed as promoting the activity that they are trying to reduce.

1.7 HIV/AIDS, Hepatitis C Virus (HCV) and Harm Reduction

Current statistics indicate that Aboriginal populations remain over-represented in the HIV/AIDS epidemic in Canada with the overall infection rate 2.8 times higher than among non-Aboriginal persons. Almost two-thirds of new HIV infections are attributable to injection drug use (IDU), with HCV incidences in the Aboriginal population estimated at 8 times higher than in the general Canadian population.²

For First Nations; of all reported AIDS cases (2205) among First Nations people, 44.9% of cases can be attributed to IDU. Females represent 27.6% of cases, while youth (less than 30 years of age) account for 21.1% of all reported cases.³ For Métis, 30% of all reported AIDS cases are attributable to IDU, and



few cases (7.3%) indicated as being female; For Métis, youth account for nearly 31.7% of reported AIDS cases. Within the Inuit population, the IDU exposure category represents about a third of reported AIDS cases at 31.8%. Females represent 40% of the reported cases, while youth represent 31.8%.

The Public Health Agency of Canada (PHAC) reports that by the end of 2005, more people (in Canada) were living with HIV infection (including AIDS) at an estimated 58,000 (48,000 - 68,000). PHAC also reports 'a steady rise in the proportion of reported AIDS cases and positive HIV test reports among Aboriginal peoples in Canada in recent years';⁴ Aboriginal peoples account for 16.4% of the total reported AIDS cases for which ethnicity were known.^D

- Aboriginal persons represent 3.3% of the Canadian population and yet an estimated 3,600 to 5,100 Aboriginal people were living with HIV (including AIDS) in Canada in 2005. This represents about 7.5% of all prevalent HIV infections
- Aboriginal people are diagnosed with HIV at a younger age than non-Aboriginal peoples. A third (32.2%) of new positive HIV test reports among Aboriginal persons represent youth (aged < 30 years) as compared with 20.8% among non-Aboriginal persons.
- Aboriginal women represented 47.3% of all positive HIV test reports among women, as compared with 20.5% of reports among non-Aboriginal females.
- Among Aboriginal Canadians the proportion of new HIV infections in 2005 attributed to injection drug use (53%), was much higher than among all Canadians. (14%)

CAAN reports that the number of people with HCV in Canada is growing and increasing at a steady rate. The PHAC reports that currently, the major mode of contracting HCV is through the sharing of contaminated needles and other needle works among injection drug users. Other risk behaviors reported include the use of contaminated equipment for tattooing, body piercing, acupuncture, and intra-nasal (snorting) cocaine use.⁵ Health workers are also at risk due to accidental needle sticks. Infants born to HCV infected mothers, Aboriginal people who are or have been in prison, and injection drug users, are high risk groups relative to this project. IDU in the prison system is a significant factor in the transmission of HCV and both HIV/HCV rates of infection are thought to be much higher than reported.⁶

CAAN estimates that more than 1500 HIV positive Aboriginal people are co-infected with HCV^E. Further, people with HIV have a higher viral load and are more likely to transmit HCV to others.⁷ An important diagnostic factor is that the detection of HCV can be more difficult in people with HIV because a false negative may be obtained when individuals are HCV positive, even if they have not developed antibodies⁸.

Treatment protocols are complicated for people with HCV and lower success rates are cited.^F Liver toxicity is a concern; HIV positive women may pass on HCV to their unborn babies; there is a slowing of T-cell counts during HIV treatment; some people have difficulty detoxifying medications by the liver; and other drug related issues are all factors for consideration in co-infected individuals.



1.8 Harm Reduction Activities and Practices

Aboriginal groups, organizations and communities may establish creative ways to address Harm Reduction within their communities and/or organizations. Harm Reduction may be viewed as a continuum of services, which provides services to a target group where no services have previously existed. Prevention/education to reduce the risk of harm, testing for injection drug users to determine early diagnosis and facilitate treatment, and health promotion activities to minimize negative health outcomes, are all strategies towards effectively reducing the harm of chaotic substance use and decreasing the risk of HIV transmission.

Outreach services may address Harm Reduction by providing a glass of water, or a sandwich to someone who may not have eaten in days, gradually building trust in the process. At a future date, the same client may trust this individual enough to disclose abuse issues or to ask for further care. Within the continuum of care, this Model bridges an area that is not currently being addressed. In viewing the full spectrum you can see a person engaged in high risk behavior, who is not receiving any services or information, to the opposite end of seeing a person going to treatment and making life changes. Using a Harm Reduction approach means that within this continuum of services gaps are bridged, people educated, and a normalizing of service provision for the target groups.

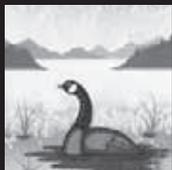
Needle exchanges, condom distribution, counseling and the provision of methadone are all activities which mitigate the risks of becoming HIV positive. People will decide their own course and move forward when they are ready. Facilitating this process assists clients in moving forward on their healing journey with hopes of eventually choosing a less harmful life path for themselves.

Many people are aware of how HIV/AIDS and HCV are transmitted, yet they continue to engage in risky behaviors. With an increase in education, prevention, direct services and support, people will have increased awareness and will reduce incidences of HIV/AIDS and HCV.

A less challenging example of Harm Reduction could be the provision of pamphlets that provides information on anonymous testing for HIV/AIDS. A more challenging one could be the incorporation of a methadone clinic, or a needle exchange program.

Throughout the various elements of the model, barriers will need to be identified and addressed. Barriers may vary according to community and/or organization and may include:

- Homophobia: This barrier has negative impacts on the entire community; it can affect entire organizations and can lead to hate crimes against people. In light of promoting a Harm Reduction Strategy or programs/services, homophobia can lead to the inaction within a community or service. Individual rights and needs of all people need to be promoted and requires education, support and services within a community or organization.
- Family relationships: Family may provide the basic foundation for an individual, yet, if there are problems within the family, problematic issues result. For example, in some extreme situations, individuals raised within an unhealthy family environment can lead to homelessness, suicidal ideation, chaotic substance use, incarceration, low self respect and low self-esteem. A woman may be disrespected by her husband, a young person may break the law and become imprisoned, a



youth may decide to run away from home, a Two-Spirit Man may become ostracized by his family. There are cases of entire families engaging in high risk behaviors together, such as IDU. This has catastrophic results and requires creative Harm Reduction approaches.

- The impact of colonization: Colonization, with the resultant racism, loss of language and sense of cultural identity among other negative outcomes, impacts an individual's self-esteem, care and support systems. There is often a connection between chaotic substance use and a negative sense of self, with deep rooted anger and a sense of powerlessness resulting.
- Chaotic Substance Use: When a person uses drugs it can often times result in the creation of chaos and havoc within their lives. Individuals who are using drugs and alcohol often remove themselves from difficult feelings and struggle to cope in their day to day lives. The challenges of living in a society that is unkind and un-accepting of people who engage in high risk activities compound the issue.
- Socio-economic factors- such as poverty and unemployment need to be part of a holistic approach for those attempting to recover from chaotic substance use and/or who may be at risk of HIV/AIDS. This applies to all stages of care, support and treatment. A state of poor health may be exasperated by the inability to eat healthy, purchase required medications, or to access reasonable housing, etc. A sense of powerlessness may be felt and this may lead to the individual's engaging in high risk activities, and experiencing a low sense of self-esteem.
- Confidentiality: Service Workers require appropriate training in confidentiality and HIV/AIDS disclosures and counselling to ensure that the strictest protocols and privacy are respected.
- Outreach and the need for cultural and emotional support: Aboriginal people who self identify as being lesbian, gay or Two-Spirit, trans-gendered, and bisexual have mobilized and established networks for themselves. For example, the 2-Spirited People of the First Nations is a non-profit social service organization providing care and support and treatment to its clients. Often, organizations such as this one are the only source of cultural support for many Aboriginal people who may have experienced isolation and ostracism from their families and communities.



Section Two – Service Delivery Model

2.1 Aboriginal Harm Reduction Task Force

CAAN has created a National Aboriginal Task Force on Injection Drug Use that will work to increase knowledge and awareness of issues of chaotic substance use and HIV/AIDS transmission/treatment, and will promote the creation of improved programs and services.

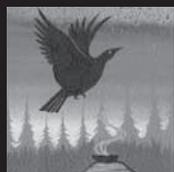
The Task Force will support, advise and provide coordination and actions on Harm Reduction issues. Population-specific approaches are being designed which will assist people who are at risk of infection, and those living with HIV/AIDS, to ‘directly shape policies and programs that affect them’⁹. The task force will provide input into projects, offering a voice on behalf of the people that CAAN serves and informs on a regular basis.

2.2 Partnerships

There is a wealth of HIV/AIDS and addictions expertise in Canada who can come together to collaborate and provide support to those developing and providing Harm Reduction programs and services. There are many HIV/AIDS and addictions agencies, programs and organizations at the local, Provincial, Territorial and National levels, Aboriginal AIDS Service Organizations, community health centres, researchers, social workers, hospice professionals, community workers, medical personnel and volunteers make up the profile of those in positions to provide informed support. The National Native Addictions Partnership Foundation (NNAPF) currently partners with CAAN for the purpose of sharing information on Harm Reduction. CAAN will be participating in NNAPF’s upcoming National training conference to provide training sessions for government, National Native Alcohol and Drug Abuse Program (NNADAP) workers, and other interested service organizations who will be participating in this conference (over 400 participants at the 2004 training conference). CAAN will provide training on the model, and exchange information with various organizations and engage in the networking and sharing of information at the NNAPF conference.

Collaborative efforts can help the community to gain an understanding and acceptance of Harm Reduction approaches. Providing communities with appropriate education and the training of front-line workers, the establishment of needle exchange programs, methadone maintenance, and outreach components, all represent a part of the journey towards safer drug use.

Various stakeholders addressing HIV/AIDS may include government, (Federal, Provincial and Territorial), non-profit groups, APHA’s, National networks, communities, Health Centres and any other groups who feel a need to advance the proposed Harm Reduction approach from an Aboriginal perspective. Partnership protocols will facilitate improved and efficient partner relationships which will increase the effectiveness of services for clients, increase adherence to the treatment approach and increase client support and satisfaction. Many communities, organizations and professionals have existing partnerships and do not work in isolation. Within the structures of this Harm Reduction Strategy, however, new partnerships may be developed which can lead to on-going collaboration in HIV/AIDS and HCV education, awareness and program development.



2.3 Legal Issues

When planning and/or implementing a Harm Reduction Strategy for an organization or community, various legal issues will need to be considered and explored. Planning and coordinating the Harm Reduction Strategy will require research and/or involvement with police services. Passing a band council resolution (BCR) may need to be considered and there may be a possibility that community by-laws need to be changed to support the Harm Reduction Strategy.

Various legal issues to consider can include (but are not limited to):

- HIV/AIDS testing and confidentiality
- Community approval, Band Council Resolutions, by-laws and protocols for crack kits and needle exchanges
- Safety issues for workers
- Confidentiality issues surrounding disclosures
- Privacy and confidentiality as essential elements of good practice
- Occupational safety needs of guards, counselors, workers at the needle exchange sites, etc
- Violations of human rights
- Working with organizations dealing with the law to ensure appropriate measures are taken to follow by-laws, procedures etc

2.4 Harm Reduction Model

The Harm Reduction model is a tool which can be used in collaboration with the training modules to enhance services within organizations or implement new Harm Reduction programming. The Model begins with an Individual's rights and needs, found at the centre of the circle. This model has been developed to fill a gap where particular target groups may not be receiving the care, support and treatment that they rightly deserve. The four phases that may be used by a service provider, organization or community has been broken down into four groups: Assessment and Visioning, Prevention and Education, Implementation and Evaluation.

All service agents will have the ability to apply this model regardless of where they are in providing Harm Reduction services. All organizations that receive training may or may not choose to apply the model within their agency, may or may not choose to provide needle exchange, for example, yet the training will provide examples of ways in which action may be taken. Whether an organization is at the planning stage, (with no current programming), or whether there is a need to enhance existing services, the model and training modules may be used to assist in the process. This service delivery model will provide the flexibility to apply creative, relevant, and diverse programs and services.



Harm Reduction Model



2.5 How to use the Harm Reduction Service Delivery Model

The Harm Reduction model has been developed to assist groups, communities and organizations in incorporating a Harm Reduction Program or Strategy which would include the needs of the community, while incorporating relevant cultural elements. To begin the process, an assessment or visioning exercise will be conducted which will review past, present and future goals of programming and needs of the community. Once the assessment has been completed, services, prevention activities, cultural elements and implementation procedures and issues will be outlined for the community and/or organization. The model will provide tools to assist in outlining appropriate cultural elements to a Harm Reduction Strategy. The goal is to lower incidences of HIV/AIDS and HCV within Aboriginal communities. This in turn will have a positive impact at both a national and international level.

The Model begins with its centre, being the individual, where services are created to respect their rights and needs through the development and implementation of appropriate services in Harm Reduction. This Harm Reduction Model is providing a service to a target population which has escalating rates of HIV/AIDS. An individual may not receive services when they are injecting drugs due to stigma and discrimination associated with their life on the streets. Or they may be struggling and not in a position considered as acceptable to service providers. Regardless of the actions of any person, each individual deserves the right to be educated on how to reduce the harm to themselves or to others, and to receive services that meet their individual needs.

The determination and application of Harm Reduction approaches will be provided to the four target groups. The services that may be provided for the target groups are 1) Assessment and Visioning, 2) Prevention and Education, 3) Implementation (of services and activities) and 4) Evaluation. Important aspects which need to be considered at all levels of planning and implementing of the programs and services include: accountability to all being served, partnerships (because you never plan a strategy alone), safe disclosure, evidence based practices, holistic health (physical, emotional, mental and spiritual health), and respect for the diversity of all three Aboriginal groups. Partnerships are encouraged within the framework of this model, although, Harm Reduction practices may be provided independently.



Section Three – Four Target Groups

3.1 Target Groups

Aboriginal Women, Aboriginal Youth, Aboriginal people who are or have been in Prison, and Aboriginal Two-Spirit Men are the four main target groups for this model. Four training modules will compliment this manual, with a focus on methods of providing care, support and treatment. The target groups have been identified as being at the highest risk and therefore, information will be applied to the four main target groups. The term Aboriginal refers to the Inuit, Métis and First Nations people, living on and off reserve, and in every part of Canada.

When considering Harm Reduction services, it is important to ensure that data is specific to the population served. Ethnicity data for positive HIV test reports are reported for 29.1% of records and are not available for all provinces and territories.¹⁰ This is an issue of concern in that even with limitations on surveillance, Aboriginal people remain over-represented. This situation coupled with the under-reporting of ethnicity data indicates that Aboriginal HIV cases are underestimated. It is reported that available statistics do not indicate the actual number of infected Aboriginal women, because many cases from this group go unreported. Variations in reporting ethnicity within and between provinces, delays in reporting, and misclassifications in ethnic status are other contributing factors¹¹.

3.2 Women and Harm Reduction

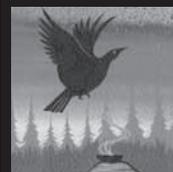
Aboriginal women within this target group include all women, heterosexual, bisexual, trans-gendered, Two Spirit women, and women who have sex with women.

Aboriginal women are becoming infected with HIV/AIDS at higher rates than other women in society. The high transmission rates have been reported through the medium of intravenous drug use and through having unprotected sex. Reported numbers of HIV/AIDS incidence among Aboriginal women reveal that this group is over-represented in the HIV positive classification.

In Canada, PHAC reports that a total of 1,786 AIDS cases and 8,849 HIV cases were reported in adult women up to December 31, 2005.¹² In addition, women represent ‘an increasing proportion of those with positive HIV test reports in Canada and in 2005 accounted for one quarter of such reports. Heterosexual contact and injection drug use are the two main risk factors for HIV infection in women.¹³

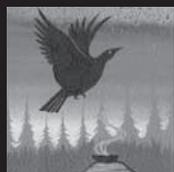
PHAC also reports that HIV/AIDS has had a significant impact on Aboriginal women.

- During 1998 - 2005, women represented 47.3% of all positive HIV test reports among Aboriginal peoples as compared with 20.5% of reports among non-Aboriginal peoples.¹⁴
- Before 1995, females represented 12.3% of reported AIDS cases among Aboriginal peoples, yet by 2005 the proportion had increased to 38.9%.



Various issues have led to Aboriginal women becoming a high risk for HIV/AIDS. Some of these include:

- Issues of power imbalance and violence: NWAC notes that socio-economic conditions, gendered discrimination and the lack of recognition of land and collective rights of Indigenous peoples have all had a negative impact on a woman's ability to live free from violence. In addition, NWAC reports that the unique needs and perspectives of Aboriginal women will not be met if the right and fundamental freedom to live free from violence is not respected, protected and fulfilled. ¹⁵
- Social determinants of health issues: Aboriginal women suffer from high rates of poverty and related ill-health, low education and low employment levels and homelessness. ¹⁶ Risk behaviors for Aboriginal women include those that often assist them in surviving the harsh socio-economic conditions that are strongly associated with a positive HIV test. These include rural to urban migration, homelessness, sex trade and/or sex work, injection drug use and alcohol abuse. ¹⁷ Aboriginal women are also considerably more likely to experience sexually transmitted infections. ¹⁸
- Survival: Women are more likely go to the streets and to the sex trade in order to receive money, drugs, lodging and food for their survival, to support their chaotic substance use, and to live, when they feel they have run out of other options. These drastic coping measures pose great harm to the women, children and their families.
- Relationship issues: having a partner who is an injection drug user may put a woman at higher risk for IDU herself, and of sharing needles or engaging in unprotected sex. ¹⁹ Addiction, the effects of residential schooling and family violence, among others, often contribute to a women's sense of low self-esteem. This makes it difficult for her to assert herself with her partner, and to demand he/she use condoms or have HIV testing.
- Maternal and reproductive health factors: Women are often the primary caregiver in Aboriginal families and will often put the needs of their children or family ahead of themselves, often compromising her health. Stigma and discrimination may be experienced by the HIV positive woman who chooses to give birth. Addressing the issues of mother-to-child transmission and breast feeding requires a more concerted effort. ^{20,G}
- Women who have sex with women (WSW) specific issues: WSW struggle for increased visibility and awareness about their issues and are beginning to organize and undertake advocacy and awareness activities.



3.3 Youth and Harm Reduction

Aboriginal youth vary in life experiences at all stages of their development. Prevention methods, education and awareness are important in teaching and thus normalizing Harm Reduction practices. Youth may learn about the various ways of reducing harm and will be able to incorporate practices into their lives and reduce the incidence of transmission of HIV/AIDS and HCV.

Many Aboriginal youth are experiencing chaotic substance use more frequently than their mainstream peers. But many are also seeking information on how substances may be used in a safe way, and how

to inject properly, and vein maintenance. It is important to understand their population-specific issues and ensure that they receive appropriate prevention and testing information.

Research shows that 33% of newly diagnosed Aboriginal people were under the age of 30 as compared with 20% of non-Aboriginal people. This means that Aboriginal youth are at high risk of HIV/AIDS. <http://www.harmreductionjournal.com/content/3/1/9>

PHAC reports that youth represent a 'small proportion of the total number of reported HIV/AIDS cases'.

- Individuals between the ages of 10 and 24 are reported as accounting for 3.5% of cumulative AIDS cases.
- For positive HIV test reports, youth between the ages of 15 and 19 accounted for 1.5% of all reports²¹.
- Aboriginal people receive a diagnosis of HIV at a younger age than non-Aboriginal people with a third (32.2 per cent) of new positive HIV test reports among youth. (<30 year) This figure is significantly higher than non-Aboriginal persons at 20.8 per cent.²²
- MSM and IDU each account for approximately a third of reported AIDS cases among Aboriginal youth. IDU is the largest factor at 33.9 per cent and MSM was at 30.6 per cent.^H

Foster Care: In Canada, Aboriginal children and youth are entering foster care at an alarming rate, with between 22,500 and 28,000 Aboriginal children in the child welfare system – three times the highest enrollment figures of residential school during the height of those operations²³.

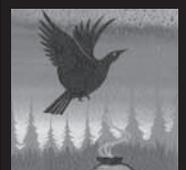
Aboriginal youth are over-represented among criminalized young people. In 2000, 41.3% of all federally incarcerated Aboriginal people who were or had been in prison were 25 years of age or younger. Aboriginal people have much higher education and employment needs than do other incarcerated people. A high percentage (80%) of Aboriginal people who are or have been in prison report early drug/or alcohol use; physical abuse (45%); parental absence or neglect (41%); and poverty (35%) in their family backgrounds. 28% of Aboriginal people who are or have been in prison have been raised as wards of the community²⁴. These percentages are all indicators of young people being at high risk for contracting HIV/AIDS and HCV.

Youth at risk who are not being tested: Underserved Aboriginal adolescents and young adults, many of whom have involvement with the juvenile justice system or are in custody, are HIV positive or are at risk for HIV infection; many male and female teens are trading sex for survival or to purchase drugs; there are cases of chaotic substance use, young women are becoming pregnant, or two-spirit young people are runaways, street involved, homeless, or otherwise living on the edge of the community.

Unprotected sex: PHAC reports that the prevalence of sexually transmitted diseases (STD) and teen pregnancy may indicate the frequency of unprotected sex.²⁵

There is a lot of confusion and misinformation regarding HIV/AIDS: PHAC reports that studies indicated many youth believe that there is a vaccine to prevent HIV/AIDS and that the disease can be cured if treated early.

Addressing potential knowledge gaps: There are other contributing factors that are an area of concern. If a youth drops out of school, for example then he/she may not be privy to HIV/AIDS information.



Taking risks: Normal limit-testing is common place behaviour in adolescent development, however, vulnerable adolescent's ramp up the risks by taking sexual risks, being engaged in chaotic substance use and living on the streets²⁶.

Educational materials designed by and for youth: Youth designed materials, counseling for sexuality issues; access to health services, intervention and appropriate Harm Reduction approaches can help engage youth and address high risk behaviours.

Gateway Drugs: Youth require education and awareness of gateway drugs and the possibility that these could lead to harder drugs and more chaotic substance use. Various gateway drugs include tobacco, marijuana, alcohol, and ecstasy.

Aboriginal youth: Aboriginal youth need to be full participants in determining actions that will address their needs. CAAN has developed a youth link to its website which has been designed with and for youth which provides a means for communication regarding HIV/AIDS, while allowing for access to confidential information.

To view Canadian Aboriginal AIDS Network, Youth website go to: http://www.caan.ca/youth/html/index_e.html

3.4 Aboriginal People who are or have been in Prison and Harm Reduction

Aboriginal people comprise 2.7% of the adult Canadian population and women make up 50-55% of the Aboriginal population²⁷. The incarceration rate of Aboriginal people in Canada is high and Aboriginal people are over-represented. Approximately 18.5% of Aboriginal people who are now serving federal sentences are of First Nations (68%), Métis (28%) and Inuit (4%) ancestry. In the Prairies, where Aboriginal peoples comprise a larger portion of the general population, they account for a staggering 60% of Aboriginal people who are or have been in prison.

Aboriginal people who are or have been in prison experience longer periods of incarceration, are placed in maximum security, and are segregated more frequently than non Aboriginal people who are or have been in prison. These conditions reduce Aboriginal access to programming intended to prepare Aboriginal people who are or have been in prison for eventual release, and to increase their chances for successful integration into their communities²⁸.¹ This situation has caused negative impacts in the areas of public health, civil rights and social justice.

While the federally incarcerated population in Canada declined by 12.5% from 1996 to 2004, the number of First Nations people in federal institutions has increased by 21.7%. The number of incarcerated First Nations women also increased by 74.2% over the same period.

It is important to understand the many reasons why Aboriginal people are over-represented in prisons.

- Many Aboriginal people end up on the streets for varying reasons, due to abusive home situations,



inability to afford housing, chaotic substance use, etc; Aboriginal people are struggling with the legacy of residential schooling, and are subjected to systemic racism and attitudes based on racial or cultural prejudice on a regular basis. Prejudice leads to living on the fringe of mainstream and in poverty.

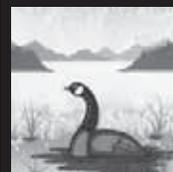
- Racism: Aboriginal people attract more police attention than non Aboriginal people as a general rule (i.e. they are more likely to be stopped and questioned)²⁹. They often end up in prison not because they are hardened criminals, but as a result of racism based on issues related to colonization and deterioration of their social, cultural, emotional, and spiritual well-being³⁰.
- Homophobia: Two-Spirit men and women are at particular risk of abuse, violence, racism, and sexual assault/rape; these issues increase their vulnerability to HIV/AIDS and HCV.

HIV/AIDS and HCV have become emergency issues in Canadian prisons. The rate of HIV seroprevalence is ten times higher in prisons than it is in the general population³¹. The rate of HCV in prison is approximately 39% of the population. The high incidence of HIV/AIDS and HCV is a result of IDU, unprotected sexual activities and tattooing. The rate of IDU by incarcerated Aboriginal men is between 43% to 54% and 8% of Aboriginal women who are or have been in prison. Aboriginal people who inject drugs in prison are at high risk of sero-conversion.

- High risk environment: Once someone becomes entrenched in the system they will face risks, especially if they use drugs and inject needles. Needles and other paraphernalia are considered contraband in prison (unless an inmate is diabetic) which leads to Aboriginal people who are or have been in prison to share needles with others. In this regard Aboriginal people who are or have been in prison are not permitted access to the very things that can prevent them from getting HIV/AIDS or HCV.
- Need for information: Significant energy and resources are required to ensure that accurate and timely information is being delivered³². If a person in conflict with the law has never been given information that they can relate to about HIV/AIDS and HCV, they may never ask to go for a test, and this potentially poses risks to sexual partners. There is a need to increase knowledge of sexually transmitted infection including symptom recognition and screening.
- Testing: If Aboriginal people who are or have been in prison have never been given information that they can relate to about HIV/AIDS and HCV, they may never ask or go for a test and as such pose risks to sexual partners out of ignorance. This also has implications on their health needs as they may go un-diagnosed and develop more serious health threats for themselves, their partner and their community.

3.5 Two-Spirit Men and Harm Reduction

Fact sheets regarding men-who-have-sex-with-men (MSM) have stated that the term “men who have sex with men” “describes a behavior rather than a specific group of people. It includes self-identified gay, bisexual, trans-gendered or heterosexual men. MSM are often in married [heterosexual] relationships, particularly where discriminatory laws or social stigma of male sexual relations exist.”^{33, K} MSM may



also include men who are not gay but who have sex with men in the sex trade in order to obtain food, drugs, and/or shelter. In terms of HIV/AIDS and HCV, sex between men is significant because it can involve unprotected anal sex, which is high risk behaviour.

The Public Health Agency of Canada reported in 2006 in Epi Update: HIV Infections among MSM in Canada:

- MSM account for 76.3 per cent of cumulative reported AIDS cases and 68.8 per cent of cumulative positive HIV test reports among adult males.
- Of all new HIV infections in Canada in 2005, MSM were estimated to make up 45 per cent of these cases.³⁴ PHAC reports that new infections among MSM has not decreased in 2005 and may have increased slightly compared to 2002.
- MSM account for 11 per cent of the prevalent infections and 10 per cent of incidence among Aboriginal peoples in Canada in 2005.³⁵ While there are only a few research studies on this sub-group of APHAs, some research is illuminating emerging trends. An example is found in the Vancouver Injection Drug Users Study (VIDUS) which is an open cohort study of IDU.
- In VIDUS surveys between 1995 and 2000, of 910 MSM who had injected drugs in the previous year; MSM/IDU 'were younger than MSM and more likely to be HIV sero-positive, Aboriginal, economically disadvantaged, engaged in the trade of sex for money and drugs and to report having female partners'.³⁶

Key prevention issues for Two-Spirit men include the following:

- Prevention and care programs are often neglected when there is a taboo on MSM behaviour:³⁷ Information and education and other prevention programs targeted specifically at MSM help save lives and curb the epidemic.
- Low self esteem, gay bashing and homophobia issues: These issues may lead to chaotic substance use, depression and various high risk behaviors.
- Transmission to female partners: This becomes an issue when MSM may also have sex with their female partners or wives.³⁸



Section Four – Aboriginal People – Inuit, Métis, and First Nations

4.1 Culture – Holistic Healing

The healing journey of Aboriginal people is more in-depth than seen in Western practices. The healing process includes information, prevention activities, crisis interventions, counseling and follow-up; all of which are typically included in a plan of care or treatment plan. The difference in practices for Aboriginal people will include the incorporation of community practices, customs, beliefs, ceremonies and use of Elders and Traditional medicine people. This holistic approach to the plan of care includes considering the physical, emotional, mental and spiritual aspects of a person's healing.

4.2 Aboriginal People in Canada – Inuit, Métis and First Nations

Inuit

The Inuit have determined a need to reduce harm within their communities, using creative and innovative strategies which differ from methods found in the south. Services are few and far between in many of the isolated and remote communities, and access to care, support and treatment may mean that many Inuit have to leave their community, family and homes in order to access such care. Many Inuit have been subjected to multi-generational trauma, coping through chaotic substance use, have high rates of suicide, and are affected by other determinants of health. Many northern communities have unsafe drinking water, poor housing and living conditions, and high rates of incarceration, with limited resources at their disposal. The Inuit live in isolated, northern communities where food security, a harsh environment, lack of access to quality health care and education, and lack of recreational activities often lead to negative social behavior.

Métis

The Métis in Canada have their own distinct culture, and service organizations, and deal with their own set of difficulties while combating HIV/AIDS and HCV. Lifestyle issues for the Métis range from dealing with the high costs of medications to receiving Métis specific services, to dealing with obtaining Métis specific data and research.

A Report by the National Aboriginal Health Organization 2001 Census Profile lists the Métis as:

- Being primarily young, and urban-based
- One in three, or 31% of the total Aboriginal population



- Median age of Métis is 27 years compared to 38 years for the non-aboriginal population
- 31% of Métis children live with a lone-parent

Métis leaders, communities and organizations may apply this culturally relevant Harm Reduction Model to their existing services. This service delivery model is designed to allow all Métis to address their own needs and to apply their own cultural elements while introducing relevant Harm Reduction approaches.

First Nations

Indian and Northern Affairs Canada (INAC) reports that there are 704,851 status Indians in Canada with 614 First Nation communities. However, there are many First Nations people who are not entitled to be registered as status Indians under the current Indian Act so the First Nations population is higher than is reported by INAC. Within all First Nation communities there are differences in languages, customs and culture.

Similarities amongst First Nations people in all of the communities across the country include the negative experiences of the residential school system, loss of culture and language, and the multi-generational impact that this has had on the people. Among many First Nations peoples there has been a high incidence of poverty, chaotic substance use, family violence, and high rates of incarceration, suicide, school drop outs, and HIV/AIDS infections.

4.3 Aboriginal Culture - Inuit, Métis and First Nations

Balance, holistic healing, and cultural programming are appropriate to the Inuit, Métis, and First Nations people and include these elements:

- Use of Elders
- Use of Medicines and Medicine people
- Circles
- Incorporation of dance and music which instill pride
- Council of Elders
- Language
- Healing ceremonies
- Connection with the land
- Camping and outdoor activities and services
- Incorporation of teachings
- Role clarification
- Extended family

The application of culturally appropriate services have been identified as a key element in increasing pride and self esteem as well as reducing suicide amongst First Nations, Inuit and Métis. The impact of instilling pride amongst Aboriginal people through cultural promotion is an evidence based practice which is crucial to the interventions for high risk Aboriginal people.



The Inuit, Métis, and First Nations people of Canada are diverse groups of people who engage in many different practices that vary according to the location of the people, their values and beliefs, the teachings that have been passed down from generation to generation, and the lifestyle they have practiced throughout the years. The different cultural practices inform this model, and tools are provided to outline beliefs, values and customs in order to apply these elements to their respective programs, policies and services.

4.4 Determining Inuit, Métis and First Nations cultural practices

The Harm Reduction Service Delivery Model has been developed within a holistic framework. Participants determine the appropriate cultural elements that fit their respective region, customs, values, beliefs and practices, through an assessment process. It has been determined that culture and a positive Aboriginal identity is important to healing and increased self esteem of Aboriginal people. Discovering or rediscovering pride in being Aboriginal leads to a healthy outlook on life and can move a person from feeling a low sense of self worth to a place where they experience pride in who they are, walk with their head high, experience happiness, freedom, and improved health. Through the application of this model and through accessing effective community services, a person will no longer walk alone and will feel proud as an Aboriginal person, walking with their head held high.

Various methods of incorporating cultural components to your organization, client, or community may involve the inclusion of:

- Input from community Elders
- Incorporation of an Elders Council within your community
- Individual questionnaires upon initial stages of assessment with a client
- Application of traditional teachings during prevention activities
- Review ceremonial practices, unique foods, and languages spoken
- Ensuring that the appropriate medicine people are assisting people within the community
- Visiting Aboriginal service organizations to determine appropriate protocols for each diverse group
- Discussing the cultural elements with the community at large and determining what other areas may need to be researched in order to meet the needs as determined by the clientele.



Section Five – Implementation of the Harm Reduction Model

5.1 Assessment and Visioning

When elected leaders, para-professionals/professionals, communities or service organizations feel the need to make changes within their respective departments or services, they begin with conducting a needs assessment, or visioning exercise. A community may require changes within service provisions (in order to apply Harm Reduction) and this change may be recognized through the assessment and/or visioning process. This exercise will provide an opportunity for all of the people who receive services to have input into how the change should occur, and to explore possible ways of reaching the desired outcome.

Individuals require information to assist them in making decisions about the levels of risk they are willing to accept, and the types of activities they are willing to engage in.³⁹ Service providers need resources to provide them with the information required to undertake effective health promotion with individuals they may see in their practice.^L

Reviewing where the organization has come from and looking at its growth over the years, and determining where it would like to go in the future, is an effective planning exercise. Planning a review of the adoption of Harm Reduction approaches which will be incorporated within the various areas of services or with the service providers will assist in the development of policy and program delivery. An assessment and visioning exercise may be used with a client to look at individual services, or it may be used with an entire service organization.

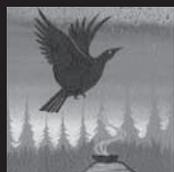
One of the objectives of establishing Harm Reduction approaches or practices is to address the need for change. Clients and/or community members may be engaging in harmful activities and the community may be seeking action and searching for methods that will reduce harm.

An assessment will determine the various program and community goals, interviewing/counseling and/or service goals. Short and long term goals of programs and policy changes will be discussed and reviewed within the assessment. The assessment tools used will include:

- Individual interviews
- Focus groups
- Public meetings with facilitated discussions
- Use of surveys/questionnaires
- Or through a combination of these methods.

A visioning exercise for communities will review the past, present and future of an organization or service. Questions that will be answered in the visioning exercise would include:

- Where we are
- Where are we going?



- Where do we want to be?
- How do we get there?

Things to consider when doing a community assessment or visioning exercise may include:

Cultural aspects of conducting a community assessment – Be sure to ask questions regarding how best to implement Harm Reduction approaches which incorporate culturally relevant aspects appropriate to the community or organization. Methods of conducting your assessment or visioning may include ceremonies, use of Elders, or it may be conducted orally, using focus groups, for example, rather than through the use of written tools. Or through a combination of all methods may be implemented.

Creating a safe space – Ensuring safety is crucial when planning for an assessment or visioning exercise. Participants need to feel safe to speak openly as they begin looking at making positive changes.

Angry community members wanting change – Many community members may be fed up with chaotic substance use within their community and seek immediate prevention initiatives. This will need to be addressed and the energy may be redirected as members begin discussing plans and hearing the voices of others from the community. Diffusing anger through positive methods (allowing community to voice their concerns, discussions around possible changes) of moving the issues forward will assist in making progress and alleviating anger.

Dealing with change – Many people experience difficulties with change. They may feel that things are great the way they are and introducing change may create havoc within the organization/community.

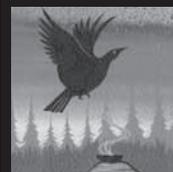
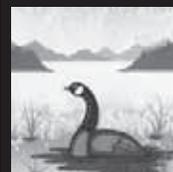
Negative Media attention – During crisis situations within an organization or community, the media may provide inaccurate or negative aspects of the crisis situation. Addressing the role of the media within the assessment, or during the visioning exercise, needs to be discussed with the community.

Innovative ways of creating change – Trying something new can be fun and exciting. Through research and training, a community may introduce evidence based methods into their programming which will produce effective change and reduce the incidence of HIV/AIDS and HCV.

5.2 Prevention and Education

Once the assessment is complete the organization, staff or leadership may wish to educate the public on the various high risk behaviors that are occurring which are negatively affecting the health of the community. The assessment and visioning is used to envision the educational and awareness needs of the organization and/or community. Prevention and education needs will vary according to age group, knowledge already received, incorporation of teachings, and location of where the activities will be taking place. For example, some schools will not allow condom distribution on school premises.

There are limitless ways in which culture may be applied to relevant programming and education within prevention activities. Use of Elders, facilitators with gifts for providing traditional teachings relevant to the people in the region, etc may all be incorporated to provide a culturally relevant prevention and educational program.



Prevention within the community and/or service organization can occur in various ways. Below are some concrete examples that service providers may wish to incorporate:

- Women need to be empowered as peer service providers. This includes programs by and for sex trade workers, women who use drugs, Aboriginal women, and women in prison⁴⁰.
- Harm Reduction measures as well as appropriate educational materials should be made available with up to date information in plain language. Discreetly packaged HIV/AIDS and HCV health information must be widely accessible.
- Transmission issues and access to needles and condoms: Few reserves have needle exchange programs but most reserves can provide condoms via their Community Health Representative (CHR), Community Health Nurse (CHN) or a health clinic to reduce the risk of HIV infection among people in the community⁴¹.
- Training and Harm Reduction: It is important to remember that the HIV/AIDS epidemic is primarily about the lack of education and not being tested. It is therefore essential to identify the target audience to determine their informational and training needs.
- Occupational safety needs: Warders and others who work in the system fear needle stick injury from contraband.
- Partner transmission: Male and female sexual partners have been known to become HIV positive through having unprotected sex and/or sharing needles.⁴²
- Prisoner transmission: The HIV infection rate among Aboriginal people who are or have been in prison is 10 times higher than it is in the general population. "HCV is 29 times more prevalent behind bars than in the general population."⁴³ In addition, regulations that prohibit the use or possession of drugs or needles make the likelihood of sharing much higher on the inside and therefore increase the risk for both HIV/AIDS and HCV infection. IDU is labeled as a 'major public health issue' and it is noted that Aboriginal people who are or have been in prison will continue to use after release. Dr. Peter Ford^M of the Ontario Medical Association reports that with the frequency of movement of individuals between prisons and the community means that 'any transmission of the disease within prisons will increase the risk for transmission in the community. Unfortunately, attitudes towards imprisoned injection drug users stem from stigma of criminality which discourages others from helping injection drug users. Secondly, it can be noted that prison officials do not want to appear soft on drugs and are unwilling to incorporate Harm Reduction programs.⁴⁴
- HIV/AIDS and HCV pre and post counseling must be provided as a mandatory part of all testing. Access to anonymous testing is essential and no one should be tested without counseling.



5.3 Implementation

Implementation of the Harm Reduction model has been discussed as a continuum of services designed to fill gaps for the four target groups, and where bridging is required, in order to address the issues faced on a daily basis.

- Aboriginal-specific services will create a culturally relevant program which Aboriginal people may relate to when they receive a holistic treatment plan throughout the care, support and treatment services.
- Social Justice Issues must be addressed when considering the individual rights and needs of the entire community. That is, Aboriginal people who engage in high risk activities have the right to receive appropriate services according to their specific needs.
- The diversity within the three groups of Aboriginal people must be respected and incorporated into the services developed and implemented within the community and/or organization.
- Safe disclosure by clients, in a safe environment, will promote healing within the physical, emotional, mental and spiritual aspects of the person.
- Evidence based methods of services within the model will allow for a successful implementation of the Harm Reduction program. Evidence based activities include activities such as needle exchange programs, which will provide positive outcomes within the Harm Reduction strategy.
- Developing partnerships are encouraged in order to maintain consistent Harm Reduction messages throughout community programming, care, support and treatment.
- Risk management, or reducing harm to individuals, is a primary goal of the Harm Reduction Model.
- Capacity building will provide service providers with new tools to assist in normalizing Harm Reduction approaches and will work to reduce the incidence of HIV/AIDS and HCV.
- Outreach is an evidence based practice which reaches out to individuals who may not have had the opportunity to receive services.
- Health promotion, using a holistic perspective within a Harm Reduction approach will change the face of services within the nation, communities, and organizations.
- Policy development is a key method of applying new and innovative ways of reaching high risk clients and community members.

Within this holistic model, implementation can occur within all program areas within an organization or community.

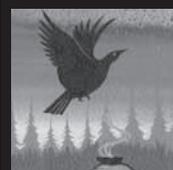
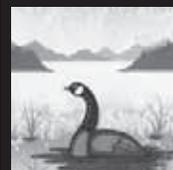
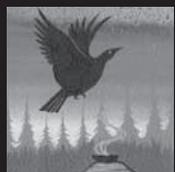
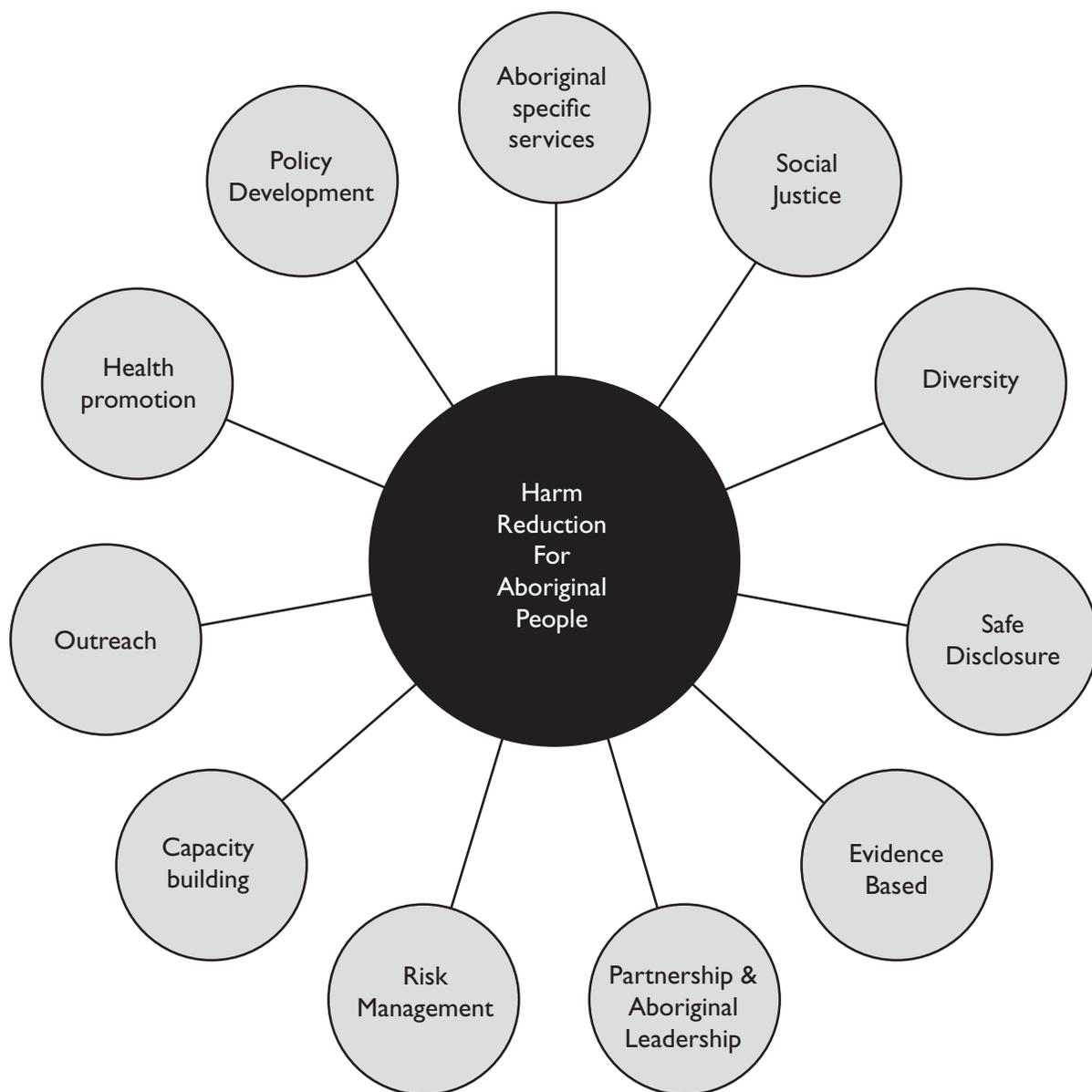


Diagram on Implementation within program areas on Harm Reduction

The diagram below provides a visual on various elements to consider when implementing Harm Reduction Practices.



5.4 Evaluation

The evaluation of programs may consist of a process that is on-going, or it may include a full scale evaluation which tracks client progress and provides data reflecting programming outcomes. Evaluating workshops, awareness sessions and the educational elements of programming will help to keep an ongoing record of how workshops can be modified and tailored to meet the specific needs of the clientele.

Follow up with clients may present a number of challenges, as when dealing with clients who are engaged in high risk behaviours, due to inconsistent and sporadic sessions. Client lifestyles are often chaotic and may be difficult to coordinate effective and regular follow up visits. Trust needs to be built and this will occur within a Harm Reduction approach. Innovative ways of tracking client's behaviour is required and workers need to be flexible and ensure that a non-structured environment is maintained.

Upon completion of the evaluation, this model may be utilized to develop methods that may be used for programming. Clients and service providers may create innovative methods of service and policy that will be relevant to the client, organization and/or community.

5.5 Scenarios

Harm Reduction Scenarios

To assist in the process of incorporating a Harm Reduction approach, the scenarios depicted below include questions to think about, which assist in understanding how to best implement appropriate services. Think of the questions and determine the ways in which care, support and treatment may be applied within a Harm Reduction approach.

Scenario Number One:

A young First Nations woman is brought into the National Native Alcohol and Drug Abuse Program (NNADAP) office by her mother. She is 19 years old and is a mother to a newborn baby. The young woman has been injecting drugs on a regular basis. Her child has been placed with the grandmother due to her high risk behaviors and involvement with the law. The grandmother attempts to "straighten" out her daughter by bringing her in to the office to receive services.

Questions to consider:

- How can the community address this situation using a holistic healing framework?
- How can a professional involve other professionals, leadership and community? What would this involve?
- What would be involved at all phases of the services for this young person and her family? What do you need to consider in the assessment, prevention, implementation and evaluation of the services?



Scenario Two:

A Two-Spirit Métis man has just been diagnosed as HIV positive after being released from prison. He is at a half-way house and will return to his home community within four months. He has been injecting drugs and also engages in other high risk activities such as engaging in unprotected sex, especially when he is intoxicated.

Questions to consider:

- What should the professional consider in arranging with the community worker for the man's return to his home community? (re-integration plan)
- What referrals should be made, from a Harm Reduction standpoint for the client and for the half-way house?
- How can the half-way house work with the community in establishing Harm Reduction strategies?

Scenario Three:

A high school located in a city centre has an increase in teen pregnancies and has some concerns about youth selling and using drugs on the school premises. The school has a high population of Aboriginal students, (the school is located in an area of the city where many Aboriginal families reside). The high school wants to educate the youth on HIV/AIDS, HCV, IDU, drinking and driving, use of condoms and other Harm Reduction activities, as well as introduce Harm Reduction approaches. At the present time, the school is not permitted to distribute condoms.

Questions to consider:

- The school has been providing harm initiatives, such as a drinking and driving campaign and sex education. What are the school's options for implementing other Harm Reduction approaches?
- Which would be best applied to this school, an assessment, or a visioning exercise? And why?
- How can the school incorporate the three cultures into its Harm Reduction strategy? List possible options for cultural programming related to Harm Reductions.
- What policies need to be reviewed, and who needs to be involved in making these changes?



Scenario Four

A guest speaker is invited to a remote Inuit community by the leadership and speaks to community members about the links between drug use and HIV/AIDS and HCV. The speaker introduces the idea of people traveling to urban centres, who engage in high risk activities while there and then return to the community. Community leaders are aware of two spirit men within the community who travel to urban centres and engage in sexual activities with other men.

Questions to consider:

- What exercises can the guest speaker use to determine the cultural practices of the community?
- What can the leadership do to promote Harm Reduction initiatives within their community? How might they envision policy development impacting community members' travel? How can they become aware of legalities surrounding this issue?
- How can Harm Reduction approaches work in a community when the harm is happening outside of the community? How can the community put a strategy in place for this kind of situation?



Section Six – Moving Forward

Through the training and implementation of the Harm Reduction Model, it is hoped that the communities will reduce the incidence of HIV/AIDS and HCV. With every new Harm Reduction Strategy that will be created, there will be a new hope for new Pathways to Health. People will walk together on their journey to healing.

Providing new needles can open the door to counseling. Counseling may help the individual understand how their chaotic substance use may be high risk and help them to make healthier lifestyle choices. They may never give up their drug use, nor abstain from sex, but they may learn to use safe practices, get tested on a regular basis and practice safe sex.

There needs to be a concerted effort within Canada to bring an end to stigma and discrimination; the WHO states that action towards achieving this objective must be supported by top leadership and at every level of society. Further, that 'it must address women's empowerment, homophobia, attitudes towards sex workers and injecting drug users, and social norms that affect sexual behavior – including those that contribute to the low status and powerlessness of women and girls'.⁴⁵

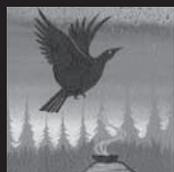
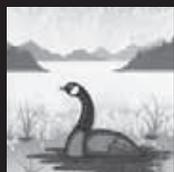
A key recommendation from the World Health Organization (WHO) Global HIV/AIDS Report – 2006 is that products for HIV prevention and treatment must be made available and affordable, and that national governments should remove legal or regulatory barriers that block access to effective HIV prevention interventions and commodities such as condoms, Harm Reduction services and other prevention measures.⁴⁶

In Canada, the focus needs to be on advocating for work that needs to be done for Aboriginal people. CAAN and other Aboriginal Service Organizations (ASO) have clearly stated these needs; the work being done by groups such as the Aboriginal HIV/AIDS Harm Reduction Task Force and others will move strategies into action. The political will to do so, is an integral component and positive advancements such as the Federal Government's recent announcement regarding AIDS vaccines is an example.⁴⁷ HIV/AIDS organizations need to be adequately resourced to continue the advocacy and service work in communities.

The World Health Organization (WHO) reports that the global HIV/AIDS epidemic is growing and in fact that some countries are seeing 'resurgence' in new HIV/AIDS infection rates which were previously stable or declining.⁴⁸ WHO also reports that HIV prevention programs need to be sustained and be adapted to the changes of the epidemic in order to lower the infection rate. In November 2006, 'UNAIDS/WHO 2006 AIDS Epidemic Update', stated that in North America, HIV/AIDS prevention programs have not been sustained and the number of new infections has remained the same.^N

The current Canadian picture of HIV/AIDS prevalence in Canada's Aboriginal population is also acknowledged internationally. The WHO, in 2006 AIDS Epidemic Update: North America, Western and Central Europe, reports that Canada's current data, highlights the need to ensure effective strategies are in place to prevent new HIV/AIDS.

There is a documented need for more research for Aboriginal people with respect to Harm Reduction and HIV/AIDS. Wise practices need to be grounded with a solid evidence base. An important aspect of



research related to Aboriginal populations is the need for Aboriginal people themselves to take control and lead their own research practices⁹.

The WHO calls for aggressively addressing HIV/AIDS-related stigma and discrimination, and to put an end to the pandemic. This will depend largely on 'changing the social norms, attitudes and behaviors that contribute to its expansion.'⁴⁹ When an individual's rights and needs are met and they are able to begin their healing journey, it will in turn affect their family, which will have an effect on the community, and on to the nation and the globe. It is a positive effect and as each community embraces community-driven Harm Reduction approaches, there will be global change. Harm Reduction needs to become normalized and awareness of such approaches may be extended to all walks of life. Embracing Harm Reduction will help in preventing the spread of HIV/AIDS and HCV.

6.1 Actions for Change

Accepting Harm Reduction initiatives may be introduced into every department throughout all levels of services being provided to clients. Providing training on the model to service providers, leadership, community members, etc, while addressing policy is a crucial step to reducing HIV/AIDS and HCV. Actions for change are listed below for incorporating a Harm Reduction Strategy within various elements of programming and services. The listed activities are not limited to the following lists and are meant to serve as an example of possible activities/tasks which are meant to be a starting point. It is expected that through brainstorming sessions and focus groups, communities and organizations may develop their own activities and policies that would best meet their needs.

Actions for change for Elected Leaders would include:

- Presenting awareness of change to community members.
- Administering change and delegating duties to staff in order to incorporate a full Harm Reduction strategy throughout all departments.
- Assessment of current policies and making appropriate changes in order to incorporate Harm Reduction practices.
- Conducting assessment, visioning and evaluations within the community.
- Creating forums involving clients, service providers and community members to discuss Harm Reduction Approaches.

Actions for change for para-professionals/professionals:

- Assessment of clients, incorporating culturally appropriate assessment tools, reviewing the client's personal, drug, and social history etc.
- Providing culturally relevant prevention and education to all clients in group settings or on an individual basis. These include education sessions on the impacts of IDU, transmission issues, and the importance of HIV and HCV testing
- Providing a model of healing to the client which is holistic and provides access to cultural elements important to a client's healing journey. These include, access to medicine people, ceremonies, teachings as a foundation for learning healthy living, etc
- Partner with Aboriginal organizations to address the needs of Aboriginal clientele (if a non-Aboriginal organization).



Actions for change within a community:

- Discussions at community meetings addressing the introduction of Harm Reduction approaches to chaotic substance use.
- Partnerships with other communities to apply a strategy that is consistent and reaches neighbouring communities and services.
- Providing safe access to Harm Reduction initiatives within the community, including the provision of free condoms, new needles, needle works, or needle exchange services.
- Incorporate information and prevention activities to various community events to incorporate the normalizing of Harm Reduction.

Actions for change within volunteer groups or individuals in promoting and providing Harm Reduction within a community or organization:

- Share personal stories on how Harm Reduction approaches have or have not been utilized, and how it has affected the family, community and self.
- Advocate for services, education and activities which incorporate a Harm Reduction approach.
- Provide assistance to staff during workshops, education sessions and various programming. Organizations are often short staffed and volunteers are encouraged.
- Volunteers can get involved in committees where their expertise would be valued and put to good use for the introduction and implementation of Harm Reduction strategies.

Actions for change which are applicable to service organizations:

- Partner with various organizations and services that can assist with legalities, policies, ideas and sharing of services, such as Addictions organizations, CAAN, and neighbouring communities.
- Applying relevant policies to address and support Harm Reduction strategies in all programs within the service organization.
- Incorporating appropriate tools for collecting data on Harm Reduction services being provided, and recording changes resulting from Harm Reduction initiatives.
- Within non-Aboriginal organizations, full scale implementation of Aboriginal specific services may be incorporated, such as the hiring of Aboriginal staff, training of Aboriginal volunteers and implementing Aboriginal programming. Applying quick fixes will not provide efficient services, but working with Aboriginal communities will assist in implementing Aboriginal specific programming and services.

Actions for change for assessment and visioning can include:

- Utilizing the Harm Reduction Model to incorporate the ideas of all parties involved including community members, staff, youth, Elders, families, etc.
- Providing awareness on what Harm Reduction entails before conducting the assessment/ visioning.
- Conducting assessment/visioning within various levels of programming, in various departments, or within the organization as a whole.
- Hire a facilitator to conduct assessments, or visioning, so that they are unbiased and have no hidden agendas which may influence the outcome.



Actions for change for prevention/education:

- Using the assessment to determine the prevention and education needs of the community, target groups, and service organizations.
- Pamphlets, workshops, special guests, school programs addressing Harm Reduction initiatives, IDU services – needle exchange and new needle services, handing out condoms, HIV/AIDS and HCV testing locations, all need to reflect a culturally relevant perspective.
- Educating staff on safe practices in dealing with clients.
- Incorporating Harm Reduction into all program areas in order to normalize such practices and the strategy as a whole.

Actions for change within implementation can include:

- Having a well rounded strategy that addresses all aspects of Harm Reduction programming within a community or organization, and putting it into action.
- Reviewing legalities of incorporating Harm Reduction practices and making appropriate changes within policy, and within services.
- Providing awareness to the community, and normalizing Harm Reduction and incorporating needle exchange, etc discreetly within the community.
- Educating staff, providing all necessary tools for workers in order to provide culturally appropriate services and provide Harm Reduction approaches on a regular basis within various components of programs offered.

Actions for change within evaluation processes in Harm Reduction can include:

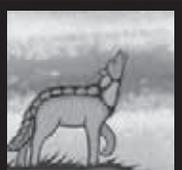
- Evaluation sheets provided to participants of workshops, education and awareness sessions.
- Providing follow-up with clients, and assessing the needs of the clients on an on-going basis.
- Incorporating the Harm Reduction Strategy into full program and community evaluations.
- Collecting and analyzing data related to Harm Reduction.

Actions for change for organizations serving Aboriginal people who are or have been in prison:

- Provide pamphlets on transmission and harmful activities which may affect their health and the health of others upon entering the prison, half-way house or treatment facility (development of an orientation package for Aboriginal people who are or have been in prison/clients, with Harm Reduction information included).
- Provide testing, with appropriate pre and post-test counseling for Aboriginal people, entering the facility.
- Work with the Justice departments to incorporate new and innovative ways of providing Harm Reduction strategies within the facility; be open to trying new things, while putting health first.
- Educate staff (at treatment centres, half-way houses, and various institutions), on possible harm, and provide safe working environments (if not currently provided).

Actions for change for increased services/programming for Two-Spirit Men:

- Create support, care and treatment services for Two-Spirit men and provide Harm Reduction prevention and awareness sessions within a community which is inclusive. Awareness sessions



need to be relevant and designed to educate the Two-Spirit population and/or to educate the community as a whole on information specific to Two-Spirit Men.

- Provide care, support and treatment for any Two-Spirit men who may be diagnosed with HIV/AIDS or HCV. Do not ignore the situation but address it and include these men in the overall goals of the community programming. Treat any ailments with equal attention as would be paid to any other health situation within the community, honouring the individual rights and needs of the client.
- Include Two-Spirit Men when incorporating the Harm Reduction Model within the community and/or organization. Involvement may be within committees, policy development exercises, and through volunteerism within the community. This will allow for acceptance and applicable services that will meet the needs of Two Spirit Men.
- Partner with organizations which will provide communities with current trends of Two-Spirit Men, Harm Reduction, modes of transmission, etc., in order to apply to current programming, and to provide consistent messages with neighbouring communities and organizations.

Actions for change for Aboriginal Youth:

- Partner with Youth organizations, schools, youth justice, and various organizations that provide services to high risk youth in the community and introduce Harm Reduction strategies which are consistent within all services.
- Advocate for changing policies within schools and communities in order to provide appropriate Harm Reduction practices applicable to the Youth. (Currently, some schools will not allow condoms, or other Harm Reduction practices that are required to reduce harm to the youth)
- Include parents in workshops designed for the youth to educate and make them aware of the issues that their children/youth may be facing. Inclusion of parents creates a bond between parents and youth which makes the youth feel that parents care. Inclusion of parents also creates a stronger team in the battle of combating harm.
- The inclusion of youth on planning committees, assessments, and policy development will allow youth to share their success stories and thus becoming role models that are Harm Reduction oriented.

Actions for change for Aboriginal Women:

- Organizations which serve high risk Aboriginal women may consider adopting a Harm Reduction approach. The creation of partnerships, education, awareness, needle exchange programming, condom distribution, (to name a few), are all necessary to help reduce the high rates of women becoming HIV/HCV positive.
- Suggested organizations where this Harm Reduction Model may be implemented may include but is not limited to Welfare Departments, Women's Shelters, Crisis Centres, Food Banks, Child Protection Agencies, Walk-in Clinics, Schools, Outreach Services, Probation, Treatment Centres, Police Departments, Volunteer Organizations, and any other agencies which address the needs of Aboriginal women.
- Teaching Aboriginal women about their individual rights, especially at a young age, helps to improve their self-esteem, and self-respect. This is especially true for women who, as a result of trauma, may feel that she has no voice. It may be instructive to practice role playing with Aboriginal women, teaching them how to say no, how to get a man to wear a condom, and to improve their voice in harmful situations.



- Create new and innovative ways of reaching Aboriginal women through Harm Reduction approaches and to begin to address unhealthy lifestyles which they may be living. Such lifestyles may include living on the street, prostitution, and finding themselves isolated in their own homes.
- Including women in the development and planning of policies and strategies which relate to women's issues and Harm Reduction will ensure that services are applicable to this target group.

6.2 Closing

In closing, the Walk with Me Pathways to Health is a Harm Reduction Service Delivery Model which reaches out to meet the needs and protect the rights of individuals who fall within the four target groups as outlined. Injecting drugs, living on the streets, engaging in the sex trade, having unprotected sex, and not being educated on what is harmful or feel worthy or empowered to want to protect oneself are no basis for why any of the individuals identified in this manual should be ignored or forgotten.

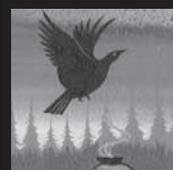
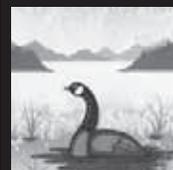
Through providing the Harm Reduction Service Delivery Model, these target groups can receive the education and awareness they need, and find supportive service providers so that healing may occur and protecting the individual and family will take place.

A holistic healing perspective is the basis of this service delivery model so that the diverse and many needs of Aboriginal people who inject drugs may be met. Ultimately ownership of the program rests with Aboriginal individuals and communities.

Leadership is an important element who can be more responsive to the populations they serve. While liability issues are important to any community, so are the cultural needs that can help design and deliver Harm Reduction services which are backed up by the right policies and community support.

Through the distribution and implementation of this Harm Reduction Service Delivery Model, the Canadian Aboriginal AIDS Network is taking one step closer to reducing harm and breaking down barriers for a healthier tomorrow by Walking with Individuals on a Pathway to Health.

These are our relatives.



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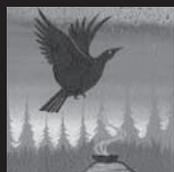
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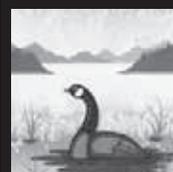
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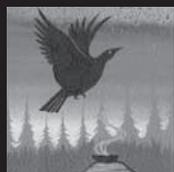
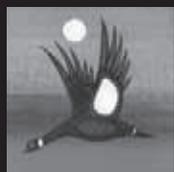
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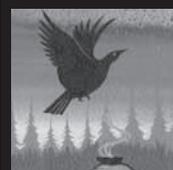
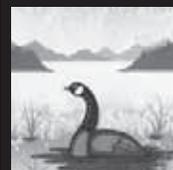
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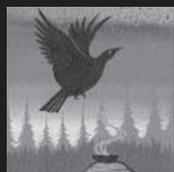
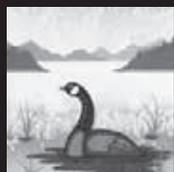
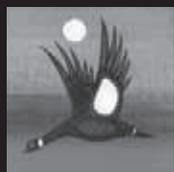
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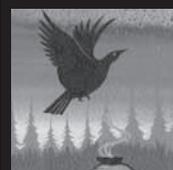
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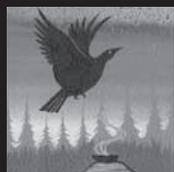


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Section Eight – Appendices

8.1 Appendix One: Harm Reduction National Steering Committee

Ken Clement
BC Healing Our Spirit HIV/AIDS Society

Monique Fong
Healing Our Nations HIV/AIDS Network

Fred Anderson
CAAN Representative

Denise Lambert
Kimamow Ataskanow Foundation

Gordon Sinclair
All Nations Hope HIV/AIDS Network

Kim Thomas
Canadian AIDS Society

Anne Marie Dicenso
Prisoners HIV/AIDS Support Action Network

Alana Klein
Canadian HIV/AIDS Legal Network

Kevin Barlow
Canadian Aboriginal AIDS Network

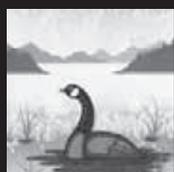
Trevor Stratton,
Canadian Aboriginal AIDS Network

8.2 Footnotes

- ¹ See CAAN – Lit Review. P. 8
- ² See CAAN – HCV and HCV/HIV Co-Infection Fact Sheets
- ³ See PHAC – HIV/AIDS Epi Updates
- ⁴ See the Public Health Agency of Canada report – HIV/AIDS Epi Update: HIV/AIDS Among Aboriginal Peoples In Canada: A Continuing Concern
- ⁵ See PHAC – About Hepatitis C: Virus Information
- ⁶ See CAAN – Harm Reduction project proposal
- ⁷ See CAAN – HCV and HCV/HIV Co-Infection Fact Sheet
- ⁸ Ibid.



- 9 See PHAC – The Federal Initiative to Address HIV/AIDS in Canada. (2005)
- 10 See PHAC – Epi Update - HIV/AIDS Among Aboriginal Peoples
- 11 See CAAN – Life Experience of Aboriginal Women Living With HIV/AIDS in Canadian Journal of Aboriginal Community-Based HIV/AIDS Research
- 12 See PHAC, Centre for Disease Prevention and Control – HIV/AIDS Epi Update HIV/AIDS Among Women in Canada – 2006
- 13 Ibid.
- 14 See PHAC, Centre for Disease Prevention and Control – HIV/AIDS Epi Update: HIV/AIDS Among Aboriginal People: A Continuing Concern. 2006
- 15 See NWAC – Companion Document First Minister’s Meeting Kelowna, British Columbia, November 24-25, 2005.
- 16 See NWAC – Companion Document First Minister’s Meeting Kelowna, British Columbia, November 24-25, 2005.
- 17 See CAAN – HIV/AIDS and Aboriginal Women, Children and Families. 2004
- 18 Ibid.
- 19 See CAAN – Strengthening Ties
- 20 Ibid.
- 21 See PHAC – Epi Update 2006 HIV and AIDS Among Youth in Canada
- 22 See PHAC, Centre for Disease Prevention and Control – HIV/AIDS Epi Update: HIV/AIDS Among Aboriginal People: A Continuing Concern.
- 23 See Farris-Manning & Zandstra, 2003; First Nations Child and Family Caring Society of Canada, 2003
- 24 See http://www.oci-bec.gc.ca/newsroom/bk-AR0506_e.asp
- 25 See PHAC – Epi Update 2006 HIV and AIDS Among Youth in Canada
- 26 See www.cps.ca and Dr Roger Tonkin, McCreary Centre, BC, Adolescent Health Training Model, NTIAH - 2003
- 27 See http://www.oci-bec.gc.ca/newsroom/bk-AR0506_e.asp
- 28 Ibid.
- 29 See The Way of The Pipes: Aboriginal Spirituality and Symbolic Healings in Canadian Prisons p 22. 1997
- 30 See <http://racisms.conference.com/2001/report.html>, Recommendation 57, p 13
- 31 Ibid.
- 32 See CAAN Strengthening Ties – Strengthening Communities
- 33 See UNAIDS – Fact Sheet – Men Who Have Sex With Men
- 34 See PHAC – Epi Update 2006 – HIV Infections Among MSM in Canada
- 35 Ibid.
- 36 Ibid.
- 37 See UNAIDS – Fact Sheet – Men Who Have Sex With Men -
- 38 Ibid.
- 39 Ibid.
- 40 See “Vectors, Victims and Vessels”: HIV/AIDS and Women’s Human Rights in Canada. Canadian HIV/AIDS Legal Network. 2005
- 41 Ibid.
- 42 Ibid.
- 43 See CBC news article – Prisons Need Needle Exchange Plans, OMA Says.
- 44 See AAN – Joining the Circle – Harm Reduction Phase I
- 45 Ibid.



- ⁴⁶ Ibid.
- ⁴⁷ See Federal Government announcement – Canada’s New Government and the Gates Foundation announce support for an HIV/AIDS vaccine.
- ⁴⁸ See WHO report – Global AIDS epidemic continues to grow
- ⁴⁹ See WHO Global Report on HIV/AIDS 2006

6.3 Endnotes

- ^A There are various terms for people who use drugs. The term chaotic substance use recognizes that there are many reasons why an individual is using drugs in his/her life and is seen as a less judgmental term.
- ^B The Literature Review entitled; ‘Literature Review and Model Building in Harm Reduction for Selected Populations’ will be available via the CAAN website.
- ^C Focus Groups were held in Vancouver in February, 2007 at the CAAN –hosted research conference ‘Walking a Path to Wise Practices’. These were with Aboriginal women, two-spirit and ex-prisoners. The Youth focus group was held in Victoria at the Healing Our Spirit Annual Conference.
- ^D It should be acknowledged that challenges related to ethnicity reporting continue to be a factor in accurately reporting about Aboriginal AIDS cases and positive HIV test reports.
- ^E Ethnicity reporting also varies among provinces and territories.
- ^F This is a 1999-2001 statistic from ‘Epidemiology of Hepatitis B and Hepatitis C in Canada, 1999-2001’. However, the Canadian Centre on Substance Abuse reports that a review of international studies suggests that 50%-90% of IDU populations are HCV infected. With the high rate of Aboriginal IDU it can be expected that the numbers are much higher.
- ^G CAAN reports that the success rate is only 25% for those with genotype 2 or 3 leaving many susceptible to accelerated liver damage and failure.
- ^H PHAC reports that this data was for the period of 1998 to 2005.
- ^J Alternatives exist to federal correctional services. Alternative justice is a non-adversarial, non-retributive approach to justice that emphasizes healing in victims, meaningful accountability of offenders, and the involvement of citizens in creating healthier, safer communities. Problem solving for the future is seen as more important than establishing blame for past behaviour. Restorative models such as, Victim-Offender Mediation, Group Conferencing, and Community Circles (Sentencing Circles, Peacemaking Circles, Healing Circles) work to repair the damage and promote healing and growth. (For more information please see <http://www.sfu.ca/crj/populars.html>.) In Canada, particularly in First Nations communities, Circle Sentencing operates on the basis that both victims and offenders require healing, and that offenders can be reintegrated into the community. A model such as this is hopeful and speaks to the complementary principles of harm reduction.
- ^K The UNAIDS Fact-sheet reports that MSM are found in all societies, yet remain invisible in many places.
- ^L The CAS document HIV Transmission: Guidelines for Assessing Risk provides a list of suggestions for further reading.
- ^M Dr. Ford is an AIDS expert who has worked in federal prisons for over 20 years.
- ^N See WHO press article – Global AIDS epidemic continues to grow (<http://www.who.int/hiv/mediacentre/news62/en/index.html>) It is noted that Europe has also not sustained programming and that this is also reflected in their HIV infection rates which have stayed the same.



- It is noted that Indigenous Peoples around the world are taking up the challenge to reclaim ownership of their traditional knowledge and are developing standards of research for and with their peoples. Aboriginal people have been researched to death as expressed bluntly by the Assembly of First Nations. (AFN) Aboriginal and non-Aboriginal groups are now looking at new ways of defining Aboriginal research protocols. This process is in keeping with current movements towards self-determination by Canada's three constitutionally recognized Aboriginal groups.



