Indigeneity and improving our response in the new era of HIV and hepatitis C

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GIM – UBC Hospital

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SFU

"Each man's and woman's liberty was absolute and inviolable. He was untainted by civilization, did what he liked, and was moved only by natural impulses, and if, the Nipissing was not a free man and independent man, then there was no absolute freedom or independence on earth."

– Jean Recollet in The Jesuit Relations

Desmond (Algonquin, Mattawa FN), Mary (Ojibwa / Mohawk, Nipissing FN) and daughter Mary (my mother)

Affaires autochtones et Développement du Nord Canada | Aboriginal Affairs and Northern Development Canada

Indigenous identity population

(2011 NHS = 1,400,685)

Indigenous percentage of Provincial/Territorial population

Non-Indigenous population

7,710
23.1%

21,160
51.9%

27,360
86.3%

232,290
5.4%

220,695
6.2%

157,740
15.6%

195,895
16.7%

301,430
2.4%

141,915
1.8%

35,800
7.1%

2,230
1.6%

22,620
3.1%

33,850
3.7%

OCÉAN PACIQUE PACIFIC OCEAN

OCÉAN ATLANTIQUE ATLANTIC OCEAN

ÉTATS-UNIS D'AMÉRIQUE UNITED STATES OF AMERICA

1:25,000,000

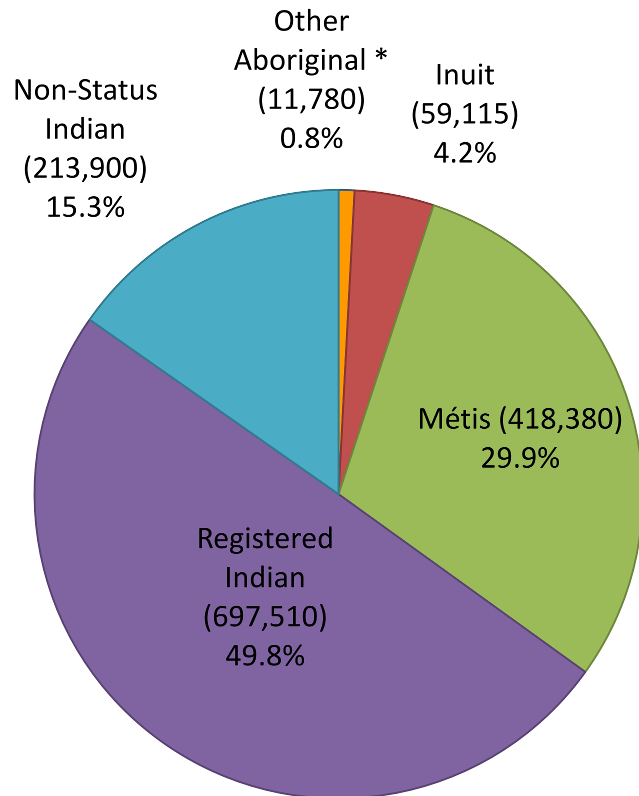
0 250 500 750 1,000 km

Statistics Canada, 2011 National Household Survey, AANDC tabulations.
Mapping: Natural Resources Canada, National Atlas.

Canada

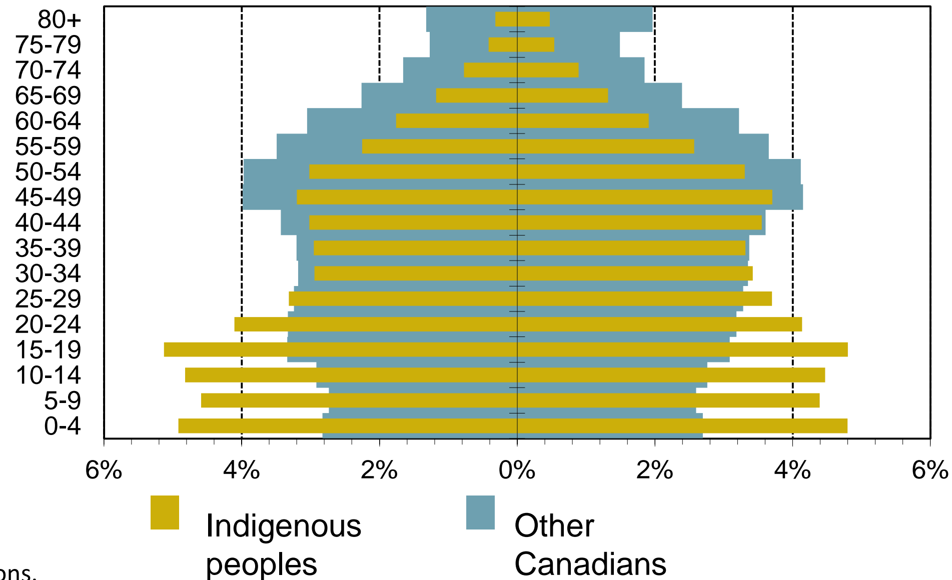
Demographics

In 2011, there were 1,400,685 Indigenous peoples in Canada. This was 4.3% of the total population.



The age structure of the Indigenous population is much younger than the rest of the Canadian population.

Amongst the Indigenous population, 46% of individuals are under age 25, compared to 29% for the rest of the Canadian population.



Statistics Canada, 2011 National Household Survey, AANDC tabulations.

Diversity

- 600+ First Nation communities.
- 50+ Inuit communities.
- 15-20 federally-recognized Métis communities.
- > 50% urbanization.
- Most of mixed ancestry, including blended Indigenous and non-Indigenous identities.
- Many co-exist in both Indigenous and Western worlds, with differing priorities depending on context.
- **No single approach – contextualization is critical**!

INDIGENOUS DETERMINANTS OF HEALTH

Indigenous health part 2: the underlying causes of the health gap

Malcolm King, Alexandra Smith, Michael Gracey

Lancet 2009; 374: 76–85

See **Editorial** page 2

See **Perspectives** page 19

See **Review** page 65

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In this Review we delve into the underlying causes of health disparities between Indigenous and non-Indigenous people and provide an Indigenous perspective to understanding these inequalities. We are able to present only a snapshot of the many research publications about Indigenous health. Our aim is to provide clinicians with a framework to better understand such matters. Applying this lens, placed in context for each patient, will promote more culturally appropriate ways to interact with, to assess, and to treat Indigenous peoples. The topics covered include Indigenous notions of health and identity; mental health and addictions; urbanisation and environmental stresses; whole health and healing; and reconciliation.

Introduction

In the companion piece[1] Gracey and King explored some of the present trends in Indigenous health. In this second review we will consider more closely the underlying causes of Indigenous health disparities. Our major thrust is Indigenous perspectives on the causes of the poor health of Indigenous peoples, which are not the usual causes of health disadvantage—as brought out, for example, in the 1986 Ottawa Charter[2] and the work of the WHO Commission on Social Determinants of Health.[3] We focus to a considerable degree on the Indigenous people of North America, although we draw on the experiences of New Zealand and Australia as well. Within that context, much of our material is drawn from our Canadian perspective.

The idea of the analytical framework of this Review is that enabling the reader to arrive at an understanding of the interplay of the processes affecting Indigenous health factors related to colonisation, globalisation, migration, loss of language and culture, and disconnection from the land, lead to the health inequalities of Indigenous peoples. The specifics will vary across cultures, dependent on a range of external factors, but the principles are the same. Indigenous health inequalities arise from general socioeconomic factors in combination with culturally and historically specific factors particular to the peoples affected.

This analytical framework aligns with the key themes identified in the Symposium on the Social Determinants of Indigenous Health held in Adelaide in April, 2007.[4] The colonisation of Indigenous peoples was seen as a fundamental health determinant. Mowbray, writing in the report[4] said: “This process continues to impact health and well being and must be remedied if the health disadvantages of Indigenous Peoples are to be overcome. One requirement for reversing colonisation is self determination, to help restore to Indigenous Peoples

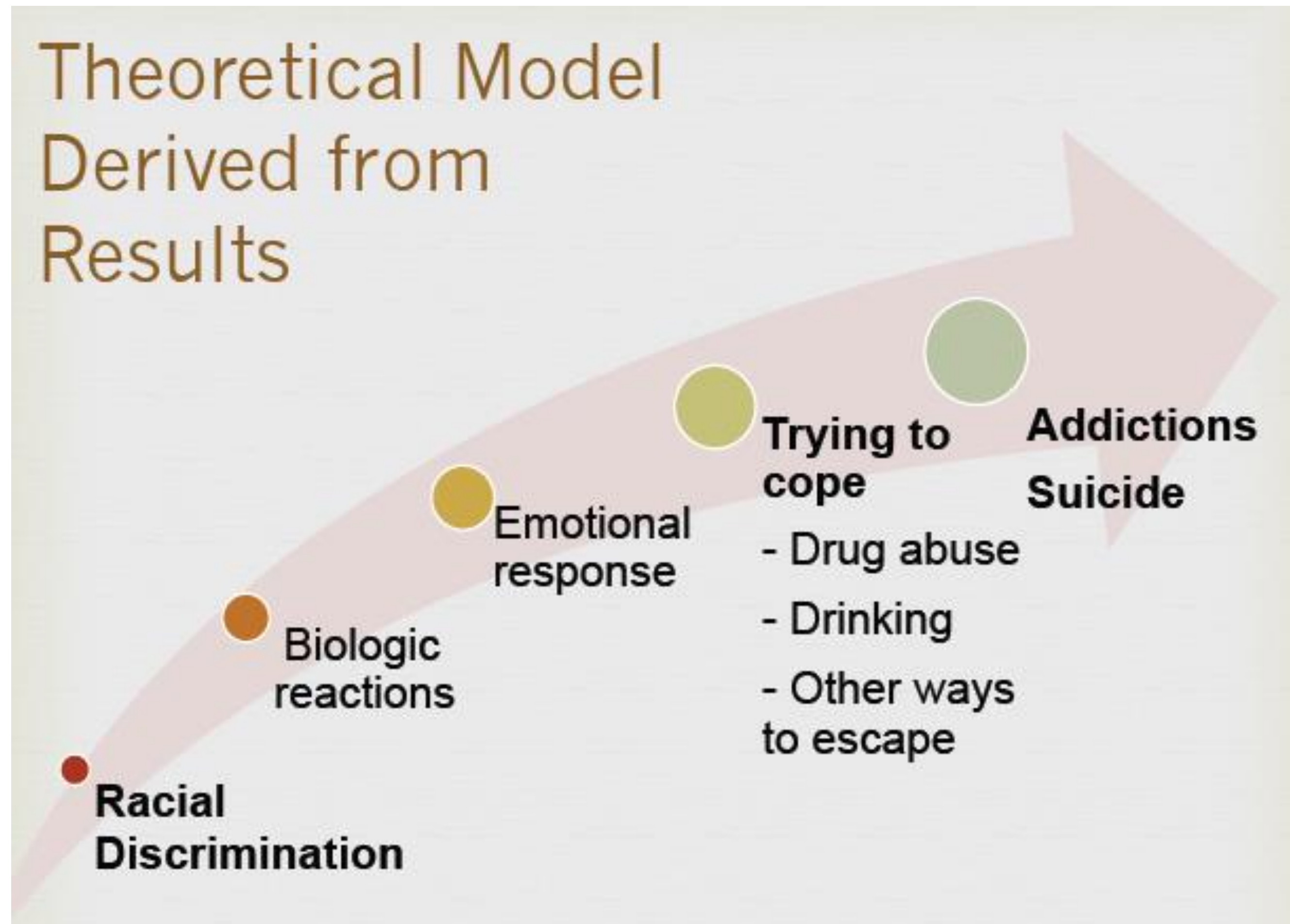
Indigenous determinants of health

- Conventional DoH:
  - Income
  - Social status / differential
  - Poverty
  - Education
  - Employment
  - Social support networks
  - Genetics

- Indigenous DoH:
  - Indigenous-specific:
    - Colonization
    - Connectivity to land / country (operationalized as land claim/title)
    - Self-determination
  - Other DoH with Indigenous-specific impact:
    - Globalization
    - Racism
    - Gender
    - Worldview

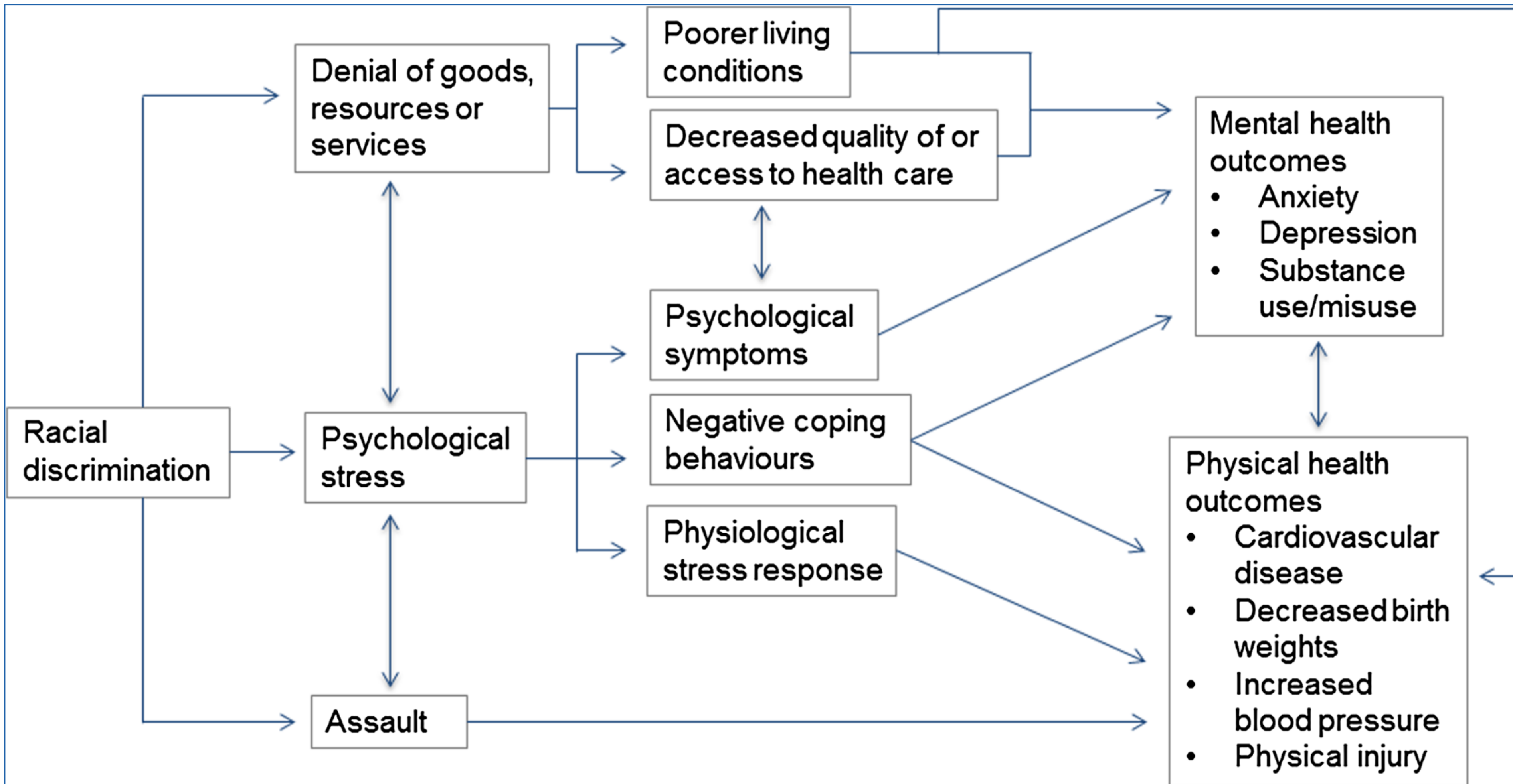
King, M. *et al.* (2009). Indigenous health part 2: the underlying causes of the health gap. *Lancet* 374: 76–85.

Indigenous university students' experiences with racism



Currie, CL *et al.* (2012). Racism experienced by Aboriginal university students in Canada. *Can J Psychiatry* 57(10):617-625.

Racism meta-analysis protocol



Paradies, Y. *et al*. Racism as a determinant of health: a protocol for conducting a systematic review and meta-analysis. Systematic Reviews 2013, 2: 85.

NATIONAL COLLOQUIUM ON RACISM, CULTURAL SAFETY AND ABORIGINAL PEOPLES' HEALTH

Report

The colloquium was presented by the Aboriginal Health Research Networks Secretariat (AHRNetS), and hosted by the Anisnabe Kekendazone Network Environment for Aboriginal Health Research (NEAHR) - CIETcanada.

National Colloquium on I

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Health Services, Racism and Indigenous Health

Gaining Traction for Systemic Change

November 21-22, 2013: Flinders University, Adelaide, Australia

Hosted by: Poche Networks for Indigenous Health (Flinders University - Adelaide and Alice Springs, and University of Sydney)

Wardliparingga Aboriginal Research Unit, SAHMRI

Southgate Institute for Health, Society and Equity

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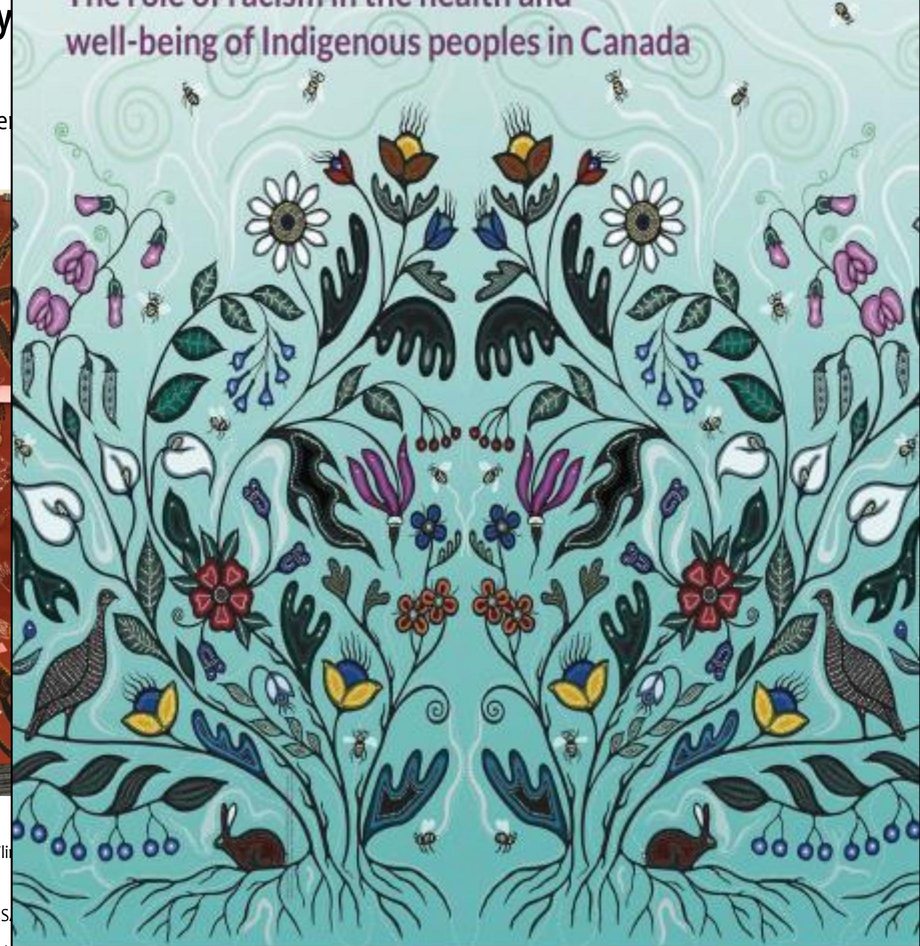
Southgate Institute for Health, Society and

First Peoples, Second Class Treatment

The role of racism in the health and well-being of Indigenous peoples in Canada



Discussion Paper

FORCED REMOVAL OF CHILDREN

Canada's Residential Schools (1876-1996)

The Truth and Reconciliation Commission of Canada. Accessed at www.trc.ca.

Canada’s Residential Schools: 1870-1996

- For more than 100 years, Canada’s residential schools systematically undermined Indigenous cultures and disrupted generations of families. Consequently, these children and subsequent generations experienced a general loss of language and culture.
- An estimated 150,000 Status Indian, Métis and Inuit children were placed in residential schools across Canada.
- Today, more than 80,000 residential school survivors remain in Indigenous communities.
- Survivors have been sharing the impact of their experiences with their families, their communities and with other Canadians *(Truth and Reconciliation Commission of Canada)*.

First Nations Children in Care (1960s to present)

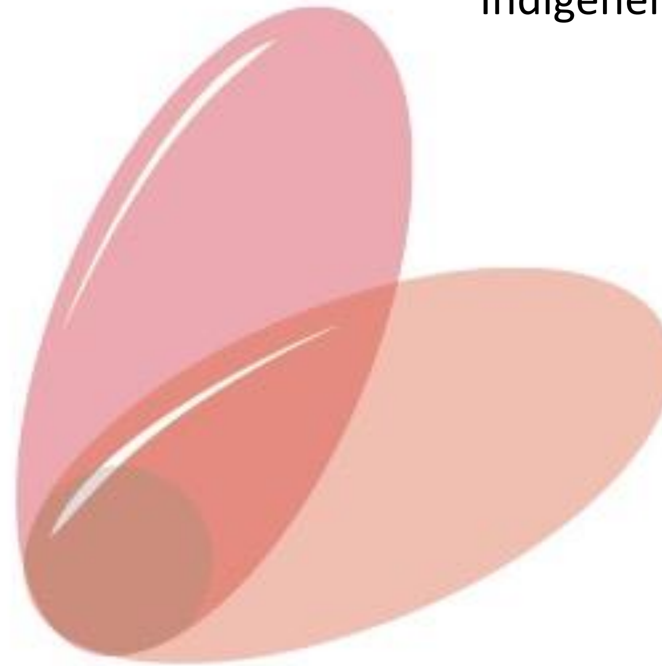
- Starting in the 1960s, under funding transfer agreements, First Nations children were increasingly placed in foster care under provincial jurisdiction.
- Most children were taken from their home communities, and raised away from their cultures, their languages and their extended families.
- This is known as the *60s scoop*; many never re-connected.
- The traumas of disconnection bear many similarities to those of the residential schools.

Royal Commission on Aboriginal Peoples, 1996 [3].

First Nations Children in Care (1960s to present)

- The problem is ongoing …
- In 2011, 14,225 (3.6%) of Indigenous children were foster children, compared with 0.3% of non-Indigenous children.
- Roughly half of the 30,000 or so children (aged 14 and under) who are in foster care are Indigenous.
- Most are placed away from their communities, even today.

Statistics Canada. Ottawa. (2013). 2011 National Household Survey: Aboriginal Peoples in Canada: First Nations People, Métis and Inuit,



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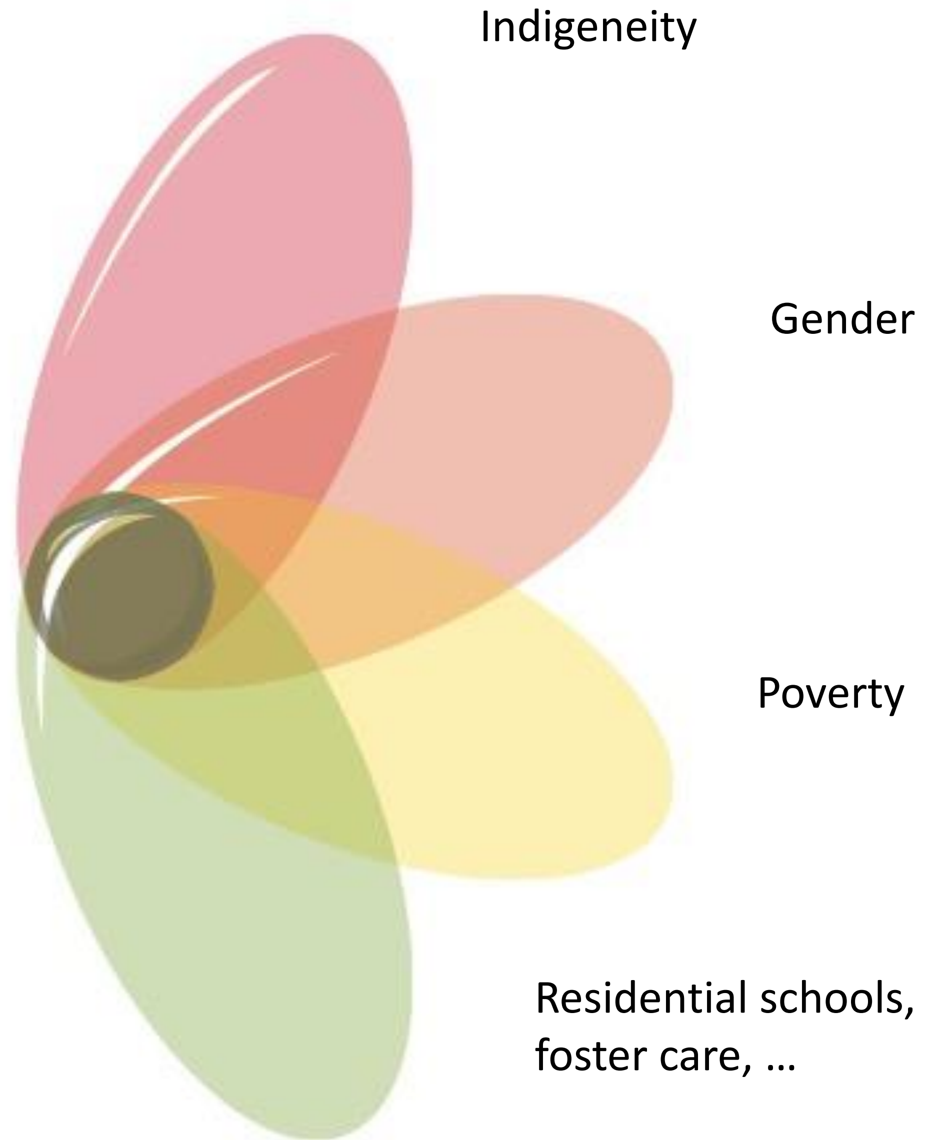

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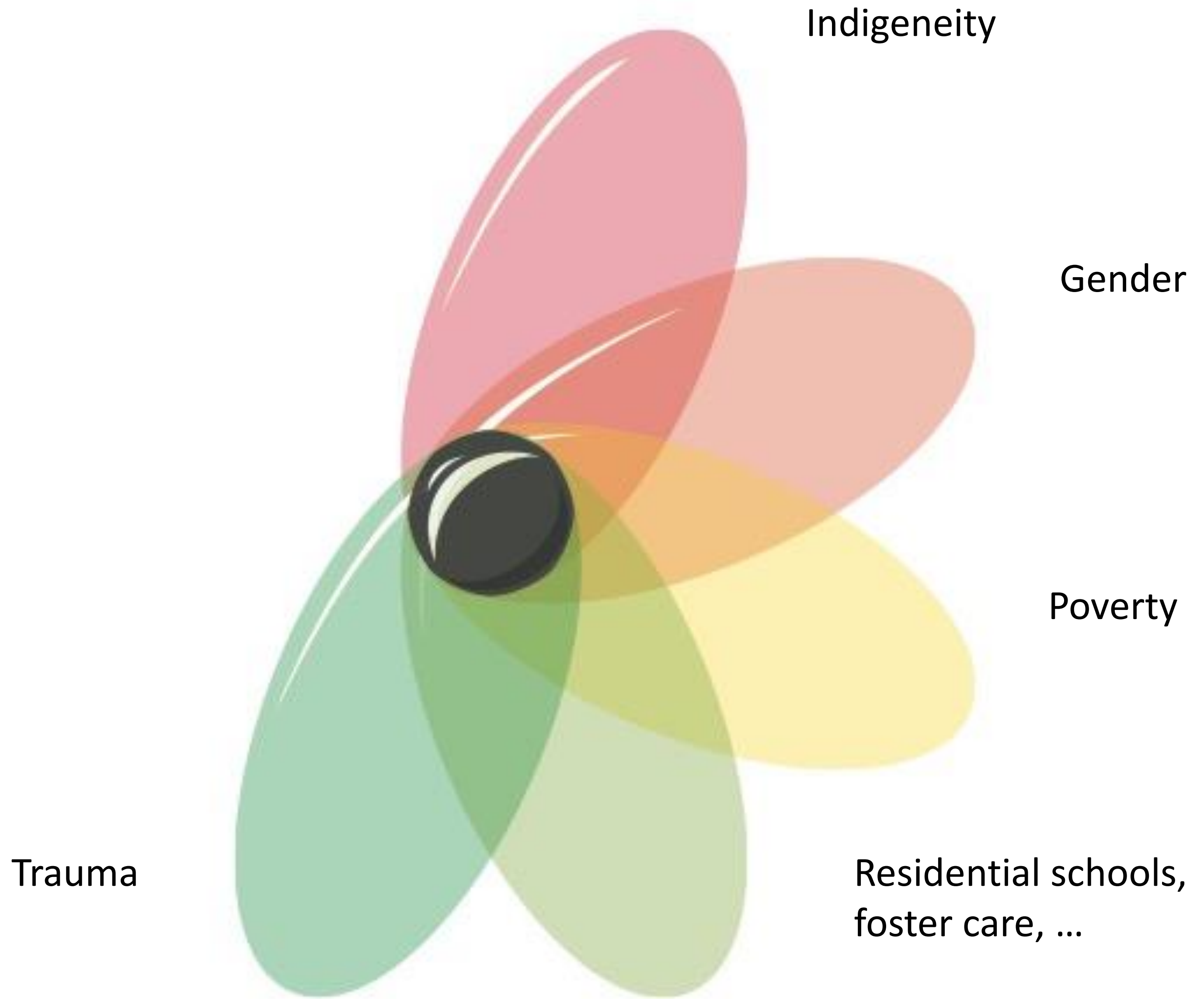

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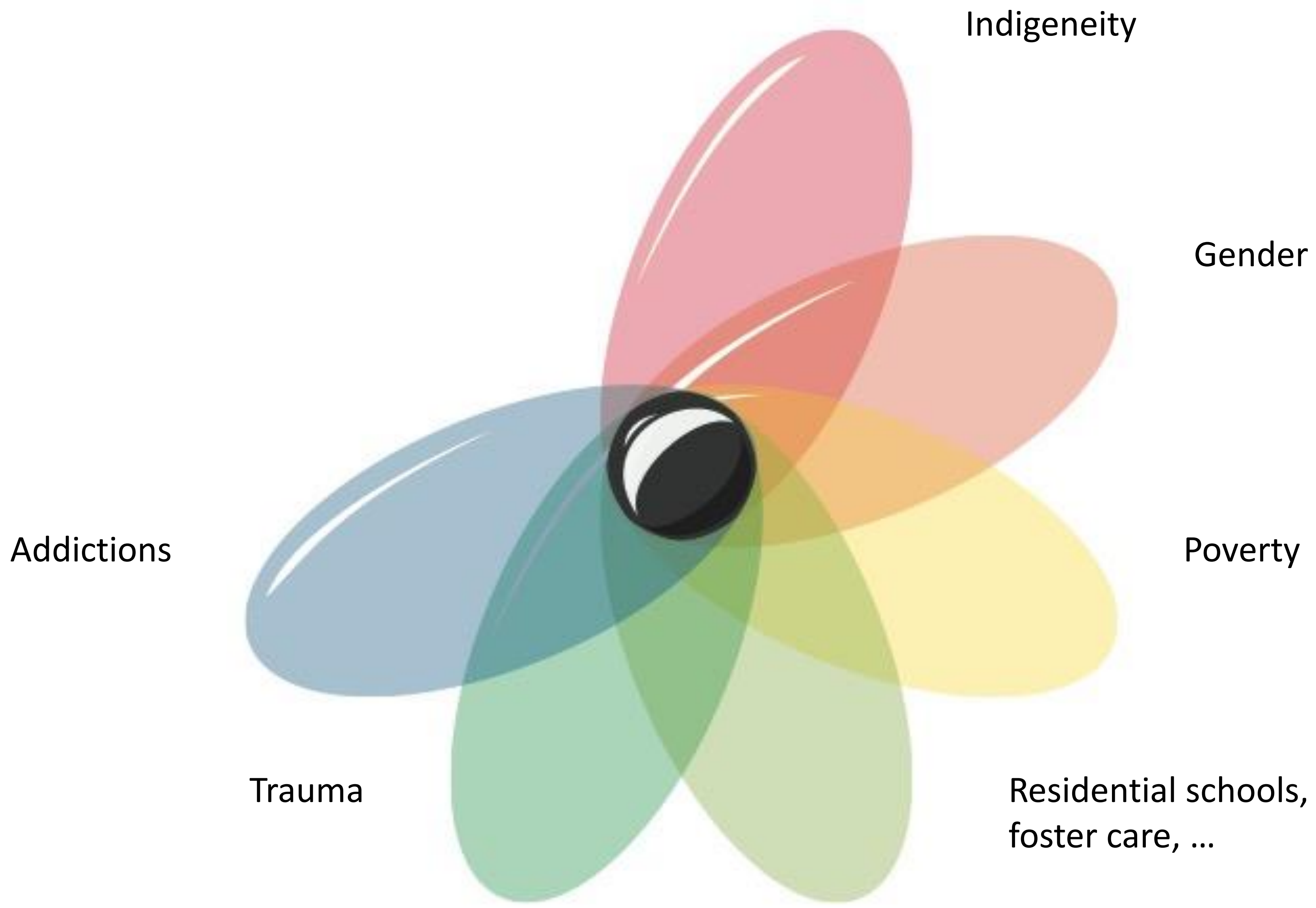

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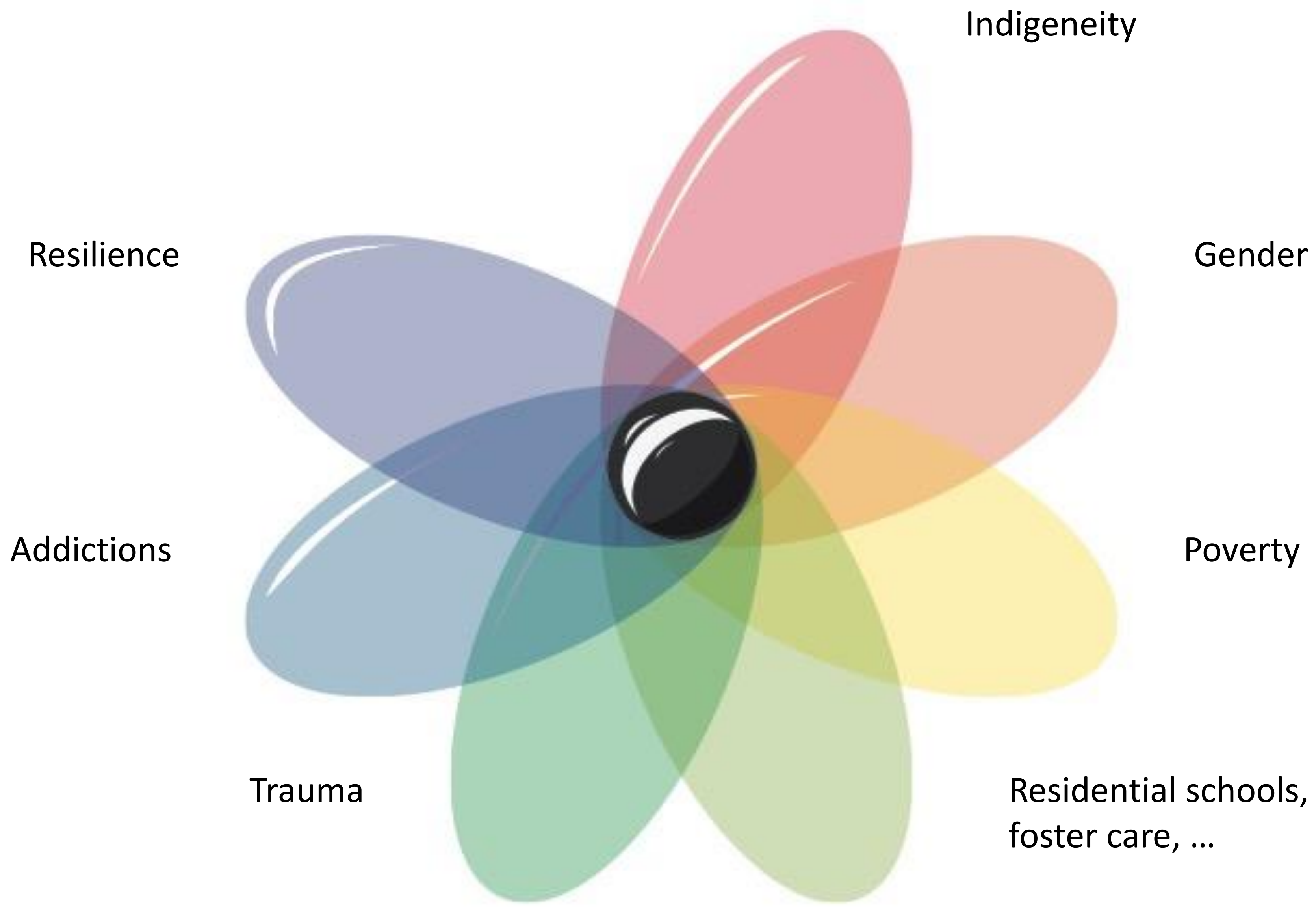

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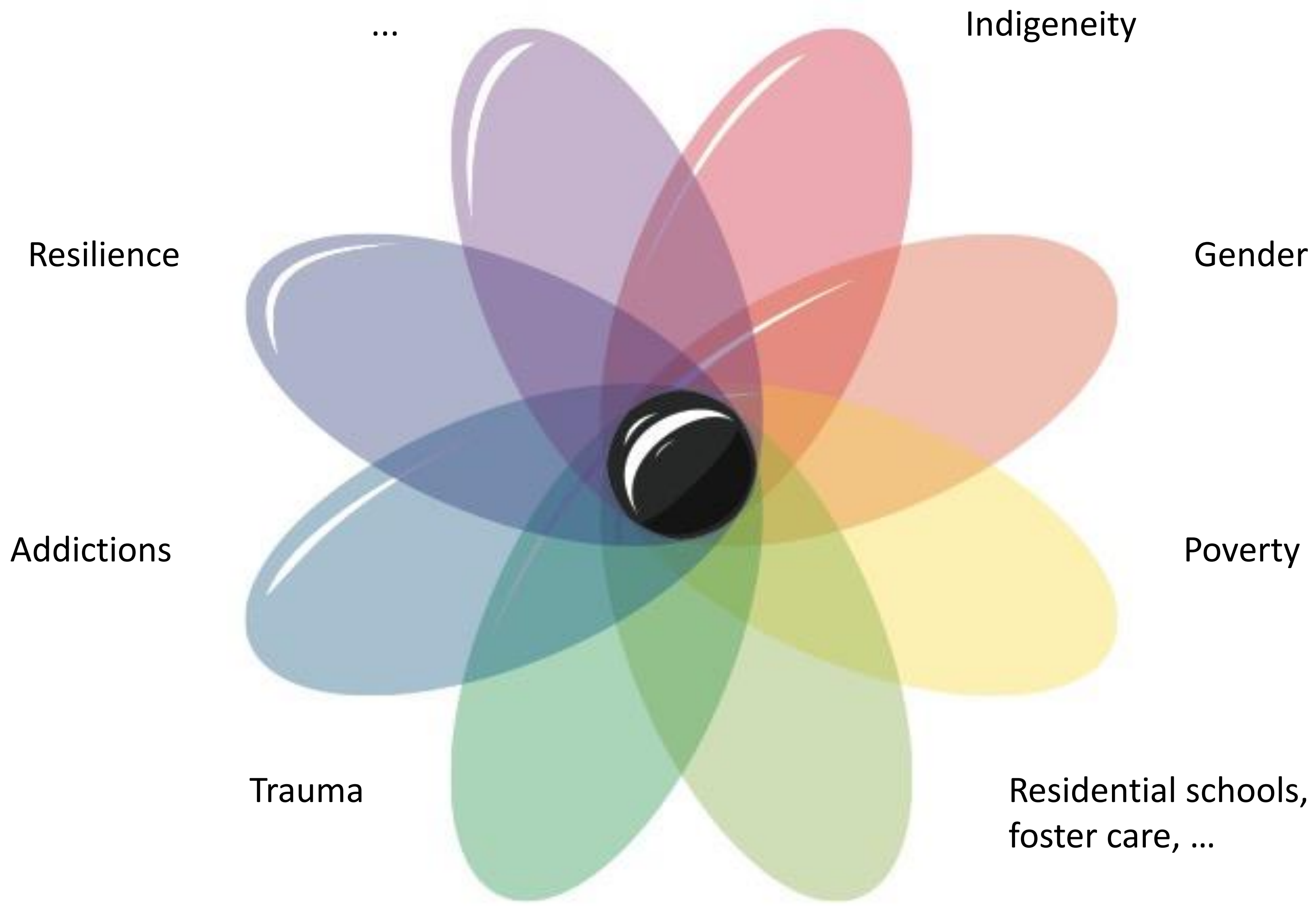


jessalyn king

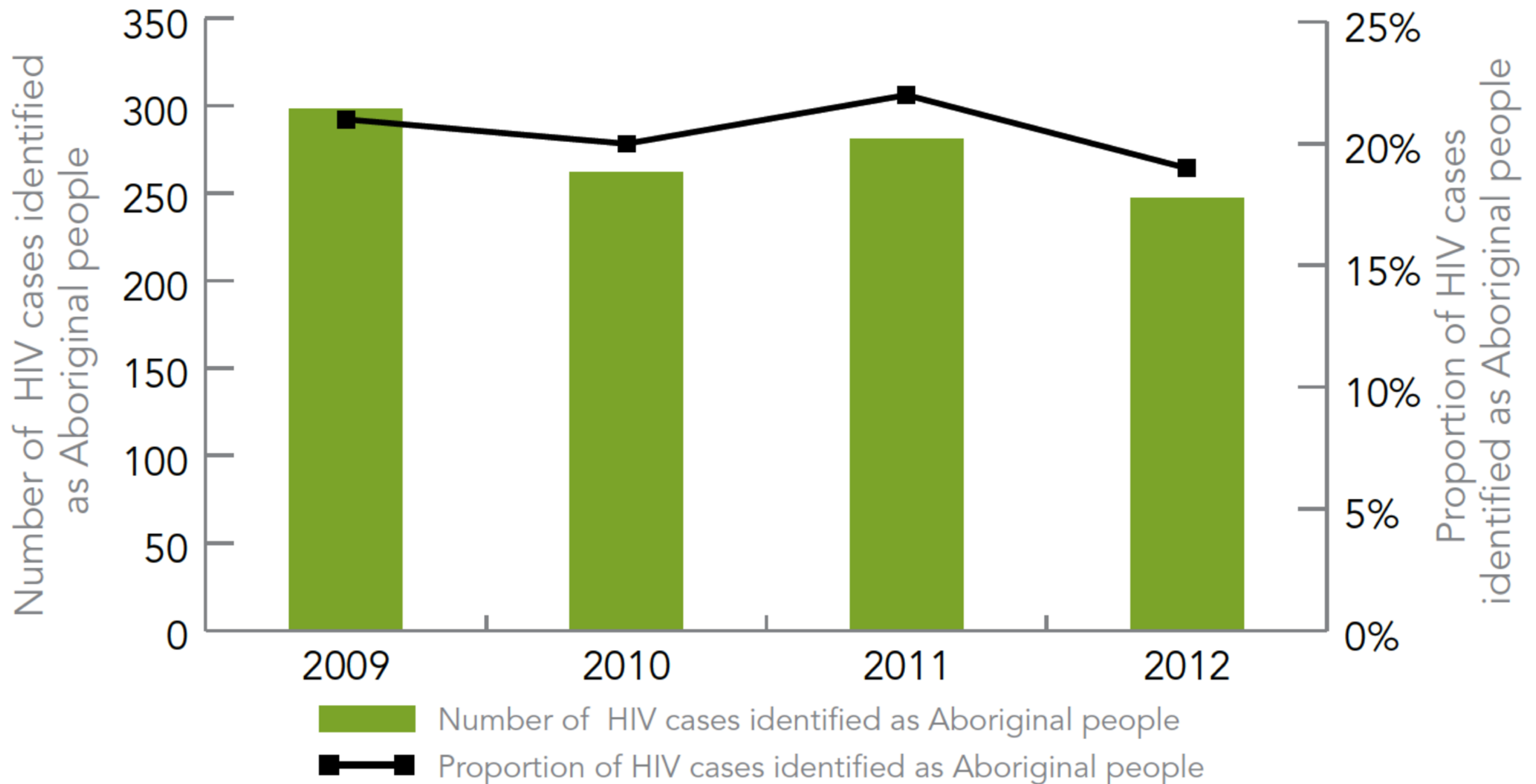
Indigeneity is foundational

- Indigenous peoples are disproportionately over-represented in many areas, including HIV, Hep C and co-infections.
- Indigenous health determinants may contribute to:
  - Increased high-risk activities.
  - Decreased engagement in healthcare.
  - Worse health outcomes.

Indigeneity is foundational

- Improved health and wellness through:
  - Connectivity to family and community.
  - Cultural continuity.
  - Self-defined and wholistic healing.
- Solutions centred on identity, relationality and Indigenous approaches.
- Indigeneity is contextual in time and place.

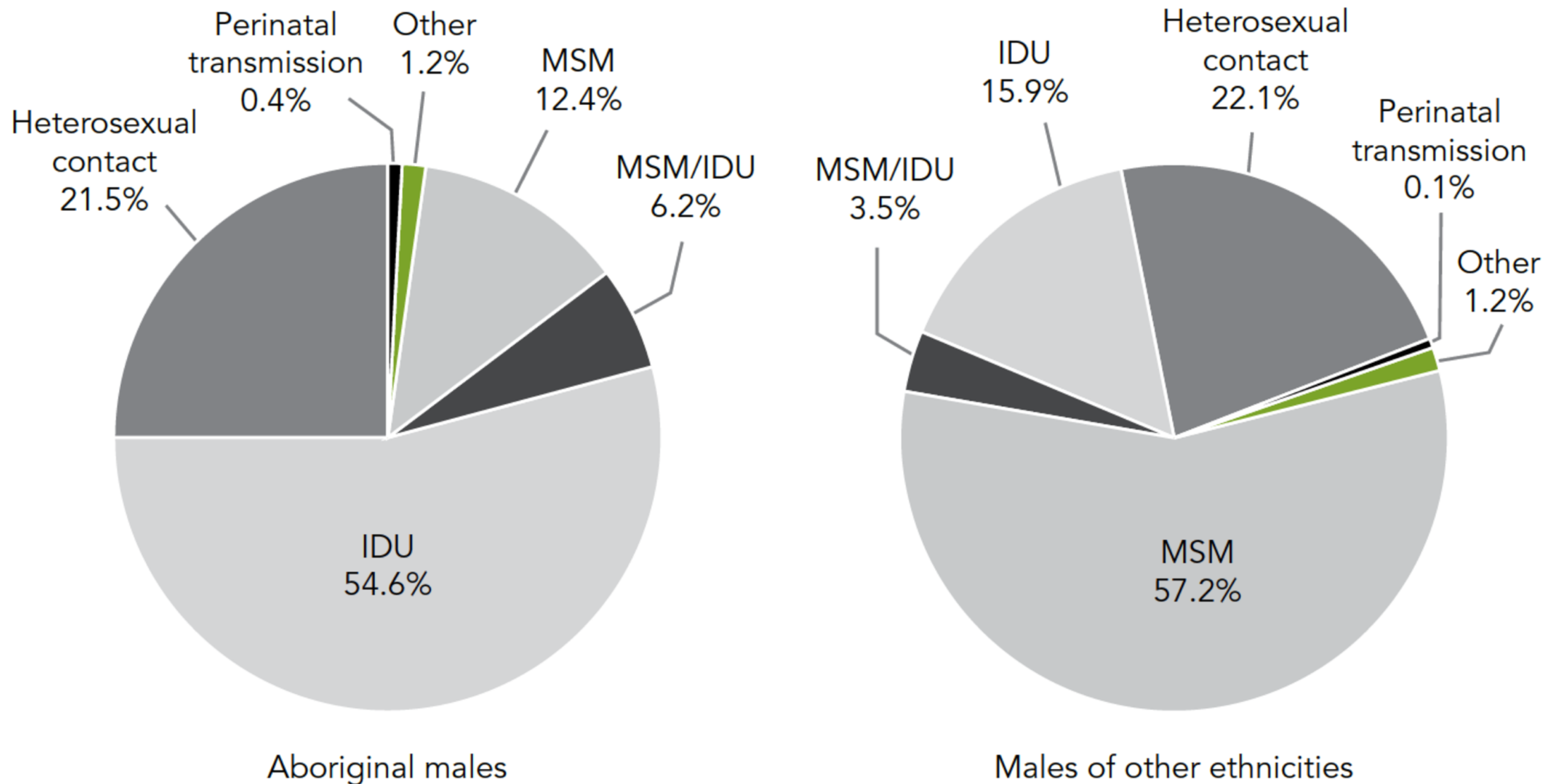
FIGURE 1. NUMBER AND PROPORTION OF REPORTED HIV CASES IDENTIFIED AS ABORIGINAL PEOPLE*, 2009 TO 2012



*Data from: BC, AB, SK, MB, NS, NB, ON, PEI, NL, NU, NT and YT.

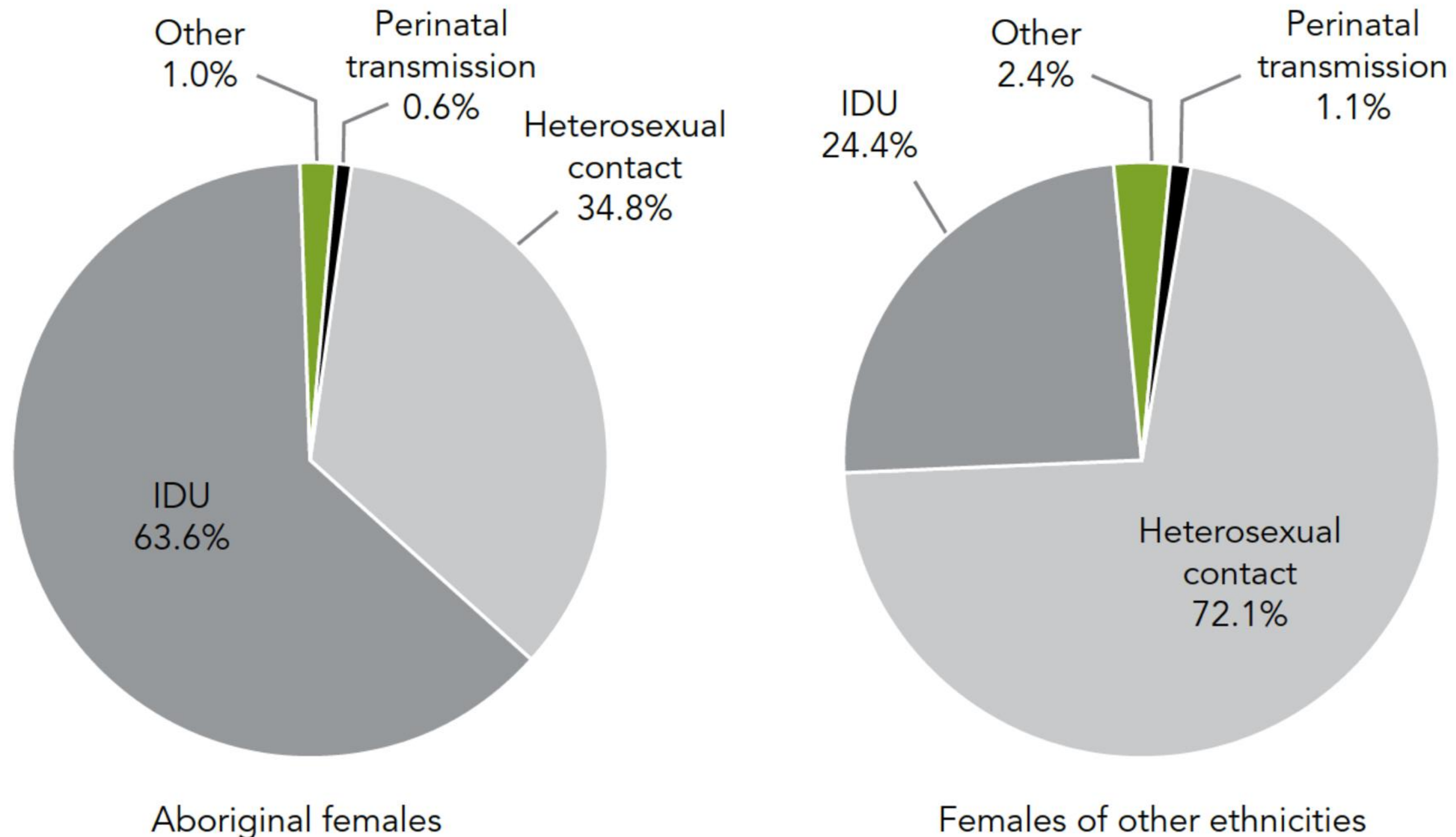
Public Health Agency of Canada. (2014). *HIV/AIDS Epi Updates – Chapter 8: HIV/AIDS among Aboriginal people in Canada*

Exposure categories - males



Exposure categories - females

FIGURE 2B. EXPOSURE CATEGORY DISTRIBUTION OF REPORTED HIV CASES IN CANADA, COMPARING ABORIGINAL FEMALES (N = 1,389) WITH FEMALES OF OTHER ETHNICITIES (N = 1,579), 1998 TO 2012



HCV Epidemiology

- Prevalence:
  - Worldwide: 3 out of 100
  - Canada: 1 out of 125
  - Indigenous peoples in Canada: 7-10 out of 100

HCV prevalence is 10 times higher in Indigenous peoples in Canada!

FIGURE 8. Reported rates of acute HCV infection by year and ethnic group, EHSSS, 2004-2009

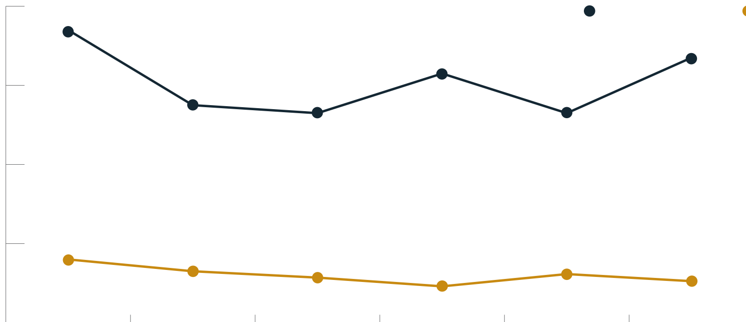
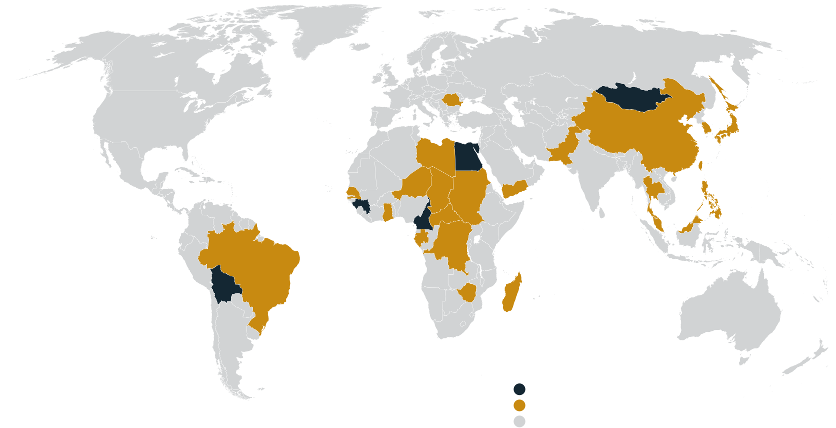


FIGURE 9. Epidemiology of hepatitis C globally, 2004 (Adapted from D. Lavanchy, WHO, 2009)



PHAC. 2011. Hepatitis C in Canada: 2005-2010 Surveillance Report

Gender Analysis – Cedar Project

HIV Prevalence ($n = 538$)				
Group	Male Prevalence (%) [95% CI] (# Infected/Total #)	Female Prevalence (%) [95% CI] (# Infected/Total #)	Odds Ratio (95% CI)	*p*-Value
All participants	4.3 [2.5, 7.4] 12/278	13.1 [9.5, 17.7] 34/260	3.34 (1.69, 6. 59)	<0.001
Injectors (ever)	8.5 [4.8, 14.5] 11/130	16.7 [11.8, 23.0] 28/168	2.16 (1.03, 4.5)	0.037
Non-injectors (ever)	0.7 [0, 3.7][1] 1/148	6.5 [2.4, 13.7][1] 6/92	10.26 (1.21, 86.62)	0.014[2]
HCV Prevalence ($n = 518$)				
All participants	25.4 [20.5, 30.9] 68/268	43.6 [37.6, 49.8] 109/250	2.27 (1.57, 3.30)	<0.001
Injectors (ever)	50.4 [41.8, 59.0] 63/125	65.4 [57.8, 72.3] 106/162	1.86 (1.56, 3.00)	0.010
Non-injectors (ever)	3.5 [1.1, 7.8][1] 5/143	3.4 [0.7, 9.6][1] 3/88	0.974 (0.23, 4.18)	1.00[2]

Cedar Project Partnership. Mehrabadi, A. *et al.* (2009). Gender differences in HIV and Hepatitis C related vulnerabilities among Aboriginal young people who use street drugs in two Canadian cities. *Women & Health*, accessed at http://www.tandfonline.com/loi/wwah20.

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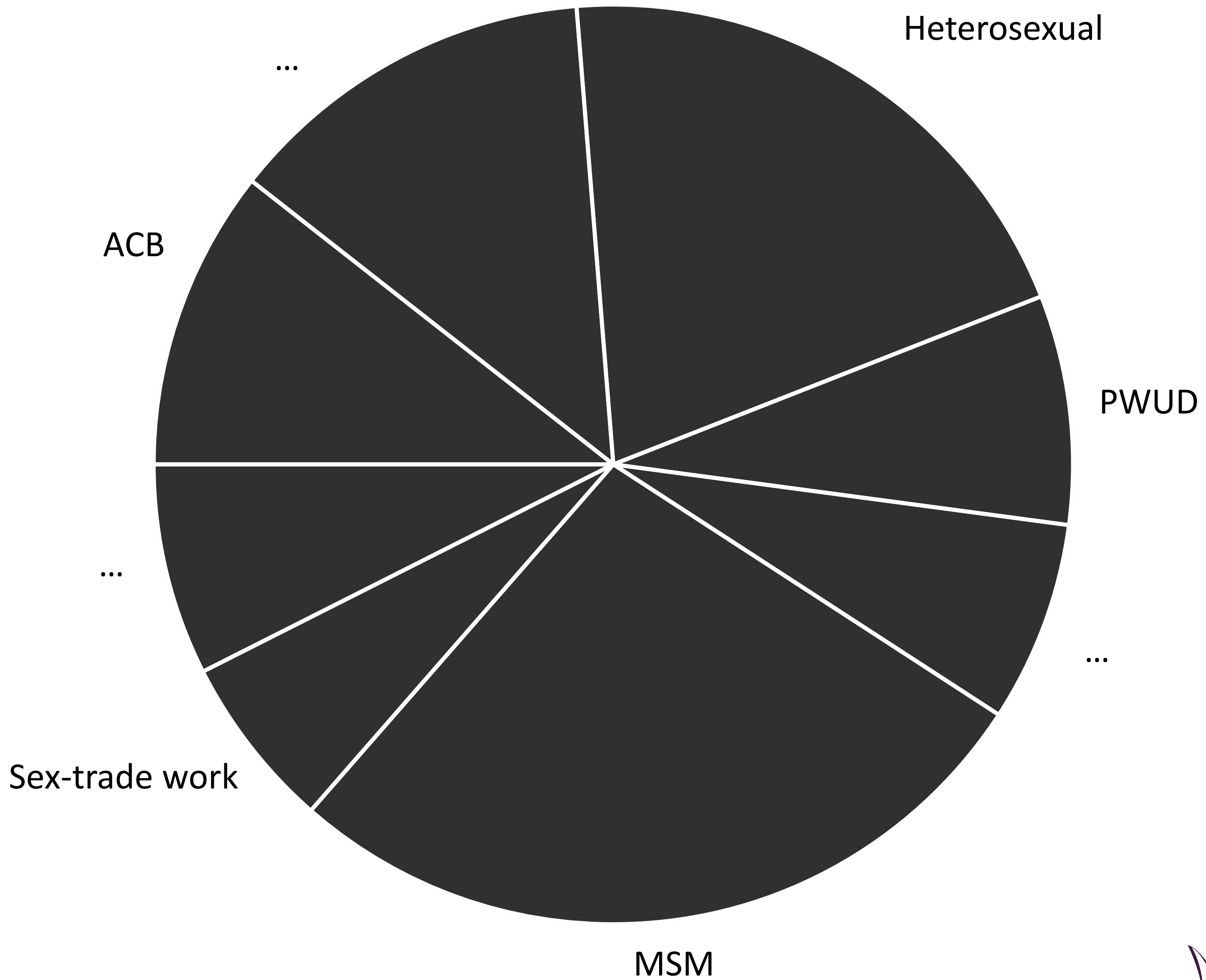

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BRITISH COLUMBIA CENTRE *for* EXCELLENCE *in* HIV/AIDS

Together, we can stop HIV/AIDS

VIDUS

The **Vancouver Injection Drug Users Study (VIDUS)** is UHRI's longest-running cohort study. VIDUS participants, who number about 1500, have been followed since 1996 and were originally recruited through street outreach efforts. Every six months, VIDUS participants provide blood samples to be tested for HIV and hepatitis C, and they're interviewed about their drug use patterns and practices, health status and access to health and social services, and interactions with the criminal justice system. Data from this cohort have been the basis for hundreds of published scientific studies.

The analysis of this information has contributed to a number of policy developments, including the expansion of needle exchange and distribution services, and the evaluation of Insite, Vancouver's supervised injection site. In addition to the valuable information gained through VIDUS, the study also performs an important public health function by providing regular HIV and hepatitis C testing (including pre- and post-test counselling) to local injection drug users.

Recently, the original VIDUS cohort was divided into two separate studies: VIDUS now follows HIV-negative participants and its sister study ACCESS follows HIV-positive injection drug users.

Visit the VIDUS page on the Addiction and Urban Health Research website.

In this section

- Epidemiology & Population Health
- Gender & Sexual Health Initiative
- Incentives
- International Program
- Laboratory Program
- **Urban Health Research Initiative**
  - ACCESS
  - ARYS
  - Mitsampan
  - SEOSI
  - **VIDUS**

For Healthcare Providers

Therapeutic Guidelines

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- SEOSI
- VIDUS

ACCESS

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The **ACCESS** cohort (**A**IDS **C**are **C**ohort to **E**valuate **A**ccess to **S**urvival **S**ervices) follows HIV-positive injection drug users based in the Greater Vancouver area, primarily in Vancouver's Downtown Eastside. The primary goal of the ACCESS cohort is to determine the health needs of HIV-positive injection drug users. As with all UHRI cohorts, participants complete an interviewer-administered questionnaire every six months and give blood samples for analysis. Data from the ACCESS cohort allow UHRI investigators to monitor HIV disease and identify how various policies or programs affect outcomes from HIV treatment. Aside from generating data to inform the delivery of HIV treatment services, a central objective of the UHRI research team is to connect study participants with HIV care and other services.

ACCESS follows HIV-positive injection drug users while its sister study VIDUS follows HIV-negative injection drug users. Splitting the original cohort in this way allows UHRI investigators to more effectively study HIV infection and disease progression among injection drug users in Vancouver, and to identify those programs and policies that are effective in reducing HIV and improving HIV treatment outcomes among this population.

ACCESS is an initiative of the Urban Health Research Initiative

For Healthcare Providers

Therapeutic Guidelines

BRITISH COLUMBIA CENTRE *for* EXCELLENCE *in* HIV/AIDS

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TREATMENT AS PREVENTION | RESEARCH | CLINICAL ACTIVITIES | EDUCATION & TRAINING

ARYS

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The **At-Risk Youth Study** (ARYS — pronounced 'Arise') began in late 2005 and, as its name suggests, is made up of youth aged 14 to 26. Youth can be defined as 'at risk' because of a variety of factors, including their socio-economic situation, mental or physical health, drug use, social or physical environment, or family situation.

ARYS is an initiative of the Urban Health Research Initiative

In this section

- Epidemiology & Population Health
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Therapeutic Guidelines

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AESHA

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AESHA

AESHA is the longest standing project of GSHI. Building on community-based research partnerships since 2004, AESHA extended in 2010 to a longitudinal evaluation of the physical, social and policy environment shaping sexual health, HIV vulnerability and access to care in the street and hidden off-street sex industry. To date, we have interviewed close to 1000 sex workers who work in street/public place-based settings, venue-based settings such as micro-brothels, massage parlours and health enhancement centres, independently off-street, through self-advertising and/or online, and in informal out-call venues, such as bars, saunas and hotels.

The AESHA Project is monitored by a Community Advisory Board of more than 15 agencies representing sex work, women, youth and sexual health organizations. AESHA findings have been published in dozens of peer-reviewed papers, cited in international policy recommendations (including the Global Commission on HIV and the Law) and presented at multiple community, academic, and public policy events, including expert witness testimony and legal interventions in challenges to Canada's criminalized prostitution laws and the BC Missing Women's Inquiry. The AESHA cohort serves as a platform to monitor and evaluate ongoing policies, interventions and community initiatives and their impact on the health and safety of street and hidden off-street sex workers.

For Healthcare Providers

Therapeutic Guidelines
Up-to-date HIV treatment info

Drug Treatment Program
Information on anti-HIV

SEOSI

ABOUT | NEWS | TEAM | PUBLICATIONS

SEOSI, the **Scientific Evaluation of Supervised Injecting**, is a cohort study that began in 2003. SEOSI participants have been randomly recruited from Insite, Vancouver's supervised injection facility, and form a representative sample of all Insite clients.

Download the Full Report (link)
Download the Research Summary (PDF)

Like other UHRI cohorts, SEOSI is a longitudinal study, meaning that it is made up of individuals who represent a larger specific population and who are tracked over time. After informed consent is obtained, each participant provides a blood sample and completes an interviewer-administered questionnaire. Participants return every six months for a follow-up interview and blood testing. The information collected through SEOSI relates primarily to the use of Insite and how the facility affects drug use practices such as syringe sharing, public drug use and other factors in participants' lives that may compromise their health.

More than 30 research studies evaluating Insite, Vancouver's supervised injecting facility, have been published in such prestigious peer-reviewed journals as The Lancet, the New England Journal of Medicine and the British Medical Journal.

In short, the evaluation has found that Insite has had an overall positive impact on the community in which it is located. Specifically, Insite has:

- Reduced the kinds of drug using behaviours that increase the risk of HIV transmission and overdose death
- Led to increased use of addiction treatment services among the people who inject at Insite

SHAWNA

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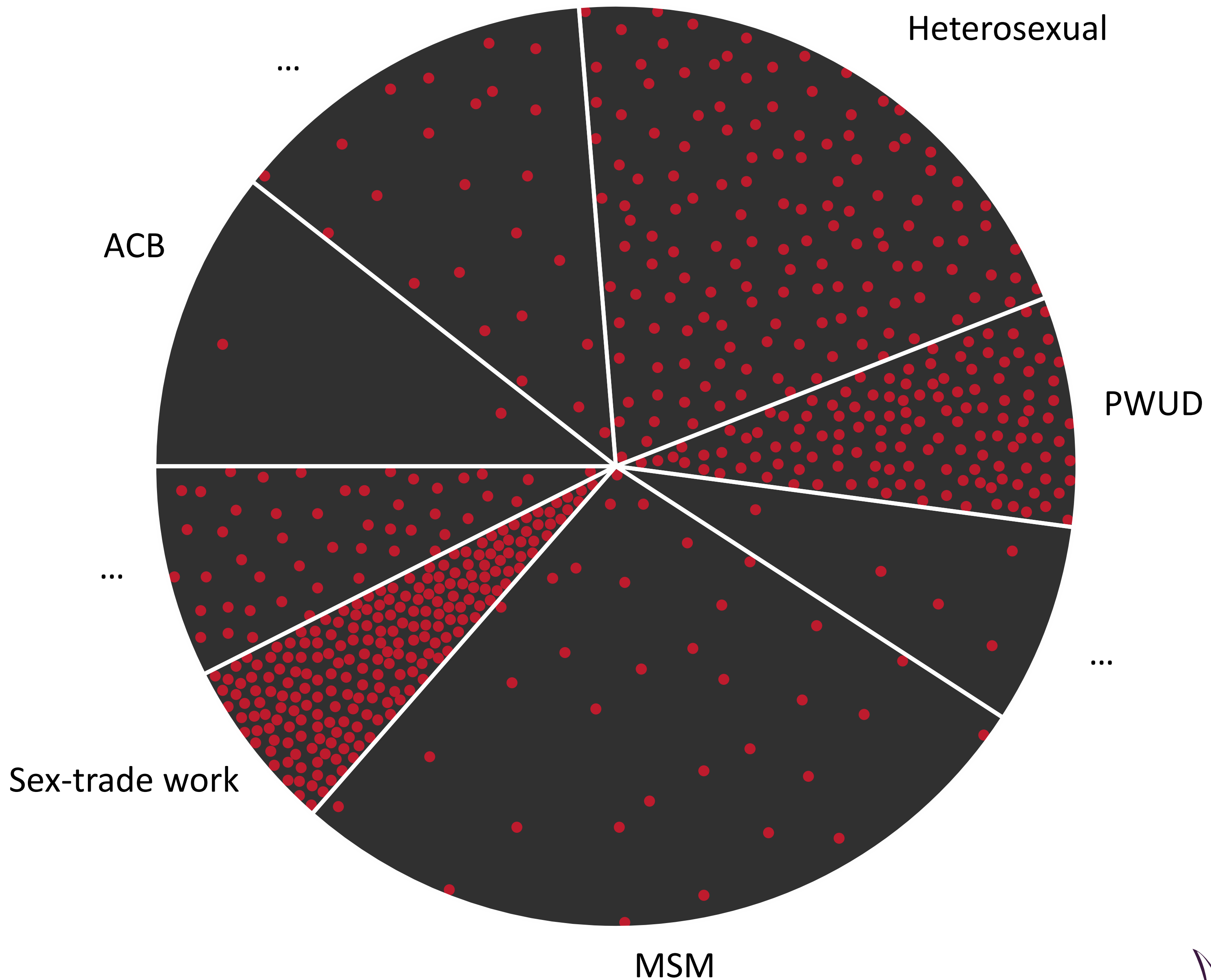
The SHAWNA Project (Sexual Health and HIV/AIDS: Women's Longitudinal Needs Assessment) is a five year CIHR-funded research project that will focus on the social, policy, legal, gender and geographic gaps in women's sexual health and HIV care across Metro Vancouver, led by the Gender & Sexual Health Initiative. SHAWNA is a collaboration with a diverse team of researchers, community, legal and policy experts and women living with HIV/AIDS (WLWH).

Recent evidence suggests that new infections among women in BC and across Canada are not declining despite harm reduction and prevention efforts, and that women are representing a greater proportion of people living with HIV. Given ongoing concerns of sub-optimal HIV care and treatment outcomes for women, and complex issues of criminalization of HIV, stigma, gender, poverty, racism, institutional and geographic barriers negatively impacting women's sexual health and HIV care experiences, SHAWNA aims to interview and follow 500 women living with HIV across Metro Vancouver, Canada as part of a multi-year study funded by the Canadian Institutes of Health Research (CIHR). Through mixed methods research, we hope to document broader barriers and examine over time how women navigate their sexual and reproductive health, HIV, and access to care to improve women-centered sexual health and HIV care policy and practice in BC.

With the overall goal of improving women-centered sexual health and HIV care policies and practices, the SHAWNA Project core objective is to document over time how various social, policy and place-based factors shape WLWH's experiences navigating their HIV status; sexual and reproductive health rights and needs; and access and uptake of sexual health and HIV care and how do these factors intersect to impact on WLWH's sexual and reproductive health and HIV outcomes. Drawing on the diversity of expertise and experiences of the team (community, HIV service providers, clinical, legal, and research) and mixed methods, we hope to better understand the broader HIV, sexual and

- Important world-class research, focusing on groups with increased vulnerabilities to STBBIs.
- High-powered cross-sectional and longitudinal analyses.

About 30% of participants of each study are Indigenous. And yet, Indigeneity is buried within these studies.


Heterosexual
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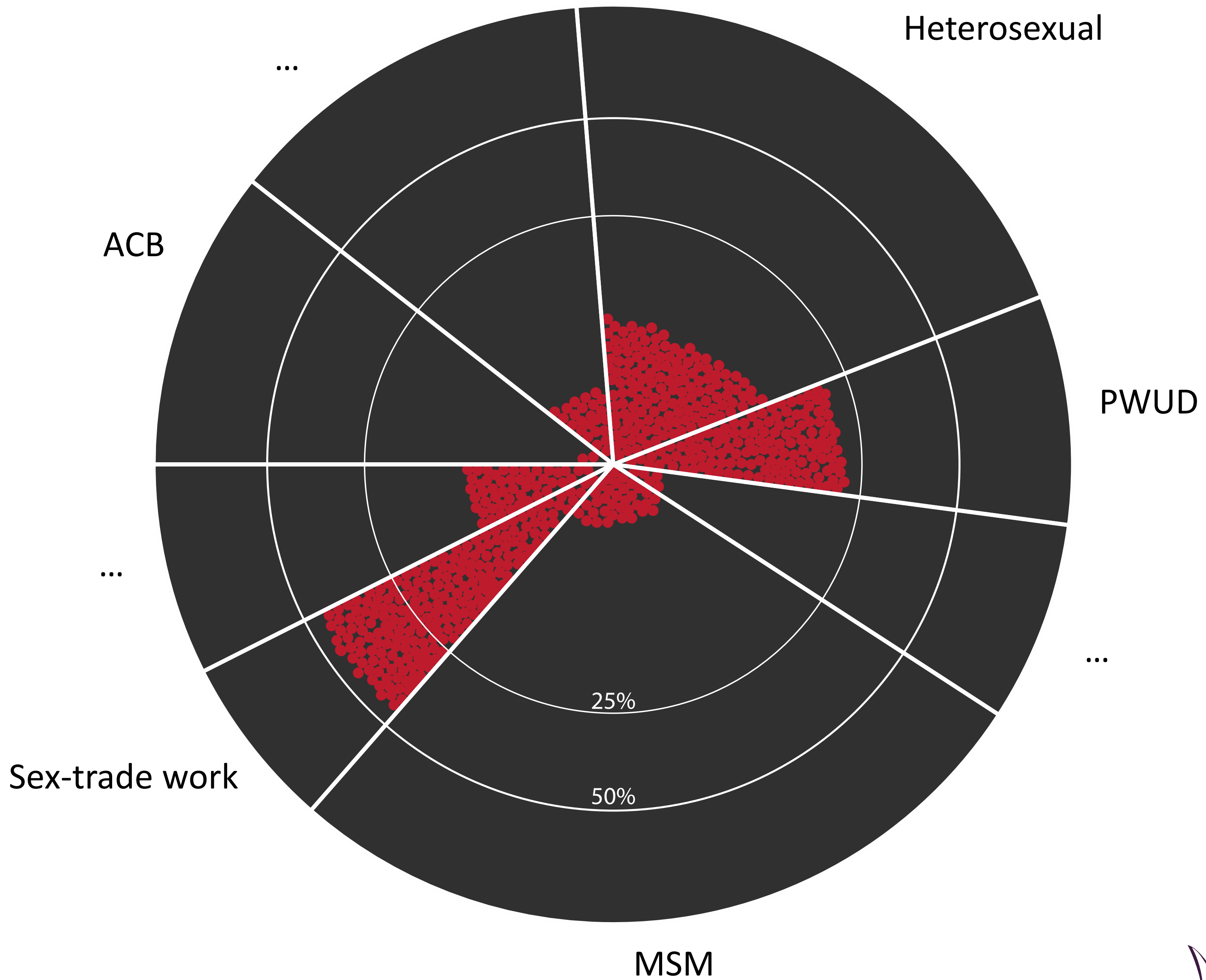
Sex-trade work
MSM
jessalyn
king



jessalyn king

(Inuit examples)

- No text

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INUIT WOMEN OF CANADA

CELEBRATING 25 YEARS

INUIT FIVE-YEAR STRATEGIC PLAN ON SEXUAL HEALTH

2010 – 2015

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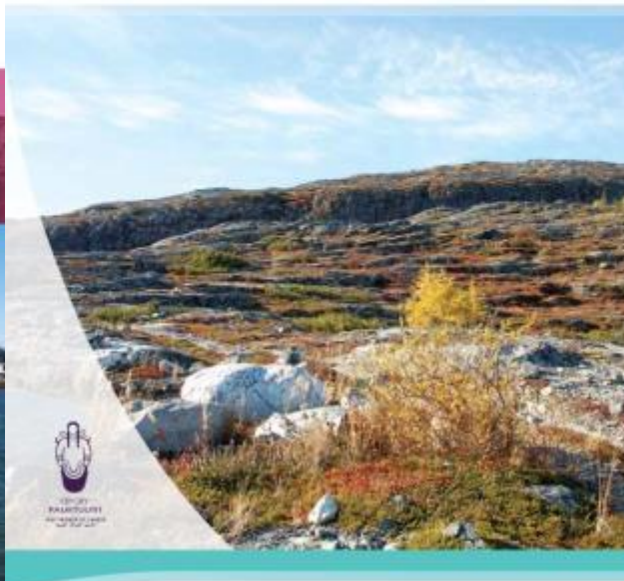
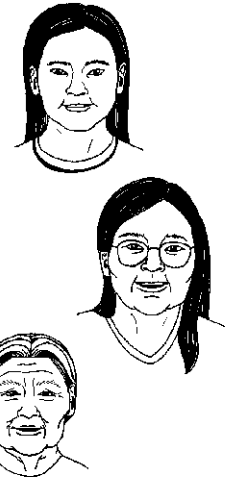
INUIT WOMEN OF CANADA



INUIT FIVE-YEAR STRATEGIC PLAN ON HEPATITIS C

2013 – 2018



Ilitokhaknik 1 — TIGUKLUKNIK C-MIK ANEAGEPKUTINIK ILITOKHAON

Hivulik ilitokhaon naoneagutoayok inuk aneagutikakhimakmagaa tigukluknik C-mik.

Pikaginikan

Inuk aneagutikakhimaetok tigukluknik C-mik.

Pikaknikan

- Tigukluknik C-mi aneagepkutin talvanetun.
- Inuk aneagutikakhimayok tigukluknik C-mik ataohekhoni.
- Naonaegutaogitok inuk aneagutikakhimakmagaa tigukluknik C-mik.

Ilitokhaknik 2 — TIGUKLUKNIK C-MIK KUPILGUNIK ILITOKHAON

Naonaeyaklogo inuk aneagutikakhimakmagaa tigukluknik C-mik.

Pikaginikan

Inuk aneagutikagoektok tigukluknik C-mik.

Pikaknikan

Inuk aneagutikaktok tigukluknik C-mik.

Okaohigenaklogin monakhilo tukitaagutinik ilitokhaotinik ila kigoagun monagiyaoyageakakmagaa naonaegeagani.

Hivonikhivaaligumaniguvin, takoenageaglik www.pauktuutit.ca uvalunen www.bccdc.ca nakilogin ukoa titikan "Attendance Project" kinikhaeveani kagitaoyami.

www.pauktuutit.ca info@pauktuutit.ca

ᐸᐅᒃᑑᑎᑦ Pauktuutit

"I want to stay healthy. When I heard about hepatitis C I decided to find out what puts a person at risk. If you are at risk, get tested."

Hepatitis C

ASK YOUR HEALTH CARE PROVIDER FOR MORE INFORMATION.

KNOW THE RISKS.

PROTECT YOURSELF.

pauktuutit.ca

ᐸᐅᒃᑑᑎᑦ Pauktuutit

"If you have hepatitis C, there is hope. There is treatment. The first step is to get tested if you are at risk."

Hepatitis C

ASK YOUR HEALTH CARE PROVIDER FOR MORE INFORMATION.

KNOW THE RISKS.

PROTECT YOURSELF.

pauktuutit.ca

Kanuinnak

Pinguagit

Apigit

CATIE

Mitsanut Pauktuutit:

What we're learning …

- Nurture community and allies.
- Health is political.

UN Declaration on the Rights of Indigenous Peoples

Article 24:

- Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the **right to access, without any discrimination**, to **all** social and health services.
- Indigenous individuals have an equal right to the enjoyment of the **highest attainable** standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

What we're learning …

- Nurture community and allies.
- Health is political.
- Define and redefine.
- Comprehensive and culturally appropriate approaches.
- Innovation centred on strengths, resilience.
- Connectivity and contextualization.

Working towards …

- Innovative and comprehensive wise practice, evidence-based care

  … throughout care continuum.

  … culturally safe and appropriate.

  … regardless of location, regardless of service provider/funder.

  … not subject to non-clinical constraints.
- Coordinated national response which prioritizes Indigenous-led approaches, strategies, targets and accountabilities
  - Indigenous Identifiers.

  … accountability throughout the system.
- Achieving health equity.

Targets ...

THE TREATMENT TARGET

diagnosed

on treatment

virally suppressed

UNAIDS. 2014. 90-90-90: An ambitious treatment target to help end the AIDS epidemic.

... 27% left out

UNAIDS. 2014. 90-90-90: An ambitious treatment target to help end the AIDS epidemic.