



POPULATION-SPECIFIC HIV/AIDS STATUS REPORT

Aboriginal Peoples



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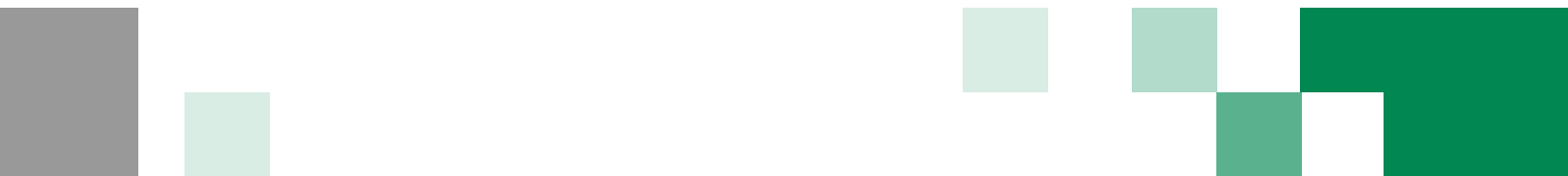
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FOREWORD

The Public Health Agency of Canada (PHAC), with the support of many partners, is pleased to release this status report as the second of eight reports intended to summarize current evidence¹ about the impact of HIV/AIDS among key populations in Canada. Communities, governments, public health practitioners, non-governmental organizations, researchers and others are encouraged to use this report to inform the future direction of HIV/AIDS policy, programming and research to positively affect the health and well-being of Aboriginal peoples.

This series of status reports was initiated to support the actions set out in the *Federal Initiative to Address HIV/AIDS in Canada*², the Government of Canada's framework for federal investment in HIV/AIDS, and to provide a comprehensive evidence base for other partners and stakeholders involved in the Canadian response. Launched in 2005, the Federal Initiative identifies the need for more effective interventions and improved HIV/AIDS prevention, research, diagnosis, care, treatment and support initiatives for specific populations living with, or at risk of, HIV and AIDS. These populations include people living with HIV/AIDS, gay men, people who use injection drugs, Aboriginal peoples, people in federal prisons, youth at risk, women and people from countries where HIV is endemic.

In addition, these status reports support the objectives of the report *Leading Together: Canada Takes Action on HIV/*

*AIDS (2005-2010)*³. Developed and launched by stakeholders in 2005, *Leading Together* renews Canada's collective efforts to deal with not only HIV/AIDS but also with the underlying health and social issues that contribute to new infections and have devastating effects on people who are living with HIV/AIDS. *Leading Together* encourages collaboration and the sharing of knowledge, skills and resources so that, together, we can stop HIV.

This status report was guided by a national working group with expertise in research, epidemiology, community development, policy and program development and the lived experiences of Aboriginal people living with, and affected by, HIV/AIDS. Their input and advice was instrumental in ensuring that the report presents the most current, relevant evidence and innovative responses that exist in Canada today.

This population-specific HIV/AIDS status report focuses on Aboriginal peoples in Canada. This is the first time PHAC has attempted to present HIV/AIDS-related information relevant to this population in a comprehensive manner. The decision to focus on Aboriginal peoples stems from the fact that the HIV/AIDS epidemic among this population in Canada needs to be better understood to adequately address the cultural and historical context relating to the population's vulnerability to, and resiliency against, HIV/AIDS.

The preparation of this report yielded a number of lessons that will influence future reports in this series. As is the case in any work of this nature, limitations were encountered in the data gathering, analysis and reporting phases. Nevertheless, the report is comprehensive and includes valuable information to further our knowledge and understanding of the epidemic. PHAC welcomes comments on the report to assist with the development of future population-specific HIV/AIDS status reports.

1 There are many different forms of evidence including research evidence, anecdotal reports, and personal experience which can be disseminated to improve practices. These include but are not limited to: (1) research evidence including findings from individual studies, systematic reviews, and primary research including community-based research; (2) informed practices including "best" practices and "wise" practices; (3) expert opinion from researchers and service providers; (4) lived experience from people living with HIV/AIDS; (5) reports and evaluations from a range of sources including government, community-based agencies, universities and funding agencies; and (6) practice-based evidence including programming materials informed by practice such as training manuals, guidelines, and position papers.

2 More information on the *Federal Initiative to Address HIV/AIDS in Canada* is available at www.aidsida.com.

3 More information on *Leading Together: Canada Takes Action on HIV/AIDS (2005-2010)* is available at www.leadingtogether.ca.



FOREWORD

After 25 years of collective commitment and investment, HIV/AIDS continues to be a major public health challenge that requires a concerted, collaborative and comprehensive response. Examining the underlying factors and conditions that create resiliency or increase vulnerability to HIV is the key to understanding how best to structure an efficient and sustainable response to the epidemic. It is with this objective in mind that this report was prepared.

EXECUTIVE SUMMARY

Aboriginal peoples—First Nations, Inuit and Métis—make up a unique segment of the concentrated HIV/AIDS epidemic in Canada.

Aboriginal peoples made up about 3.8% of the total Canadian population in 2006. This includes nearly 60% of Aboriginal people who self-identified on the census as First Nations, 33% as Métis and 4% as Inuit. The Aboriginal population is growing more quickly than the non-Aboriginal population; it grew by 45% between 1996 and 2006, almost six times faster than the non-Aboriginal population. The Aboriginal population is also younger than the non-Aboriginal population. The median age of the non-Aboriginal population is 40 years, compared to 27 years for the Aboriginal population. Various health measures (e.g., life expectancy, rates of chronic and infectious diseases) indicate that the health status of Aboriginal peoples is generally poorer than the non-Aboriginal population.

Data indicate that Aboriginal peoples are over-represented among HIV and AIDS cases in Canada. It is estimated that Aboriginal people made up 8.0% of all those living with HIV (including AIDS) in Canada in 2008. In that same year, it is estimated that 300 to 520 new HIV infections occurred in Aboriginal persons, representing 12.5% of all new infections. Overall, the HIV infection rate for Aboriginal people was about 3.6 times higher than among non-Aboriginal persons in 2008. HIV infections among Aboriginal persons are diagnosed at a younger age than in non-Aboriginal persons and also affect a higher proportion of women when compared to the non-Aboriginal population. Unlike the general Canadian population, injection drug use is the main category of exposure to HIV for both Aboriginal males and females. Studies also suggest that Aboriginal people who inject drugs may be more likely to contract HIV than non-Aboriginal people who inject drugs. After injection drug use, heterosexual contact is the second most common exposure category for both Aboriginal males and females. Although the HIV exposure category of men who have sex with men continues to account for the greatest number of new HIV infections in the general Canadian population, it is the third most

frequent exposure category after injection drug use and heterosexual contact among Aboriginal males.

The determinants of health clearly influence the Aboriginal population's vulnerability to HIV infection. A person's vulnerability increases or decreases based on income, education, unemployment, access to stable housing, early childhood development (e.g. history of child abuse), physical environments (e.g. geographically isolated communities, prison environments), access to health services, support networks and social environments (e.g. homophobia, HIV/AIDS-related stigma and discrimination), gender, a history of sexual violence, and, for this population in particular, racism and the multigenerational effects of colonialism and the residential schools system. The report also details some of the lived experiences of First Nations, Inuit and Métis individuals in relation to these determinants and supports an approach that addresses the root causes of HIV infection. Connection or reconnection to cultural traditions, values and spirituality is emphasized in the literature as an important component of resilience against HIV, both for Aboriginal people living with the disease and in terms of developing appropriate and effective prevention approaches.

The report identified 49 Canadian research projects underway between 2006 and 2008 that focused on HIV/AIDS among Aboriginal peoples. The general areas of investigation include HIV prevention, access to care, and community research capacity development. Many projects also focused on key cross-populations, including Aboriginal people living with HIV/AIDS, women, youth and people who inject drugs. Few research projects identified focused specifically on First Nations or Inuit, and none focused on Métis. In addition, little research or comprehensive evaluations have been conducted to determine the effectiveness of specific interventions in preventing new HIV infections or responding to the needs of Aboriginal people living with HIV/AIDS. Such population-specific and evaluative information is integral to developing future evidence-based interventions.

The report examined the current response to HIV/AIDS among Aboriginal peoples at both the policy and programmatic levels. This includes an overview of population-specific strategies at the national and provincial/territorial level; population-specific networks, coalitions and advisory bodies; organizations and projects focused on the delivery of programs and projects addressing HIV/AIDS among Inuit, Métis and First Nations populations residing off-reserve; projects addressing HIV/AIDS on-reserve; and the response to HIV/AIDS for Aboriginal people in federal and provincial/territorial prisons. The report found that a variety of organizations are involved in delivering prevention, care, treatment and support services to Aboriginal peoples, including community-based HIV/AIDS organizations; Aboriginal HIV/AIDS organizations; other Aboriginal organizations such as health centres and friendship centres; and others such as community health centres. In addition, most of the policies and programs identified in the report do not focus specifically on the particular needs and realities of First Nations, Inuit or Métis in relation to HIV/AIDS prevention, care, treatment or support.

Communities and organizations across Canada have taken up the challenge and are doing their part to reduce the growing number of infections in this population and to meet the needs of Aboriginal people living with, and at risk for, HIV/AIDS. Despite these important and significant efforts, much remains to be done. Effective, culturally specific and continued efforts in preventing the transmission and acquisition of HIV and improving the quality of life of Aboriginal people living with HIV/AIDS are required to successfully address the epidemic in this population.

ACKNOWLEDGEMENTS

PHAC would like to acknowledge the individuals, population representatives, community representatives, researchers and government officials who contributed their time, expertise and experience to the development of this population-specific HIV/AIDS status report. Thank you also to PHAC staff in the Centre for Communicable Diseases and Infection Control (CCDIC), as well as regional staff for their insightful contributions at various stages of the report.

Working Group Members

PHAC also acknowledges and thanks working group members for their exceptional commitment and for ensuring that this report accurately reflects the reality of the HIV/AIDS epidemic among Aboriginal peoples in Canada.

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LIST OF TERMS⁴

AIDS	Acquired Immune Deficiency Syndrome – the syndrome caused by HIV and a diagnosis made on the basis of certain clinical criteria (e.g. AIDS-defining illnesses, specific blood tests). Also known as late-stage HIV disease.	Gay	An adjective used to describe a person who is physically and emotionally attracted to the same sex. More commonly used to describe males.
APHA	Aboriginal Person Living with HIV/AIDS	Gender	“The array of socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis” [1].
ART	Anti-Retroviral Therapy – Treatment with western medicines that suppress or inhibit the ability of HIV to multiply in the body.	HAART	Highly Active Anti-Retroviral Therapy (see ART – Anti-Retroviral Therapy)
ASO	AIDS Service Organization – an organization providing AIDS services	HCV	Hepatitis C Virus – a virus that infects the liver. Prolonged and acute hepatitis C infection can often result in liver disease and cirrhosis. The virus is transmitted largely by blood transfusion or percutaneous inoculation, such as needle sharing among people who inject drugs.
CAAN	Canadian Aboriginal AIDS Network – a national Aboriginal non-governmental HIV/AIDS organization	HIV	Human Immunodeficiency Virus – the virus that causes AIDS
CAHR	Canadian Association of HIV Research	Homophobia	An irrational fear of, aversion to, or discrimination against homosexuals or homosexuality. ⁵
CCDIC	Centre for Communicable Diseases and Infection Control – a Centre of the Infectious Disease Prevention and Control Branch, Public Health Agency of Canada	IDU	An epidemiological classification for HIV transmission among people who inject drugs.
CIHR	Canadian Institutes of Health Research	Indigenous	Refers generally to the original peoples of any land, country or geographic area.
CIHAN	Canadian Inuit HIV/AIDS Network – a national Inuit HIV/AIDS network	Inuit	Canada’s Aboriginal people of the Arctic. Inuit are one of the three recognized Aboriginal peoples in Canada, along with First Nations and Métis.
CSC	Correctional Service of Canada – a government agency responsible for maintaining Canada’s federal correctional system	Inuk	Singular form of Inuit
First Nations	A term which usually refers to both Status and Non-Status Indians. First Nations People are one of the three recognized Aboriginal peoples in Canada, along with Métis and Inuit.	Inuktitut	Language of the Inuit
FNHIB	First Nations and Inuit Health Branch – a branch of Health Canada	Lesbian	A woman attracted sexually to other women
F/P/T AIDS	Federal/Provincial/Territorial Advisory Committee on AIDS		

⁴ This list was adapted from a list of commonly used HIV/AIDS terms and acronyms prepared for the National Aboriginal Council on HIV/AIDS.

⁵ Further discussion of homophobia and how it contributes to vulnerability to HIV can be found in the forthcoming *Population-Specific HIV/AIDS Status Report: Gay, Two Spirit, Bisexual, and other Men who have Sex with Men*.

Métis	Peoples of mixed Aboriginal and European ancestry. Métis are one of the three recognized Aboriginal peoples in Canada, along with Inuit and First Nations.
MSM	Men who have Sex with Men – An epidemiological classification for HIV transmission
NACHA	National Aboriginal Council on HIV/AIDS
Pauktuutit Inuit Women of Canada	— A national Inuit women’s organization
PHA	Person Living with HIV/AIDS
PHAC	Public Health Agency of Canada
Reserve	A First Nations community
RHAN	Regional HIV/AIDS Network – a network of Public Health Agency of Canada Regions focusing on HIV/AIDS issues and programs
SSHRC	Social Sciences and Humanities Research Council of Canada
SRAD	Surveillance and Risk Assessment Division – a division of the Centre for Communicable Diseases and Infection Control, Infectious Disease Prevention and Control Branch, Public Health Agency of Canada
STI	Sexually Transmitted Infection
Two-spirit	A term that refers to sexual orientation within some Aboriginal cultures ⁶ . The organization 2-Spirited People of the

1st Nations defines the term as follows: “Native people who are gay, lesbian, bisexual, transgendered, other gendered, third/fourth gendered individuals that walk carefully between the worlds and between the genders” [4]. The term is primarily used by some First Nations people.

TB Tuberculosis – an infectious disease caused by a bacterium that affects the human lungs and lower respiratory system.

Transgender A person who defies the biological definition of gender and who may have had surgery or hormone therapy to change his or her biological sex [5].

References

- [1] Health Canada. Exploring concepts of gender and health [document on the Internet]. Ottawa: Health Canada; 2003 Jun [cited 2009 Aug]. Available from: http://www.hc-sc.gc.ca/hl-vs/alt_formats/hpb-dgps/pdf/exploring_concepts.pdf.
- [2] McGill University. Two-spirited people [document on the Internet]. Montreal: Project Interaction, McGill University; 2006 [cited 2009 Aug]. Available from: <http://www.mcgill.ca/interaction/mission/twospirit/>.
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- [5] O'Brien Teengs D. Two Spirit Women. 2nd ed. Toronto: 2-Spirited People of the 1st Nations and Ontario Aboriginal HIV/AIDS Strategy; 2008.

6 Careful consideration must be given to the special cultural situation of two-spirit people and the roots of this identity in Aboriginal tradition, in the context of the effects of colonization and homophobia. Native people, prior to colonization and contact with European cultures, believed in the existence of three genders: the male, the female and the male-female gender, or what we now call the two-spirit person. The term two-spirit, though relatively new, was derived from interpretations of Native languages used to describe people who displayed both characteristics of male and female. Traditionally, the two-spirit person was one who had received a gift from the Creator. Two-spirit beings were historically revered as leaders, mediators, teachers, artists, seers, and spiritual guides. They were treated with the greatest respect, and held important spiritual and ceremonial responsibilities. The concept of two-spiritedness has been adapted to current concepts of gay, lesbian, bisexual and transgender persons of Native origins [2;3].

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CHAPTER 1 - Introduction

1

This status report focuses on HIV/AIDS and Aboriginal peoples in Canada, a term which refers to First Nations, Inuit and Métis as recognized under Section 35 of the *Constitution Act*, 1982. First Nations, Inuit and Métis are distinct populations with unique cultural, linguistic, geographic and historic characteristics. This report respectfully acknowledges these important distinctions, and wherever possible, presents evidence about differences between First Nations, Inuit and Métis populations relating to demographic characteristics, the burden of HIV/AIDS, factors which impact on vulnerability to, and resiliency against, HIV/AIDS, and research and response initiatives.

This report also covers current evidence about factors and/or conditions that increase or decrease vulnerability, and affect resiliency to HIV infection and AIDS among Aboriginal populations. Vulnerability is defined as a variety of social and economic factors that increase a person's susceptibility to HIV infection, including stigma and discrimination, gender inequity, poverty, human rights violations, and lack of HIV/AIDS awareness and access to education, health and other services [1]. When these factors are present, individuals may engage in behaviours, such as having unprotected sex or using contaminated needles that put them at higher risk of becoming infected with HIV. In this context, risk is not certain, but based on probability. Therefore, not everyone who is exposed to these factors may experience adverse outcomes [2].

It is important to note that an individual, group or community can successfully adapt to vulnerabilities by adopting approaches that foster resilience. The Canadian Aboriginal AIDS Network (CAAN) asserts that “resilience is far more than simple survival. It is about the ability to withstand challenges and maintain identity...” [3]. In preparing this report, the expert working group emphasized the importance of highlighting sources and examples of resiliency among Aboriginal people living with, and at risk of, HIV/AIDS. This report seeks to identify and honour these sources of resiliency amongst Aboriginal peoples.

1.1 Meaning and Use of Evidence in this Report

CAAN notes that “within the Aboriginal community literature may be used in combination with traditional knowledge to demonstrate the many kinds of insight that already exist regarding an issue” [4]. This report makes use of the following two types of evidence, both in print form: peer-reviewed and “grey” literature⁷. The focus on the printed word as the only form of evidence included in this report speaks to an important limitation of this approach, which must be acknowledged. The methodology utilized in preparing this report does not include the richness of personal experience and other ways of knowing, including oral teachings, which are a fundamental aspect of many Aboriginal cultures.

In Chapter 4, this report has tried to capture the voices of First Nations, Inuit and Métis people living with, and affected by, HIV/AIDS. As these personal quotations are derived from written publications, this approach does not fully reflect the importance of oral traditions in Aboriginal cultures. The Public Health Agency of Canada (PHAC) respectfully acknowledges this limitation.

1.2 Methodology

To support the development of this status report, PHAC established an expert working group composed of community and population representatives, non-governmental organizations, researchers, and policy and program experts. The working group acted as an advisory body, providing guidance and feedback on the report process, themes and drafts. The 10 non-governmental working group members were selected following a national open call based on their personal and professional expertise on issues related to HIV/AIDS and Aboriginal peoples. The working group

⁷ Grey literature is a term commonly used to describe any information produced by an organization for which publishing is not the primary activity of that organization. Grey literature is not subject to the same scrutiny as peer-reviewed literature.

also included representation from PHAC and the First Nations and Inuit Health Branch, Health Canada.

The methodology for each chapter was designed to ensure that the most current and relevant evidence was synthesized and presented. Demographic data were extracted from various sources, including Statistics Canada. Epidemiological information and surveillance data were gathered from published reports by PHAC and other existing published data.

Data and information on Aboriginal peoples' vulnerability to, and resilience against, HIV/AIDS were collected from peer-reviewed publications and grey literature. The literature identified for inclusion in the report met the following criteria: focused on HIV or AIDS; published between 2002 and 2008; focused on Canadian First Nations, Inuit or Métis populations; addressed 1 or more of the 12 health determinants related to HIV or AIDS, or characterized HIV or AIDS in the context of prevention, care, treatment, support or diagnosis for Canadian First Nations, Inuit or Métis populations; and written in English or French. A list of search terms and databases searched can be found in Appendix A. Additional information was also included in the report to provide context and/or address gaps identified by the working group.

Information on current research (underway between 2006 and 2008) was gathered from the following organizations: Canadian Institutes of Health Research (CIHR); Canadian Association for HIV Research (CAHR); Canadian Foundation for AIDS Research (CANFAR); and the Social Sciences and Humanities Research Council of Canada (SSHRC).

To gather information on the current response to HIV/AIDS among Aboriginal populations, including time-limited projects, networks, coalitions, committees, strategies, and policy initiatives in place between 2006 and 2008, information-gathering templates were circulated to federal, provincial and territorial officials through the following mechanisms: CAAN; Federal/Provincial/Territory Advisory Committee on AIDS; PHAC national and regional HIV/

AIDS program consultants; the Federal/Provincial/Territorial Heads of Corrections Working Group on Health; and Health Canada's Regional HIV/AIDS Sub-Working Group. Responses were received from all provinces and territories. Projects funded by the Toronto Public Health AIDS Prevention Community Investment Program were also included in the analysis. The expert working group was also instrumental in identifying additional networks, coalitions, strategies and projects for inclusion in the report.

A limitation of this analysis is the focus on HIV/AIDS-specific responses to the concentrated epidemic among Aboriginal peoples. It is recognized that while many HIV/AIDS-specific programs and services serve Aboriginal clients in addition to other key populations, for the purposes of this report, only time-limited HIV/AIDS projects that explicitly focus on First Nations, Inuit and Métis clients are included. A second limitation of this report is that although the evidence demonstrates the impact of the determinants of health on the vulnerability of Aboriginal populations to HIV/AIDS, due to time and methodological constraints, Chapters 5 and 6 focus on HIV/AIDS-specific projects only.

1.3 References

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CHAPTER 2 - Demographic Profile

2

The purpose of this chapter is to provide background information on selected demographic characteristics of the Aboriginal population (geographic location, age, language, education, employment, income, and health status) to inform the determinants of health approach used in this report and better contextualize issues related to HIV/AIDS among Aboriginal peoples.

Notes on the data used in this chapter:

First Nations people include those who are registered under the Indian Act (also known as Registered Indians or Status Indians) and those who are not registered (also known as non-Status Indians). First Nations people may also reside on-reserve or off-reserve. These distinctions have important implications, as the census data used in this chapter refer to those who self-identified as First Nations people (residing on-reserve or off-reserve), whereas other information (such as health information or the Aboriginal Peoples Survey) usually refers to a specific group of First Nations people, such as Status First Nations people who live on-reserve, or First Nations people – Status and non-Status – who reside off-reserve.

Data in this chapter are drawn from several sources including the 2006 Census of Canada, the 2006 Aboriginal Peoples Survey, Health Canada's 2005 Statistical Profile on the Health of First Nations in Canada and the 2002/2003 First Nations Regional Longitudinal Health Survey. In the census, Statistics Canada defines the term 'Aboriginal' to include individuals who self-identified as at least one of the following: a member of at least one Aboriginal group (First Nations, Inuit or Métis); a Treaty Indian or a Registered Indian; a member of a First Nation or Indian band [1]. It is important to note that 22 First Nations communities were not completely enumerated by the 2006 census and, as a result, are not included in the census data presented in this chapter. It is also important to note that the census uses a broader definition of Métis identity than the Métis National Council. Therefore information about the Métis population provided in this chapter may vary from the council's national registry [2].

2.1 Population Size and projected Growth

Over 1.1 million people self-identified as Aboriginal in the 2006 census, comprising 3.8% of the total Canadian population. Nearly 60% of Aboriginal people self-identified as First Nations, 33% as Métis and 4% as Inuit⁸ [3].

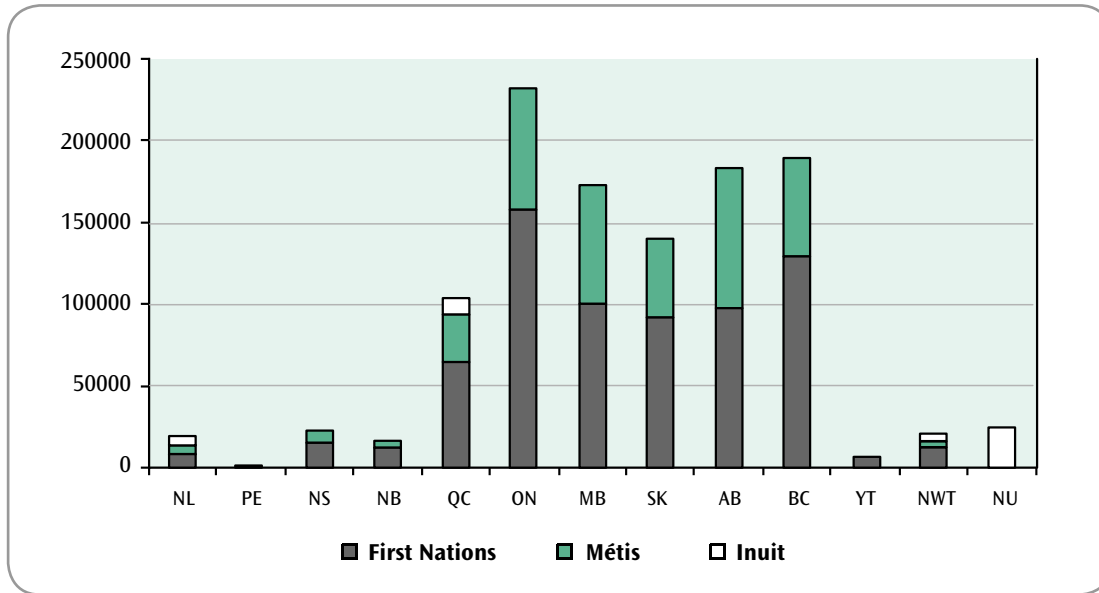
The Aboriginal population is growing more quickly than the non-Aboriginal population. Between 1996 and 2006, the Aboriginal population grew by 45%, almost six times faster than the non-Aboriginal population. The Métis population grew 91% between 1996 and 2006, the most of the three Aboriginal groups. This growth rate is attributed to higher birth rates and an increased likelihood for Métis people to identify themselves in the census [2]. First Nations and Inuit populations also grew substantially between 1996 and 2006: First Nations by 29% and Inuit by 26% [3]. Statistics Canada projects that the Aboriginal population will represent over 4% of the Canadian population by 2017 [4].

2.2 Geographic Location

In 2006, about 80% of all Aboriginal people lived either in Ontario or one of the four western provinces (see Figure 1). The following section provides information on the geographic locations of First Nations, Inuit and Métis peoples.

8 In addition, 0.7% of the Aboriginal population self-identified as more than one Aboriginal group (First Nations, Inuit or Métis) on the Census, which Statistics Canada defines as *Multiple Aboriginal Identity responses*. An additional 2% of the Aboriginal population was enumerated under the Census category *Aboriginal responses not included elsewhere*, which includes people who self-identified as Registered Indians and/or members of an Indian band but did not identify as First Nations, Inuit or Métis in the census Aboriginal identity question [1].

Figure 1: Distribution of the First Nations, Inuit and Métis populations by province/territory (n=1,138,250)



(Source: [1]. This table does not include multiple Aboriginal identity responses or Aboriginal responses not included elsewhere.)

2.2.1 First Nations

In 2006, the First Nations population was located mainly in Ontario (23%), British Columbia (19%), Manitoba (14%), Alberta (14%) and Saskatchewan (13%) [3]. In addition, about 9% of First Nations people lived in Quebec in 2006, while 5% lived in the four eastern provinces. Less than 3% of the First Nations population lives in the North, primarily in the Northwest Territories and Yukon.

There are over 600 First Nations communities in Canada. Approximately 40% of the First Nations population was enumerated by the census as residing on-reserve in 2006. However, if only Registered Indians are included in this calculation, 52% of this population was enumerated by the census as living on-reserve in 2006.

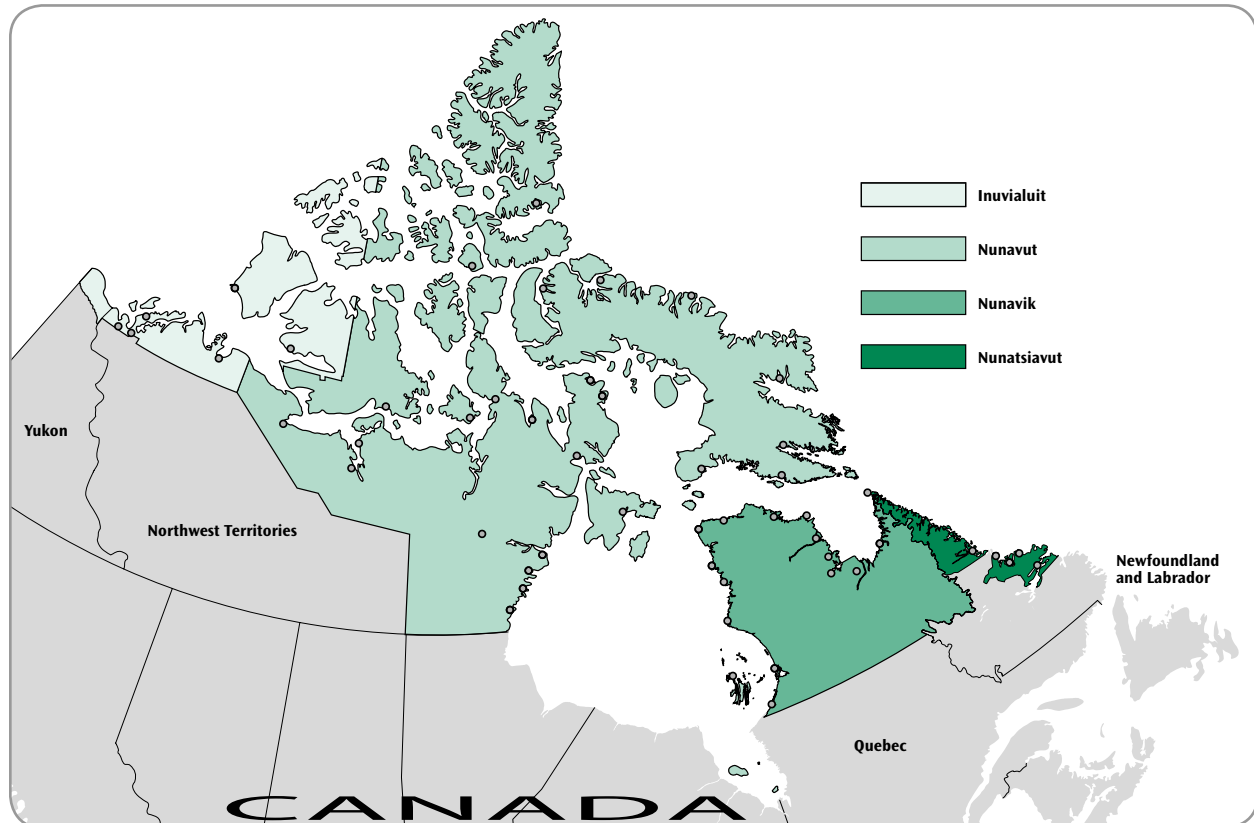
Over three-quarters (78%) of the First Nations population living off-reserve resided in urban areas in 2006, while 21% lived in rural areas [3].

2.2.2 Inuit

There are over 50 Inuit communities in Canada located in the four Inuit regions of Inuvialuit, Nunavut, Nunavik and Nunatsiavut. These regions span two provinces and two territories in the North (see Figure 2). Inuit make up the majority of the population in each region. Over three-quarters of the Inuit population (78%) or about 40,000 people lived in one of these four regions in 2006. In 2006, almost half of all Inuit resided in Nunavut (49%), while 19% lived in Nunavik, 6% in Inuvialuit and 4% in Nunatsiavut [3].

Between 1996 and 2006 the number of Inuit who live in urban areas outside the four Inuit regions increased by 60%. In 2006, about 17% of the total Inuit population lived in urban centres outside of the four Inuit regions, mainly in Ottawa-Gatineau, Yellowknife, Edmonton, Montreal and Winnipeg [3].

Figure 2: Inuit regions in Canada



Source: [5]

2.2.3 Métis

Almost 9 in 10 people who self-identified as Métis in the 2006 census lived in either Ontario or one of the four western provinces in 2006, including 22% in Alberta, 19% in Ontario, 18% in Manitoba, 15% in British Columbia and 12% in Saskatchewan. An additional 7% of the Métis population resides in Quebec, while nearly 5% of the Métis population resides in one of the four eastern provinces. One percent of the Métis population lived in the territories (Northwest Territories, Yukon and Nunavut) in 2006 [1].

In 2006, 69% of Métis lived in urban areas. However, Métis were twice as likely as urban-dwelling non-Aboriginal people to live in smaller urban centres rather than large

cities (41% of urban Métis versus 20% of non-Aboriginal urban dwellers).

2.2.4 Population mobility, housing and homelessness

The 2006 census found that the Aboriginal population is slightly more likely to move in a given year than the non-Aboriginal population. The majority of Aboriginal people (81%) reported having lived at the same address at the time of the 2006 Census as they had the year before; this is only slightly less than non-Aboriginal people (86%) who reported living at the same address as the previous year [3].

It is important to note that the census does not include all homeless or transient populations, as these groups are

difficult to enumerate. Therefore, Aboriginal homeless and transient populations are likely undercounted in the census. It is estimated that there are 150,000 to 300,000 homeless people in Canada [6], and evidence suggests that Aboriginal people are overrepresented among this population [6;7]. Counts of the homeless populations in various Canadian urban centres found that Aboriginal people made up 16% of the homeless population in Toronto, 30% in Vancouver, 38% in Edmonton and 62% in Winnipeg [7].

Overcrowding and under-housing are also significant issues among Aboriginal populations. According to the 2006 Census, 38% of Inuit in the four Inuit regions lived in crowded homes⁹, compared to 3% of the non-Aboriginal population [3]. The Ten-Year Inuit Housing Action Plan released by the Government of Nunavut in 2004 notes that 39% of Inuit living in Nunavut do not currently live in and are not able to access acceptable housing [8]. The census also reports that a significant proportion of the First Nations population experiences over-crowding; 26% of First Nations people living on-reserve and 7% of First Nations people living off-reserve lived in crowded homes in 2006 [3]. The census found that about the same percentage of Métis people in urban areas experienced crowded housing as the non-Aboriginal population (3%), however, Métis living in rural areas experienced a higher rate of crowded housing (5%) than the non-Aboriginal population (1%) [3].

2.3 Age

The Aboriginal population is younger than the non-Aboriginal population. Almost half (48%) of the Aboriginal population is made up of children and youth aged 24 and under, compared to 31% of the non-Aboriginal population. The median age of the non-Aboriginal population is 40 years, while the median age of the Aboriginal population is 27 years. Differences in the median age also exist

between Métis (30 years), First Nations (25 years) and Inuit (22 years) populations [3].

There are also fewer seniors in the Aboriginal population than in the non-Aboriginal population. Seniors represented 13% of the non-Aboriginal population, but just 5% of the Aboriginal population in 2006. However, the number of Aboriginal seniors doubled between 1996 and 2006 [3].

2.4 Sex

Women and girls constitute just over half (51%) of the Aboriginal population in Canada. This is comparable to the general population [3].

2.5 Language

2.5.1 First Nations

First Nations people speak over 60 different languages, which can be grouped into a number of language families, including Algonquin, Athapaskan, Siouan, Salish, Tsimshian, Wakashan, Iroquoian, Haida, Kutenai and Tlingit. In 2006, nearly 3 in 10 First Nations people were able to conduct a conversation in an Aboriginal language. First Nations people living on-reserve were more likely to be able to carry on a conversation in an Aboriginal language (51%) than those living off reserve (12%). One percent of First Nations people enumerated by the census were only able to speak an Aboriginal language [3].

In 2006, Cree was the Aboriginal language spoken by the largest number of First Nations people—12.5% of First Nations people could speak this language—followed by Ojibway, Oji-Cree and Montaignais-Naskapi, all of which are part of the Algonquin language family. Other languages spoken by fewer than 10,000 First Nations people include Dene (from the Athapaskan language family), Mi'kmaq (Algonquin language family), Siouan languages (Dakota/Sioux) and Atikamekw (Algonquin language family).

⁹ Statistics Canada defines a crowded home as one that has more than one person per room (not including rooms such as bathrooms, halls and rooms used only for business purposes) [3].

2.5.2 Inuit

The 2006 census found that the majority (69%) of Inuit in 2006 were able to speak Inuktitut¹⁰. Inuit living in urban areas were less likely to be able to speak Inuktitut than those living in the North. In 2006, 84% of those living in one of the four Inuit regions reported being able to speak Inuktitut, compared to 15% of Inuit living in urban areas. Similarly, while 63% of Inuit living in one of the four Inuit regions identified Inuktitut as their primary language spoken at home, just 4% of Inuit living in urban areas did so in 2006 [3].

2.5.3 Métis

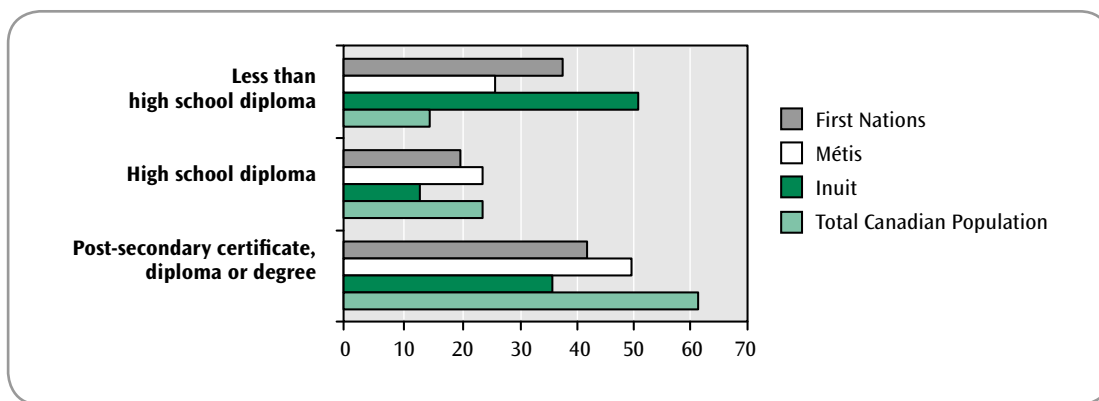
About 4% of Métis spoke an Aboriginal language in 2006, the most common of which was Cree, followed by Dene and Ojibway. According to the 2006 census there were

fewer than 1,000 speakers of other Aboriginal languages, including Michif, the traditional language of the Métis that combines primarily Cree and French [3].

2.6 Education

According to the 2006 census, about one-third of Aboriginal people aged 25 to 64 had not completed high school, compared to 15% of the total Canadian population of the same age group. In addition, 21% of Aboriginal people had a high school diploma as their highest educational attainment, compared to 24% of the total Canadian population. About 44% of the Aboriginal population had completed some kind of postsecondary training in 2006 (e.g. trades certificate, college diploma or university degree), compared to 61% of the total Canadian population [9].

Figure 3: Percentage of First Nations, Inuit, Métis and total Canadian population by level of educational attainment



Source: [9]

10 The 2006 Census notes that there are five main Inuit language dialects spoken in Canada: Inuvialuktun (spoken in Inuvialuit), Inuinnaqtun (spoken mainly in some communities in western Nunavut), Inuttitit (spoken in eastern Nunavut), Inuttit (spoken in Nunavik), and Inuttut (spoken in Nunatsiavut). The Census reports on these five distinct dialects by the collective term 'Inuktitut' [3].

2.6.1 First Nations

In 2006, 38% of First Nations adults aged 25 to 64 had less than a high school diploma, while 20% had a high school diploma as their highest educational qualification. About 42% of First Nations adults had some form of post-secondary qualification [9].

2.6.2 Inuit

Fifty-one percent of Inuit aged 25 to 64 had less than a high school diploma in 2006. Thirteen percent of Inuit had a high school diploma as their highest educational qualification, while about 36% of Inuit were graduates of post-secondary education [9].

2.6.3 Métis

Just over one-quarter of Métis aged 25 to 64 had less than a high school diploma in 2006, while nearly one-quarter had a high school diploma as their highest educational qualification. One-half of all Métis people had some form of post-secondary qualification [9].

2.7 Employment

Although employment rates rose for Aboriginal people between 2001 and 2006, they continue to experience lower rates of employment than the non-Aboriginal population. In 2006, the employment rate for Aboriginal adults aged 25 to 54 was 66%, compared to 82% for the non-Aboriginal population of the same age group. In 2006, Aboriginal people were twice as likely to be unemployed as non-Aboriginal people [10].

2.7.1 First Nations

The employment rate for First Nations people aged 25 to 54 was 61% in 2006. About two-thirds (66%) of First Nations people living off-reserve were employed, compared with 52% of First Nations people living on-reserve [10].

2.7.2 Inuit

Approximately 61% of Inuit aged 25 to 54 were employed in 2006. The unemployment rate for Inuit aged 25 to 54 was 19%, compared to an unemployment rate of 5% for non-Aboriginal adults in 2006 [10].

2.7.3 Métis

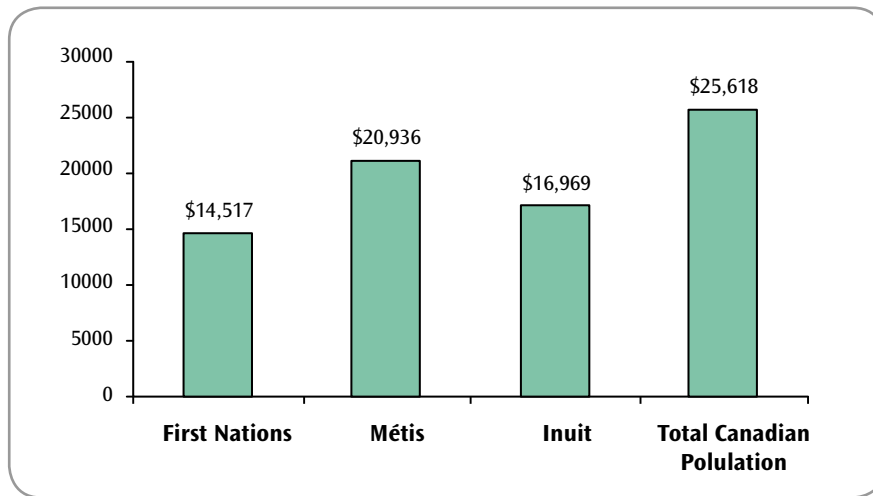
Approximately 75% of Métis people aged 25 to 54 were employed in 2006. The unemployment rate for Métis aged 25 to 54 was the lowest among the three Aboriginal groups at 8%, but still higher than the unemployment rate for non-Aboriginal adults (5%) [10].

2.8 Income

According to the 2006 census, Aboriginal people have a lower median annual income than the total Canadian population. In 2005¹¹, the median annual income for Aboriginal people aged 15 and over was \$16,796, while the median income for the total Canadian population was \$25,618. As in the total Canadian population, the annual median income for Aboriginal males was higher (\$18,787) than for Aboriginal females (\$15,682).

11 The Census collects information on income for the calendar year prior to the year it is taken. Therefore, the 2006 Census collected data on income for the year 2005 [11].

Figure 4: Median annual income for First Nations, Inuit, Métis and total Canadian population, Aged 15 and over, 2005



Source: [11]

2.8.1 First Nations

In 2005, the annual median income for people who self-identified as First Nations on the 2006 Census was \$14,517, considerably lower than the median annual income for the total Canadian population. The median annual income for females and males who self-identified as First Nations was nearly identical (\$14,516 annually versus \$14,520 annually) [11].

2.8.2 Inuit

According to the 2006 Census, the median annual income for Inuit was \$16,969 in 2005. There was a small gap between male and female earnings among the Inuit. In 2005, the median annual income for Inuit females was \$16,599 while for Inuit males it was \$17,425 [11].

2.8.3 Métis

Those who self-identified as Métis on the 2006 Census had a higher median annual income in 2005 (\$20,936) than those who self-identified as First Nations or Inuit. The gap between male and female earnings was the largest among the Métis compared to First Nations and Inuit. Métis females reported a median annual income of \$17,520, while Métis males reported a median annual income of \$26,466, a difference of almost \$9,000 per year [11].

2.9 Health Status

This section provides a brief overview of various health indicators for First Nations, Inuit and Métis populations, where information is available. This section approaches the concept of health primarily using the western biomedical model of health, including information on health indicators such as life expectancy and the prevalence of

disease and illness among First Nations, Inuit and Métis people. It is important to acknowledge that many Aboriginal people approach the concept of health from a holistic perspective that is different from the western biomedical model. For First Nations people, a traditional approach to health includes the importance of a connection to the natural world and the concept of seeking, achieving and maintaining balance in one's life [12]. Métis people's perspective on health also reflects this holistic perspective [13], noting that "healing cannot occur in the physical body without addressing and bringing into alignment the other aspects of one's being" [14], including the body, mind and spirit. For Inuit, a holistic view of health "... includes balance and harmony of social, economic, cultural, environmental and biological factors" [15]. For Aboriginal peoples, health is conceptualized as more than the absence of illness, and incorporates aspects of physical, mental, emotional and spiritual well-being and balance, while emphasizing the importance of connection with family, society and the natural world [12;15].

Aboriginal and non-Aboriginal scholars identify the importance of understanding the health disparities experienced by Aboriginal people in the context of the historical and ongoing processes of colonization [16-18]. It is also noted that, "time and again health disparities are directly and indirectly associated with social, economic, cultural and political inequities; the end result of which is a disproportionate burden of ill health and social suffering upon the Aboriginal populations of Canada" [17]. The legacy of residential schools and other policies of assimilation have also had a significant impact on the mental health of Aboriginal individuals, families and communities [19;20]. It is hoped that this section on health status will complement Chapters 3 and 4 of this report and that together these sections will provide a more complete and holistic portrait of the current status of health and well-being of Aboriginal peoples.

It is also acknowledged that this section is impeded by the limited amount of Inuit-¹² and Métis- specific health data available. This is due to a number of factors including limitations in provincial and territorial health data collection/reporting and lack of routine data collection mechanisms specific to Inuit and Métis populations. Currently, health information for Inuit and Métis populations is mainly derived from census data, surveys such as the Aboriginal Peoples Survey, and university-based research studies. This section draws on this information where possible.

2.9.1 First Nations

As discussed at the beginning of this chapter, First Nations people include those who are registered under the *Indian Act* (Registered Indians or Status Indians) and those who are not registered (Non-Status Indians). First Nations people may also reside on-reserve or off-reserve. Due to differences in the way that data are collected, certain types of health information are available for different segments of the First Nations population (e.g. Registered Indians, or First Nations residing off-reserve). Some key health indicators are summarized in the following table for Status or Registered Indians, and for First Nations people living on-reserve and off-reserve.

¹² Data collection for the first Inuit Health Survey is underway. The survey will provide baseline data on the health status of Inuit adults, preschool aged children and households, including information on chronic disease risks, nutrition, physical activity, social support and mental health, disabilities and injuries, household crowding, and food security.

Health indicators for Status Indians, First Nations residing on-reserve and off-reserve		
Status Indians or Registered Indians		
Life expectancy	In 2001, the life expectancy of Status Indian (or Registered Indian) males and females was 70.4 years and 75.5 years, respectively, while the life expectancy for the total Canadian population was 77.0 years for males and 82.1 years for females. This represents a gap of 6.6 years for both Registered Indian men and women [21].	
Tuberculosis (TB)	In 2007, the TB rate among Registered Indians was 27.9 cases per 100,000 compared to 1.9 cases per 100,000 for the total Canadian-born population and 0.7 for the Canadian-born non-Aboriginal population [22].	
	First Nations on-reserve	First Nations off-reserve
Self-rated health status	40% rated their health as excellent or very good; 27% rated their health as fair or poor [23].	53% rated their health as excellent or very good; 19% rated their health as fair or poor [24].
Chronic conditions	54% have one or more chronic health conditions, the most common of which were arthritis/rheumatism (25%), high blood pressure (20%), and asthma (9.7%) [12]. Nearly 20% of First Nations adults living on-reserve have been diagnosed with diabetes [12].	54% have one or more chronic health conditions, the most common of which were arthritis/rheumatism (21%), high blood pressure, heart problems or the effects of stroke (20%), and respiratory problems (asthma, chronic bronchitis, emphysema) (18%) [24]. 8% of First Nations adults living off-reserve have been diagnosed with diabetes [24].
Leading causes of death	The leading causes of death ¹³ among First Nations men are injury and poisoning, which accounted for 28% of all deaths in 2000, followed by circulatory disease and cancer. Among First Nations women, the leading causes of death were circulatory disease, injury and poisoning, and cancer [25].	

As is the case with other health indicators, poor mental health can be related to the experiences of colonization and marginalization experienced by First Nations people [12]. The legacy of residential schools has had a profound and multi-generational impact on the mental health and well-being of First Nations individuals, families and communities [19]. Suicide is one of the leading causes of death among First Nations youth and adults. In 2000, 22% of deaths among First Nations youth (10-19 years)

and 16% of deaths among young adults (20-44 years) were caused by suicide [24]. The 2002/03 First Nations Regional Longitudinal Health Survey found that 30% of First Nations adults living on-reserve had experienced a time when they felt sad, blue or depressed for two weeks or more in a row [12]. The 2001 Canadian Community Health Survey found that 12% of First Nations adults living off-reserve had experienced an episode of major depression compared to 7% of the total Canadian population [26].

13 Based on crude death rates.

Historically, alcohol and other substances played important cultural and ceremonial roles in First Nations and other Indigenous societies [12]. Today, substance use, including alcohol and drug use, is identified as a significant concern in many Aboriginal communities [12;27;28]. Although a national picture of illegal substance use among Aboriginal people is not available, smaller studies suggest that Aboriginal people are overrepresented among those who use illegal substances [29-31]. The 2002/2003 First Nations Regional Longitudinal Health Survey found that 27% of respondents (First Nations people living on-reserve) had used marijuana in the past year, while 7% reported using other illegal substances including PCP/Angel Dust, acid/LSD/amphetamines, ecstasy, inhalants, cocaine/crack and heroin [12].

The survey also found lower rates of alcohol use among First Nations people (66%) over a twelve-month period than the total Canadian population (79%). However, the proportion of First Nations respondents who reported heavy drinking¹⁴ on a weekly basis (16%) was higher than in the total Canadian population (6%) [12].

2.9.2 Inuit

According to the 2006 Aboriginal Peoples Survey, 50% of Inuit aged 15 and older rated their health as excellent or very good, while 6% rated their health as fair or poor [32]. In 2006, 44% of Inuit adults reported that they had been diagnosed with one or more chronic conditions, the most common of which were arthritis/rheumatism (13%) and high blood pressure (12%). Four percent of Inuit reported that they had diabetes, an increase from 2% in 2001 [32]. In addition, 6% of Inuit reported having a communicable disease (hepatitis, TB, HIV/AIDS) [24].

Inuit have a lower life expectancy than the total Canadian population. In 2001, the life expectancy for those living in Inuit regions was 64.4 years for males and 69.8 years

for females. This represents a gap of approximately 12.6 years for males and 12.2 years for females living in Inuit regions [33].

The incidence of TB among Inuit is higher than among the non-Aboriginal population. In 2007 the TB rate among Inuit was 84.2 cases per 100,000, compared to 1.9 cases per 100,000 in the total Canadian-born population and 0.7 for the Canadian-born non-Aboriginal population [22]. High rates of TB among Inuit, as in the First Nations population, are likely related to poor housing conditions and over-crowding [3].

Colonization, residential schools, and rapid cultural change have all impacted the mental health and well-being of Inuit [27]. Suicide is a significant concern among Inuit in Canada. Studies in Inuit regions have found suicide rates ranging from 3.5 to 11 times the national average, with young males under the age of 25 making up the majority of deaths by suicide. Between 2000 and 2003, 22% of all deaths in Nunavut were attributed to suicide [34].

Information is lacking on problematic substance use among Inuit populations in Canada. The National Aboriginal Health Organization notes that “marijuana is often cheaper and easier to bring into [Nunavut] than alcohol. Street drugs such as cocaine and heroin are seen in Iqaluit... [and] larger communities in other Inuit regions often see similar patterns” [27]. As in the First Nations population, abstinence from alcohol use among Inuit is higher than among the total Canadian population. However, binge drinking (defined as having 5 or more drinks on a single occasion) is prevalent among Inuit who do drink. In 2001, 37% of Inuit adults did not drink alcohol, while 30% of Nunavut residents aged 12 years and over who did drink, reported heavy drinking 12 or more times per year [27]

14 Defined as those who have 5 or more drinks on one occasion.

2.9.3 Métis

There is limited information available on the health status of the Métis population. According to the 2006 Aboriginal Peoples Survey, 58% of Métis rated their health as excellent or very good, while 16% rated their health status as fair or poor. More than half (54%) of Métis reported that they had one or more chronic health conditions, the most common of which were arthritis or rheumatism (21%), high blood pressure or other heart problems (20%) and respiratory problems (18%). In addition, 3% of Métis reported having a communicable disease, such as hepatitis¹⁵, TB or HIV/AIDS [24].

Information on diabetes in the Métis population is limited due to lack of data collection systems available for the population. In the 2006 Aboriginal Peoples Survey, 7% of Métis reported that they had diabetes [24]. A study that linked a sample of the membership list of the Manitoba Métis Federation to Manitoba provincial health databases found that the prevalence of diabetes among Métis in the province was higher than in the total Manitoba population. Among Métis aged 15 years and older, the prevalence of diabetes was nearly 10% for males and 11% for females, considerably higher than in the total provincial population (6.1% of Manitoba males and 5.7% of Manitoba females had diabetes) [35].

Métis also experience a higher rate of TB than the non-Aboriginal population. In 2007, the TB incidence rate among Métis was 9.6 cases per 100,000 compared to 1.9 cases per 100,000 in the total Canadian-born population and 0.7 for the Canadian-born non-Aboriginal population [22].

15 Available data from the 2006 Aboriginal Peoples Survey does not specify the type of hepatitis.

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CHAPTER 3 - Status of the Concentrated HIV/AIDS Epidemic among Aboriginal Peoples

This chapter summarizes the most recent data available on the concentrated HIV/AIDS epidemic in Canada among the Aboriginal population. It begins with an overview of the HIV/AIDS epidemic among Aboriginal people in Canada, and also includes data and information regarding sex; perinatal transmission; age; gay, lesbian, two-spirit, bisexual and other men who have sex with men and women who have sex with women; injection drug use; incarceration; and HIV co-infection. These issues impact prevention, care, treatment and support strategies for Aboriginal populations.

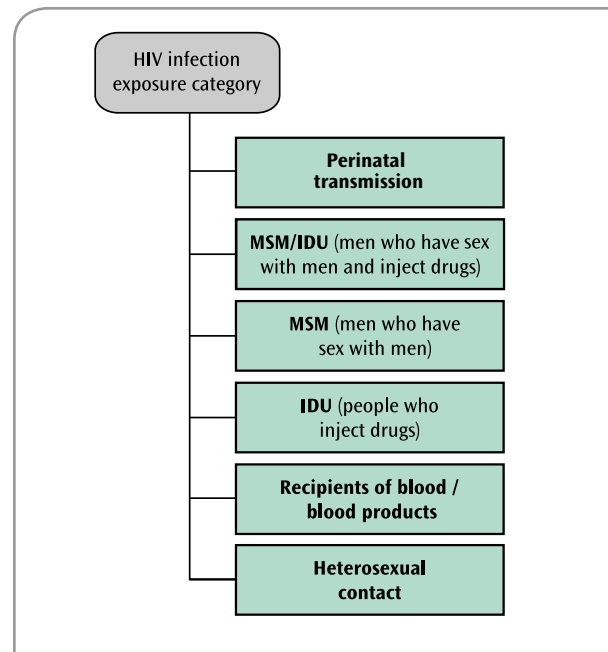
PHAC uses various types of epidemiological data, including surveillance, survey data and estimates, to monitor HIV infections and AIDS cases in the Aboriginal and other populations in Canada. There are benefits and drawbacks to each type of information. Therefore, a complementary approach is adopted in order to create a more comprehensive picture of the HIV/AIDS epidemic in Canada.

Surveillance data are provided voluntarily to PHAC by the provinces and territories, and contains reported positive HIV test results and diagnosed AIDS cases. As HIV and AIDS are both reportable in all jurisdictions in Canada, case reporting standards have been developed by PHAC to facilitate data sharing at the national level. A minimum amount of information is provided for each case. However, the amount of supplementary data provided varies between provinces and territories [1]. Specifically, with reference to the HIV epidemic in Canada among Aboriginal people, important missing surveillance data can include ethnicity.

Most reported HIV diagnoses and AIDS cases include one or more exposure categories. Exposure category refers to the most likely route by which a person became infected, as defined by a hierarchy of risk factors. For the purpose of national reporting, HIV and AIDS cases are assigned to only one single category. As illustrated in Figure 5, the first six exposure categories are 1) Perinatal transmission, 2) MSM/IDU: men who have had sex with men and have injected drugs; 3) MSM: men who have had sex with men; 4) IDU: people who inject drugs; 5) Recipients of blood/

blood products; and 6) Heterosexual contact¹⁶. The "hierarchy" simply implies that if there are two or more exposure categories reported with a positive HIV test report or AIDS case, the exposure category ranked highest according to the hierarchy will be the one recorded. For example, if a case is reported citing the exposure categories *MSM and Blood/blood products*, the case would be counted in national data as having been attributed to the MSM exposure category. It should also be noted here that the term MSM in this context is referring specifically to sexual behaviour and not a person's self-identified sexual identity [2].

Figure 5: HIV/AIDS exposure categories



Surveillance data alone do not reflect the burden of HIV/AIDS in Canada, and/or comprehensively characterizes risk factors associated with a given transmission. This is

16 The heterosexual contact exposure category contains four distinct sub-categories for risk of exposure to HIV: 1) the person is from an HIV-endemic country/has had sexual contact with a person at risk; 2) the person is from an HIV-endemic country; 3) the person has had contact with a person at risk of HIV; 4) heterosexual contact is the only HIV risk factor a person has and nothing is known about the HIV-related factors associated with the partner.

due to several factors including the reluctance of persons to state HIV-related risk factors, delays in national reporting, and the data being reliant on individuals getting tested. Many Canadians, including Aboriginal people, do not routinely test for HIV. In 2008, it was estimated that 26% of people living with HIV in Canada were not aware of their HIV-positive status [3].

Reporting on HIV and AIDS cases among Aboriginal populations is further challenging because information on ethnicity is not reported by all provinces and territories. Currently, Ontario and Quebec do not report information on ethnicity for positive HIV tests. Between 1979 and the end of 2008, information on ethnicity was reported for 79.0% of all AIDS cases, while just 29.8% of new positive HIV test reports between 1998 (when ethnicity reporting began) and the end of 2008 included information on ethnicity. As a result, data on the incidence and prevalence of HIV among Aboriginal populations in Canada is incomplete and may under-represent the extent of the concentrated epidemic in the Aboriginal population. Lack of available data is exacerbated by stigma and discrimination which work against an individual's willingness to disclose potentially sensitive information about HIV-related risk activity and sexual orientation.

Statistical modelling and estimation are used to calculate the number of HIV infections and AIDS cases in Canada. By using statistical formulas and secondary sources of data, estimates of the number of new infections (incidence) and the number of people living with HIV/AIDS infection (prevalence) can be generated. PHAC is responsible for reporting Canadian estimates of national HIV incidence and prevalence rates to the Joint United Nations Programme on HIV/AIDS (UNAIDS) [2]. The methods used to estimate HIV incidence and prevalence at the national level bring together all available forms of data and are therefore used in this report.

To complement the data collected through the system described above (known as “first generation surveillance”), PHAC's Surveillance and Risk Assessment Division has developed several second generation surveillance systems

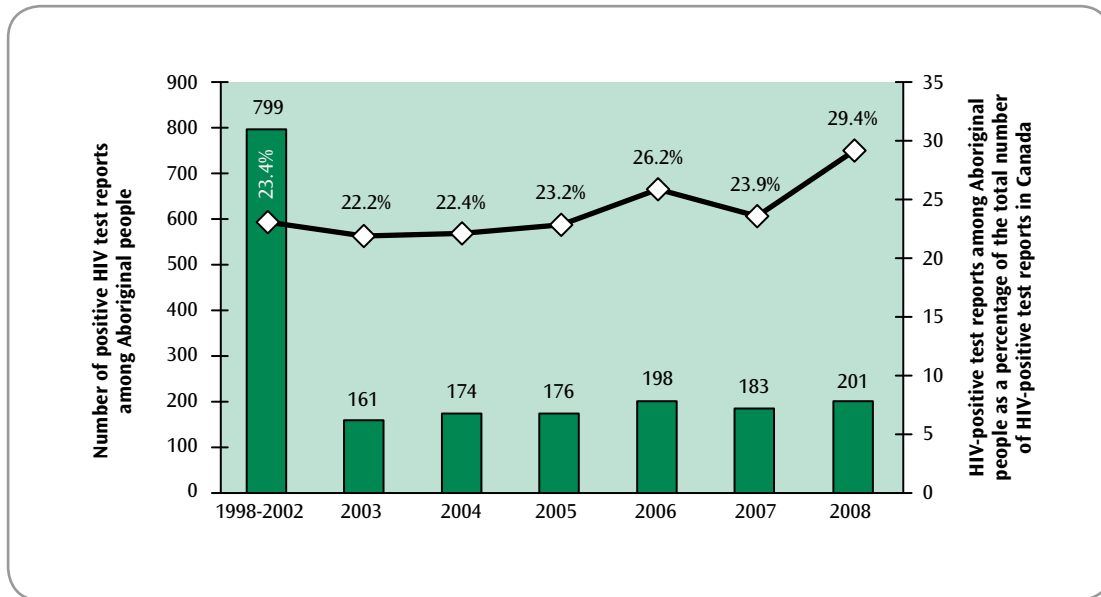
(“Track System” surveys) to capture survey information specific to key populations, and HIV/AIDS and related risk behaviours. Currently, two of these “Track” systems have been implemented and have generated results: M-Track (for gay, bisexual, two-spirit and other men who have sex with men); and I-Track (for people who inject drugs). PHAC is currently working on the development of a similar Track surveillance system for Aboriginal people (A-Track) that will monitor HIV-related risk behaviours among Aboriginal people in selected sites across Canada¹⁷. The development of A-Track was guided by a steering committee chaired by PHAC and composed of representatives from Health Canada's First Nations and Inuit Health Branch, the National Aboriginal Council on HIV/AIDS (NACHA), the Canadian Aboriginal AIDS Network (CAAN), and the National Aboriginal Health Organization (NAHO).

3.1 Overview of the Concentrated HIV/AIDS Epidemic among Aboriginal Peoples in Canada

Aboriginal peoples are overrepresented among HIV and AIDS cases in Canada. Between 1998 and 2008, Aboriginal people represented 24.0% of all new HIV-positive test reports that included ethnicity data. This is the highest percentage of any ethnic group other than those identifying as White [5]. Figure 6 shows the total number and percentage distribution of positive HIV test reports among Aboriginal people by the year of test between 1998 and 2008, where ethnicity data were reported by provinces/territories. In the year 2008, for example, there were 201 positive HIV test reports among Aboriginal people, which made up 29.4% of all the positive HIV test reports for that year for those provinces and territories that submitted information on ethnicity.

¹⁷ The surveillance system will include an optional biological component that can be used to measure/monitor HIV and hepatitis C infection prevalence. The incorporation of this component will be based on site priorities and the availability of HIV counselling/testing services for survey participants.

Figure 6: Number and percentage distribution of positive HIV test reports among Aboriginal people by year of test for those provinces/territories that submitted ethnicity data, 1998-2008 (n=1,892)



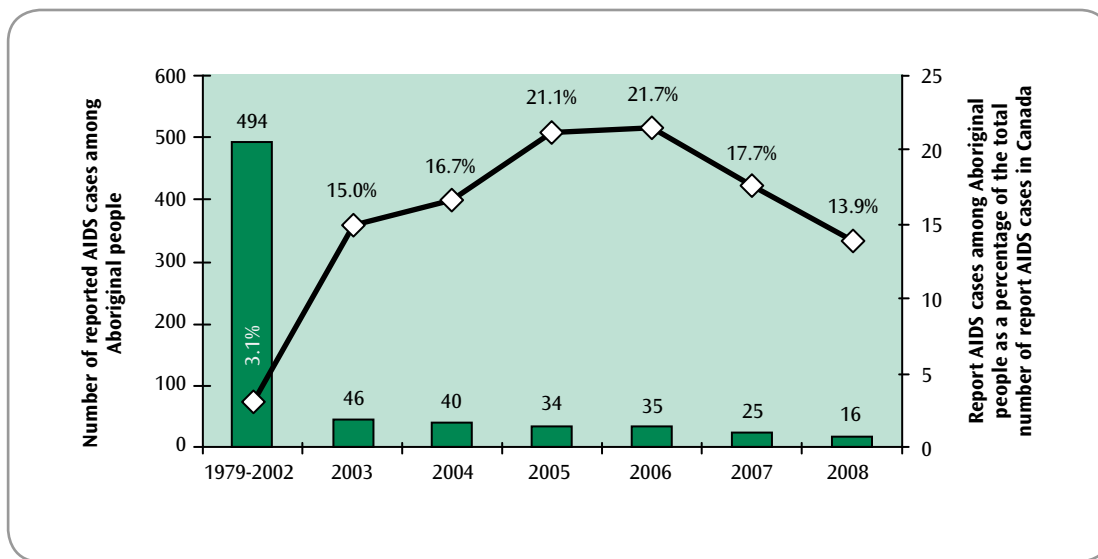
Source: [5]

Note: This table includes data from those provinces/territories that submitted information on ethnicity—British Columbia, Alberta, Saskatchewan, Manitoba, New Brunswick, Nova Scotia, PEI, Newfoundland and Labrador, Yukon Territory, Northwest Territories, and Nunavut. Ethnicity data became part of provincial/territorial submissions for HIV in 1998.

An estimated 4,300 to 6,100 Aboriginal persons were living with HIV (including AIDS) in Canada in 2008 (8.0% of all prevalent HIV infections) which represents an increase of 24% from the 2005 estimate of 3,500 to 4,900 (7.4% of all prevalent infections in 2005). An estimated 300 to 520 new HIV infections occurred in Aboriginal persons in 2008 (12.5% of all new infections), higher than the corresponding figure for 2005 of 240 to 430 (10.5% of all new infections in 2005). These proportions are much higher than the proportion of Aboriginal persons in the total Canadian population, which is 3.8% according to the 2006 census, as discussed in the previous chapter. The new infection rate among Aboriginal persons was about 3.6 times higher than among non-Aboriginal persons in 2008 [3].

Aboriginal people are also overrepresented among reported AIDS cases in Canada. Among reported AIDS cases with ethnicity information noted, there were 690 AIDS cases among Aboriginal people between 1979 and the end of 2008. Although Aboriginal people represent just 4.1% of all reported AIDS cases between 1979 and 2008, the proportion of Aboriginal persons among reported AIDS cases has increased over time (see Figure 7). During the period 1979-2002, 3.1% of all reported AIDS cases with information on ethnicity were among Aboriginal persons. However, during the period 2003-2008, the proportion was much higher, ranging from 13.9% to 21.7% in a year (year-to-year variability is due to the relatively small number of AIDS cases reported in recent years) [5].

Figure 7: Number and percentage distribution of reported AIDS cases among Aboriginal people by year of diagnosis, 1979-2008 (n=690)



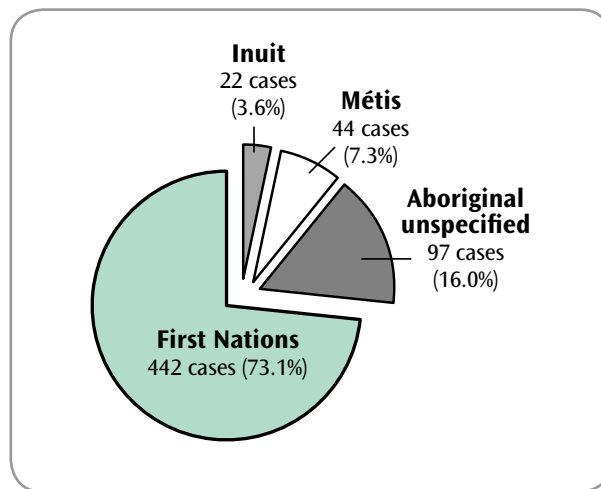
Source: [5]

Note: Due to changes in the reporting of AIDS cases in Ontario, ethnicity was not available for cases reported after the second half of 2005. These cases are categorized as “Not reported”. Percentages are based on the total number of AIDS cases minus reports for which ethnic status was not reported.

Data suggest that First Nations people are overrepresented among reported Aboriginal AIDS cases (see Figure 8). Of the 605 Aboriginal AIDS cases reported up to the end of 2006, 442 (73.1%) of these cases were among First Nations, 44 (7.3%) were among Métis and 22 (3.6%) were among Inuit [2].

In 2005, the primary HIV exposure categories among newly infected Aboriginal people were injection drug use (53%), heterosexual sex (33%), MSM (10%) and MSM/IDU (3%) [2]. For First Nations, Inuit and Métis, the four main exposure categories of reported AIDS cases between 1979 and the end of 2006 are listed in Table 1.

Figure 8: AIDS cases among Aboriginal persons reported between 1979 and December 31, 2006 (n=605)



Source: [2]

Table 1: Exposure categories of reported AIDS cases in Aboriginal groups between 1979 and December 31, 2006

Exposure category	First Nations (n=416)	Inuit (n=22)	Métis (n=43)	Aboriginal, unspecified (n=95)
n=number of cases with available information on exposure categories				
MSM	27.2%	27.3%	48.8%	37.9%
MSM/IDU	7.5%	4.5%	4.7%	6.3%
IDU	45.2%	31.8%	27.9%	24.2%
Heterosexual	17.3%	31.8%	14.0%	28.4%

Source: [2]

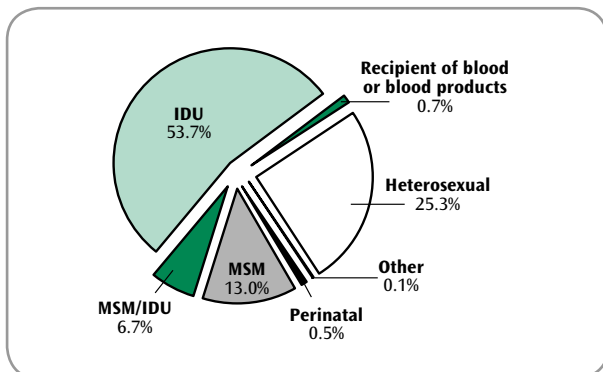
3.2 Sex

As in the non-Aboriginal population, males continue to make up the majority of Aboriginal HIV and AIDS cases. However, females constitute a larger proportion of HIV and AIDS cases among Aboriginal persons compared to non-Aboriginal females. Between 1998 and 2006, Aboriginal females made up nearly half (48.1%) of all new positive HIV test reports among Aboriginal people, whereas only 20.7% of positive HIV test reports were reported among non-Aboriginal females for the same period. Between 1979 and 2006, Aboriginal females made up 26.5% of reported AIDS cases among Aboriginal persons, while non-Aboriginal females made up 9.1% of cases among non-Aboriginal persons for that

same period. Since 2001, Aboriginal females represented above 27.0% of reported AIDS cases among Aboriginal persons every year to 2006 [2].

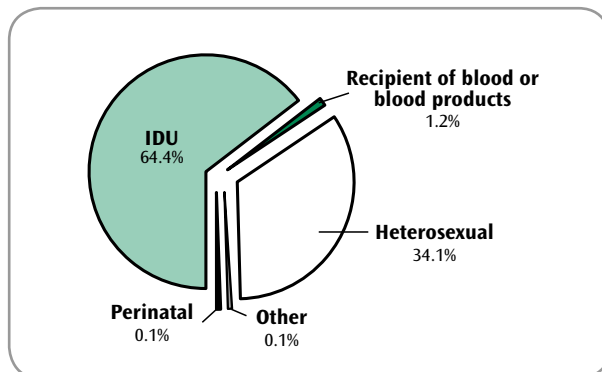
For Aboriginal males, the main exposure categories are injection drug use, heterosexual sex, MSM and MSM/IDU (see Figure 9). For Aboriginal females, the main exposure categories for HIV are injection drug use and heterosexual contact (see Figure 10) [2]. Receipt of blood or blood products and perinatal exposure to HIV accounted for very few of all HIV exposures among both Aboriginal men and women.

Figure 9: Distribution of exposure categories among positive HIV test reports of Aboriginal males (n=732), 1998 to December 31, 2006



Source: [2]

Figure 10: Distribution of exposure categories among positive HIV test reports of Aboriginal females (n=672), 1998 to December 31, 2006



Source: [2]

The proportion of females among reported Aboriginal AIDS cases are different for First Nations, Inuit and Métis. The following table describes the percentage of females and males among reported AIDS cases for Aboriginal groups.

Table 2: Sex of reported AIDS cases in Aboriginal groups in Canada between 1979 and December 31, 2006

Sex	First Nations (n=441)	Inuit (n=22)	Métis (n=44)	Aboriginal, unspecified (n=97)
n=number of cases with available information on sex				
Female	27.4%	40.9%	9.1%	26.8%
Male	72.6%	59.1%	90.9%	73.2%

Source: [2]

3.3 Perinatal Transmission

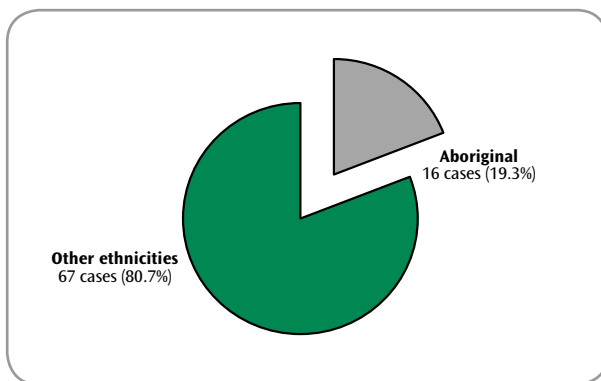
The perinatal transmission exposure category refers to the transmission of HIV from an HIV-infected mother to her child either during gestation (in utero), during delivery, or after delivery (through breast milk). It is estimated that, without any intervention, 15-30% of HIV-positive women will transmit HIV during pregnancy and delivery, and 10-20% through breast milk, to their newborn child [2]. By identifying women who are HIV positive through

prenatal HIV testing, the risk of mother-to-child transmission of HIV can be greatly reduced by using strategies, such as receiving antiretroviral therapy (ART) during pregnancy and avoiding breastfeeding [6]. However, HIV-positive pregnant women who do not seek prenatal care or who do not receive prenatal HIV testing may not be able to access care that limits the risks of transmitting HIV to the newborn. Lack of awareness of HIV serostatus and uneven HIV testing among pregnant women are major barriers to the prevention of perinatal HIV transmission [7].

The national rate of HIV infection among pregnant women ranges from about 2 to 9 in 10,000 pregnant women, although rates are not available for all provinces and territories. The HIV infection rate of perinatally HIV-exposed infants in Canada was estimated as 3% in 2006 [2]. As in the general population, perinatal transmission accounts for very few of all HIV infections among Aboriginal people. Between 1998 and the end of 2006, perinatal transmission was reported as the exposure category for just 0.5% of positive HIV test reports of Aboriginal males and 0.1% of positive HIV test reports of Aboriginal females [2]. The vast majority (94.1%) of Aboriginal infants known to have been exposed to HIV perinatally between 2001 and 2008 have been confirmed to be HIV negative [5]. Although perinatal transmission is not a major exposure category, it is an important mode of HIV transmission with serious consequences.

Available evidence suggests that Aboriginal infants are overrepresented amongst infants in Canada who acquired HIV via mother-to-child transmission [8]. Cumulative national surveillance data from 2001 to 2008 indicates that infants of Aboriginal ethnicity constituted 19.3% of the 83 cases of infants perinatally HIV-exposed and confirmed to be infected with HIV (see Figure 11) [5].

Figure 11: Cumulative number of Canadian perinatally HIV-exposed infants confirmed to be HIV positive, by ethnic status, 2001-2008 (n=83)



Source: [5]

Legend: Aboriginal includes Inuit, Métis, First Nations and Aboriginal unspecified. Other ethnicities include: White, Latin American (e.g. Mexican, Central/South American), Black (e.g. Somali, Haitian, Jamaican), Asian (e.g. Chinese, Japanese, Vietnamese, Cambodian, Indonesian, Laotian, Korean, Filipino), and Other (50 children whose ethnic status was undetermined).

3.4 Age

The Aboriginal population is younger than the non-Aboriginal population in Canada. Aboriginal persons who receive an HIV diagnosis also tend to be younger than non-Aboriginal persons. Between 1998 and the end of 2006, nearly one-third (32.4%) of Aboriginal persons diagnosed with HIV infection were under the age of 30 years, compared to 21.0% of HIV-positive tests among non-Aboriginal persons in the same age group [2].

First Nations youth aged 0 to 29 years made up 20.6% of reported AIDS cases among First Nations people. Both Inuit and Métis youth under the age of 30 years each comprised 31.8% of reported AIDS cases among Inuit and Métis. However, there were no Inuit under the age of 20 years among reported AIDS cases, while 2.3% of reported AIDS cases among Métis were in persons under the age of 20 years [2].

Between 1979 and the end of 2006, Aboriginal persons aged 50 and older made up 9.3% of reported AIDS cases among First Nations persons, 4.5% among Inuit and 2.3% among Métis.

3.5 Injection Drug Use

Positive HIV test reports from 1998 to the end of 2006 indicate that injection drug use was the main category of exposure to HIV for both Aboriginal males and females. Between 1998-2006, injection drug use accounted for 58.8% of HIV-positive test reports among Aboriginal people, and about 40% of reported AIDS cases among Aboriginal people over the years 1979 to 2006 [9].

There is a substantial difference between Aboriginal people and the general Canadian population in the injection drug use exposure category. In 2005, 53% of new HIV infections among Aboriginal people were due to injection drug use, while just 14% of new HIV infections among Canadians in general were due to injection drug use [2].

Injection drug use accounts for more HIV infections and AIDS cases among Aboriginal women than Aboriginal men. Between 1998 and the end of 2006, injection drug use was the exposure category for 53.7% of HIV-positive test reports among Aboriginal men and 64.4% of HIV-positive test reports among Aboriginal women [2]. In reported AIDS cases among Aboriginal people between November 1979 and the end of 2006, injection drug use was the exposure category for 62.3% of reported AIDS cases among Aboriginal women and 32.1% of reported AIDS cases among Aboriginal men [2].

Although Aboriginal persons have been overrepresented in Canadian studies of people who inject drugs [10-14], it is unclear if this pattern is generalizable and indicates the true picture of drug use within Aboriginal populations or if it reflects other factors. In I-Track, the national HIV surveillance system with a focus on people who inject drugs, surveys conducted in 2003-2005 in cities such as Regina, Edmonton and Winnipeg yielded significant proportions of Aboriginal persons among their sampled populations of persons who inject drugs (ranges of 70%-87%), while other cities such as Sudbury, Victoria and Toronto had fewer Aboriginal participants (ranges of 13%-27%) [14].

Studies suggest that Aboriginal people who inject drugs may be more likely to be infected with HIV than non-Aboriginal people who inject drugs [15-18]. A study of 941 people who inject drugs in Vancouver (nearly one quarter of whom were Aboriginal) found that the incidence of HIV infection among Aboriginal people was twice as high as the incidence among non-Aboriginal people [19].

Results from the I-Track surveys (2003-2005) indicate that, overall, 14.5% of participants reported injecting with used

needles in the 6 months before the survey (ranges from 8.7%-26.7%). Participants reported that they most often borrowed used needles from close friends and family or regular sex partners [2]. The study also found that nearly two-thirds (65.7%) of the sampled population of people who inject drugs had evidence of past or current hepatitis C infection. Of the study participants with laboratory samples taken and tested, 14% were positive for HIV and hepatitis C antibodies. Among those who had HIV, 91% also had evidence of current/past hepatitis C infection [20].

Injection drug use among youth is a significant concern. More than one-quarter of the participants in the I-Track surveys of people who inject drugs (25.5% of men and 29.9% of women) reported that they began to inject drugs at age 16 or younger [14]. Another study of 291 young people (aged 13-24) who inject drugs found that HIV rates among young Aboriginal people who inject drugs were higher at the beginning of the study than among non-Aboriginal participants. The study also found that young Aboriginal people who inject drugs experienced higher HIV seroconversion rates during the course of the study than non-Aboriginal young people who inject drugs [16].

Among First Nations people, less than half (45.2%) of all reported AIDS cases up to the end of 2006 were attributed to injection drug use. Among Inuit and Métis for that same time period, less than one-third of cases were attributed to injection drug use (see Table 1).

3.6 Gay, Two-Spirit, Bisexual and other Men Who Have Sex with Men

Men who have sex with men (MSM) is an epidemiological term used to describe the HIV category of men who have had sex with men. In the general Canadian population, the MSM exposure category continues to account for the greatest number of new HIV infections (45% of new infections in 2005) [2]. Among Aboriginal men, however, the MSM exposure category is the third most common after injection drug use and heterosexual contact.

Between 1998 and the end of 2006, 13.0% of HIV-positive test reports among Aboriginal men were attributed to the MSM exposure category and an additional 6.7% to the MSM/IDU¹⁸ category [2]. Among reported AIDS cases of Aboriginal men between 1979 and the end of 2006, 41.3% were attributed to the MSM exposure category and an additional 9.4% to the MSM/IDU category.

Studies of gay, two-spirit and bisexual male populations suggest that Aboriginal men who have sex with men may be at increased risk for HIV infection compared to non-Aboriginal men who have sex with men. A study of 910 MSM conducted in Vancouver found that the MSM/IDU in the study group were more likely to be Aboriginal than MSM who did not inject drugs [11]. MSM who inject drugs face higher risks for HIV infection than MSM who do not inject drugs.

Among Métis people, nearly half (48.8%) of all reported AIDS cases up to the end of 2006 were attributed to the MSM exposure category, while less than one-third of reported AIDS cases among First Nations and Inuit were attributed to the MSM exposure category (see Table 1).

3.7 Lesbian, Two-Spirit, Bisexual and other Women Who Have Sex with Women

Women who have sex with women is an epidemiological term used to describe the HIV category of women who have had sex with women. PHAC does not collect information on this exposure with the national HIV/AIDS surveillance system.

There is little information available on rates of sexually transmitted infections (STIs), including HIV infections, among women who have sex with women. Transmission of STIs among women who have sex with women is often strongly correlated with sexual contact with a male

partner [6]. Studies indicate that women who exclusively have sex with women have lower rates of STIs than women who exclusively have sex with men and women who have sex with both women and men [6]. Although sexual transmission of STIs, including HIV, have been reported among women who have sex with women exclusively with no history of a male sexual partner [6], the risk of HIV infection for a woman whose only risk factor is having sex with another woman is considered low.

3.8 People in Prison

Aboriginal people are significantly overrepresented in Canadian prison systems¹⁹. Aboriginal peoples comprise 20% of incarcerated federal offenders; Aboriginal women offenders comprise 32% of incarcerated federal women offenders, while Aboriginal men offenders comprise 20% of incarcerated men offenders [21]. In 2006, the majority (68%) of Aboriginal offenders were First Nations, 28% were Métis and 4% were Inuit [22]. The concentration of Aboriginal people in prison was highest in the prairie provinces in 2006, where 60% of people in federal prisons were Aboriginal [22].

Aboriginal people are also overrepresented among provincial prison systems. For example,

- In Nova Scotia, 5% of adult offenders are Aboriginal;
- In Ontario in 2007/08, 8% of male and 13% of female offenders were Aboriginal;
- In Manitoba, 63% of male and 74% of female adult offenders are Aboriginal;
- In Saskatchewan in 2008, 77% of adult male and 90% of adult female offenders were Aboriginal²⁰.

18 The HIV exposure category MSM/IDU refers to men who have had sex with men and have injected drugs.

19 People who receive prison sentences of 2 or more years are wards of the Correctional Service of Canada which is mandated to operate penitentiaries for the federal government. Each province and territory also has a correctional system for offenders who receive sentences of less than 2 years.

20 Data provided by representatives of provincial correctional facilities who sit on the Federal/Provincial/Territorial Heads of Corrections Working Group on Health.

Aboriginal youth are overrepresented in youth detention facilities. In Nova Scotia, 9% of those in youth facilities are Aboriginal. In Ontario in 2007/08, 10.5% of male youth and 20.1% of female youth in secure facilities were Aboriginal, while in Manitoba 81% of male and 88% of female youth in youth correctional facilities are Aboriginal²¹.

HIV prevalence is higher among persons in prison than in the general Canadian population. In 2006, 1.64% of people in federal prisons were reported to be HIV positive [23]. The rate of HIV infection in federal penitentiaries varied between regions. Data for 2004 indicate that the Pacific region reported the highest HIV prevalence rate among people in federal prisons (2.11%), followed by Quebec (2.03%), the Prairie region (1.07%), Atlantic region (1.00%) and Ontario (0.98%) [24]. Other Canadian studies have identified HIV infection prevalence rates of 0.9% to 4.7% among women in prison [25].

not known whether the number of reported HIV cases represents the actual prevalence of the disease [27].

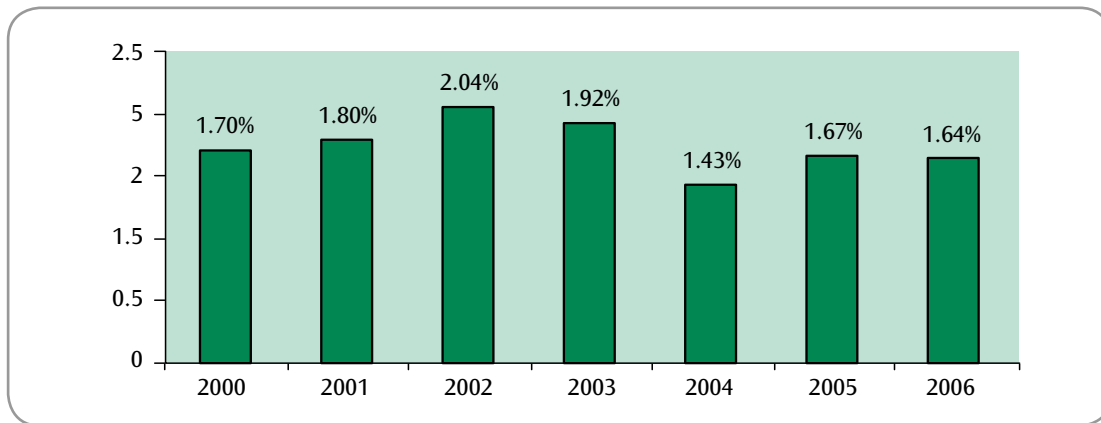
3.9 HIV Co-morbidity

Co-morbidity refers to the co-existence of two or more diseases in one person. The HIV co-morbidities that will be examined in this section are diabetes, tuberculosis, sexually transmitted infections, and hepatitis C.

Type 2 diabetes

As discussed in Chapter 2, evidence indicates that First Nations and Métis people experience higher rates of type 2 diabetes than the general Canadian population, while diabetes incidence among Inuit appears to be increasing though is still lower than the general population. Research suggests that the incidence of diabetes among HIV-positive people who are taking ART is higher than for people who

Figure 12: Prevalence of HIV at year-end in Canadian federal penitentiaries, 2000-2006



Source: [24;26]

In 2006, 52.1% of new admissions to federal prisons and 26.4% of the general population in prison had a blood test for HIV [26]. Although HIV testing is available to those new to prison and those already in prison, and is voluntary, only a proportion of people participate. Therefore, it is

are HIV-negative [28-30]. There is also research indicating that HIV and hepatitis C co-infection may also increase the risk of developing diabetes [31-33]. This suggests that Aboriginal people who are HIV-positive and taking ART may be at increased risk for diabetes. Currently, there is no research available on the correlation between HIV, hepatitis C, ART and diabetes in the Aboriginal population, nor information on the management of these diseases

²¹ Data provided by representatives of provincial correctional facilities who sit on the Federal/Provincial/Territorial Heads of Corrections Working Group on Health.

among Aboriginal people, including issues related to the challenges of managing multiple conditions and medications.

Tuberculosis

Worldwide, tuberculosis (TB) is the leading cause of death among people living with HIV [34]. Without ART, people with HIV are up to 100 times more likely to have active TB during their lifetime than people who do not have HIV. TB also causes “more rapid deterioration of the immune system of people with HIV or AIDS” [34]. At the national level in Canada, the HIV status of active TB cases, including pulmonary and non-pulmonary, is not measured [34;35]. As discussed in Chapter 2, high rates of TB in the Aboriginal population are likely mainly due to housing conditions such as overcrowding [36], which may increase exposure to TB infection. The 2006 census found that Aboriginal people were nearly four times more likely than non-Aboriginal people to live in a crowded house [37]. Because Aboriginal people are disproportionately affected by both HIV and TB infection, the population is also considered at risk for co-infections [34].

Sexually transmitted infections

Sexually transmitted infections (STIs), such as chlamydia, gonorrhoea and syphilis, increase the risk of HIV transmission and acquisition. This means that an HIV-positive person who also has an STI is more likely to transmit HIV to an uninfected sexual partner. A person who has an STI and is exposed to HIV is also more likely to acquire HIV than someone who does not have an STI [38]. Available surveillance data suggest that Aboriginal people are over-represented among cases of STIs. Although ethnicity data are not reported for the majority of STI cases, in 2006 Aboriginal people accounted for 15.0% of reported genital chlamydia cases, 27.4% of reported gonorrhoea cases and 19.7% of reported infectious syphilis cases in the four jurisdictions that regularly report ethnicity data to PHAC [39]. Higher rates of STIs contribute to increased risk for Aboriginal people in acquiring and transmitting HIV.

Hepatitis C

Hepatitis C is a chronic liver disease caused by the hepatitis C virus (HCV). Because HCV is spread through blood-to-blood contact, many of the risk factors for HCV infection are the same as for HIV infection (i.e. needle sharing among people who use injection drugs or tattooing with shared, unsterilized equipment). However, HCV transmits more easily than HIV in infected blood. As a result, people whose behaviour puts them at risk of HIV infection through blood-to-blood contact are at increased risk for HCV infection.

It is estimated that 242,500 people in Canada are infected with HCV, and almost 8,000 people were newly infected in 2007 [40]. Though some people (15-25%) appear to clear their HCV infection without treatment, the majority become chronic carriers of HCV. Long-term consequences of HCV infection can include cirrhosis and liver cancer [40]. Some studies suggest that Aboriginal people are more likely to spontaneously clear an HCV infection than non-Aboriginal people [41;42]. Nonetheless, HCV reinfection can occur after spontaneous clearance or successful completion of treatment for HCV infection [43-48].

Between 2004 and 2008, reported rates of acute HCV infection were 5.5 times higher in Aboriginal people than in non-Aboriginal people [49]. People co-infected with both HCV and HIV are more likely to transmit HCV to others [50]. Some evidence also suggests that the use of ART to treat HIV infection may contribute to more rapid progression of HCV for those infected with both viruses [51]. Studies also suggest that Aboriginal people are overrepresented among persons who are co-infected with HIV and HCV. A study of 484 HIV-infected persons in British Columbia found that study participants who were co-infected with HCV were more likely to be Aboriginal (20% versus 3%) [52]. Another study of 510 people living with HIV in Ontario found that participants who were co-infected with HCV were more likely to be Aboriginal than those who were only infected with HIV [53].

The source of the majority (70-80%) of HCV infections in Canada is injection drug use (IDU), resulting from the sharing of needles, syringes and other injection equipment [54]. IDU is also a key risk factor for HIV and HCV co-infection. In a study of HIV-positive residents in northern Alberta, HIV and HCV co-infection were found to be significantly associated with both IDU and Aboriginal ethnicity. In that study, a large proportion (40.0%) of co-infected participants were Aboriginal, while among the HIV-positive/HCV-negative cohort, just 25.7% of the participants were Aboriginal [55]. Another study of 479 youth who inject drugs in Vancouver found that more than 45% of HIV and HCV co-infected participants were Aboriginal [51].

Data from Canadian federal penitentiaries indicate that the prevalence of HCV is higher among people in federal prisons than in the general Canadian population. In 2006, 49.4% of new admissions to federal prisons and 22.6% of the general prison population were voluntarily tested for HCV. In 2006, 27.6% of people in federal prisons were known to be HCV positive [26], although the actual number of HCV-infected individuals may be higher. As Aboriginal people are overrepresented in the prison system, and among the IDU population, they may be overrepresented in federally incarcerated persons with HCV infection.

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CHAPTER 4 - Current Evidence on Factors that Impact Aboriginal Peoples' Resiliency and Vulnerability to HIV/AIDS

“It is widely acknowledged that HIV/AIDS has and will continue to have a profound impact on the health and well-being of Aboriginal (Inuit, Métis, and First Nations) people in Canada... [This] is the result of a myriad of social, economic and behavioural factors (e.g., high rates of poverty, substance use, sexually transmitted diseases, and limited access to or use of health care services) compounded by historical and cultural factors” [1].

“Resilience is far more than simple survival. It is about the ability to withstand challenges and maintain identity... The question must be asked, what cultural strengths do we have as Aboriginal people that can help us meet this challenge in a better way?” [2]

4.1 Determinants of Health

The links between the social determinants of health and the well-being of individuals and communities are well documented. “There is very little literature, however, that places HIV/AIDS in this broad population health context. Instead, the literature most often explores the association between a particular social determinant and the behaviour that places a person at risk of HIV infection” [3].

This section of the report examines the vulnerability of Aboriginal communities in Canada to HIV/AIDS. It also addresses the factors that create and promote resiliency among Aboriginal people to HIV/AIDS using a lens that will consider the following determinants of health: culture; social environments and social support networks; income, education and employment; physical environments; personal health practices and coping skills; healthy child development; biology and genetic endowment; health services; and gender. The legacy of residential schools is also examined separately as a key factor that contributes to Aboriginal peoples' vulnerability to HIV and AIDS.

4.1.1 Culture

The Canadian Aboriginal AIDS Network (CAAN) states, “Inuit, Métis and First Nations people come from diverse and vibrant cultures. Despite many challenges,... Aboriginal people still exist, speaking their original languages and practicing customs, values and beliefs that go back

thousands of years” [2]. Aboriginal peoples face health risks due to the devaluation of culture, language and traditions, and lack of access to culturally appropriate health care and services. These issues are discussed in depth in this chapter. However, culture represents a key source of strength and resilience for Aboriginal peoples in responding to health and social challenges, including HIV/AIDS.

I began practicing the HIV presentation in my language {Carrier} gradually whenever I spoke to my elders at home in my traditional territory. It started off with just talking to my community members whenever I went home for a visit {...} I would try to make them understand just how serious HIV/AIDS issues are in our communities.
- First Nations woman [4]

The integration of First Nations, Inuit and Métis cultures into HIV prevention approaches is a key element of successfully responding to HIV and AIDS in Aboriginal communities. Examples of culturally appropriate approaches to HIV prevention can include using traditional teaching methods, such as oral teachings [4] and talking circles [5], incorporating traditional values toward sexuality in prevention messages [6;7], providing prevention messages in Aboriginal languages [4;8], utilizing peer education approaches [9-11], and including Elders in HIV prevention education [12]. Approaches to HIV prevention must be tailored to the unique historical, cultural, spiritual and linguistic realities and needs of First Nations, Inuit and Métis. HIV prevention strategies that reflect a generalized

approach to these diverse Aboriginal populations are not effective [11;13]. Among Aboriginal youth, peer-to-peer sexual health and HIV prevention programs are identified as a way of ensuring that HIV prevention is culturally relevant to youth [5;13;14]. However, while using traditional approaches to address issues, such as healthy sexuality and HIV prevention, may be appropriate for some audiences, “it is important to understand that ‘cultural’ does not always mean ‘traditional’. Not all youth will respond to prevention messages that use traditional teachings or Elders as a cultural component” [13] and prevention approaches should be created based on the knowledge of participants [5].

I believe that everything that happened to me was meant to bring me to this place, and even though today I am HIV positive I can finally live with myself and love myself. For most of my life I did not love myself and did not recognize my life is a precious gift from the Creator {...} Yes, I have a virus that has no cure, but each day I choose to live with it. I am not sick with it but live with it.
- HIV-positive First Nations woman [15]

Cultural reconnection can also be a great source of strength and resilience for Aboriginal people living with HIV/AIDS (APHAs) [16;17]. A national study of 195 APHAs found that 61% of participants reported that they either used or needed traditional Aboriginal health and wellness services, such as ceremonies, healing circles and counselling from Elders [18]. Jackson et al note that “when Aboriginal people are afforded the opportunities to learn and re-connect with their culture, they generally build stronger coping mechanisms for negative life experiences associated with the disease” [18]. Peer support from other APHAs [17;19] and participation in cultural activities can improve the quality of life of APHAs, preventing depression [20] and participation in risky behaviours such as unprotected sex and drug use [16]. Two-spirit people also prefer Aboriginal AIDS service organizations (ASOs) to general ASOs due to the opportunity for increased social and cultural support, especially for those who have migrated to cities from

their home communities [21]. For these reasons, access to culturally relevant care for APHAs can increase cultural connection and improve quality of life [17].

4.1.2 Social Environments and Social Support Networks

The social environment for HIV/AIDS is characterized by discriminatory behaviours of people and governments. According to Spigelman, “prejudice, discrimination and stigma have played a central and defining role in the history of HIV/AIDS in Canada and historically, where discrimination exists, the virus is more likely to proliferate. Discrimination occurs when particular aspects of some people with HIV/AIDS, such as sexual orientation or drug use, are magnified to the exclusion of the individual humanity of each person with HIV/AIDS and the diversity of all people with HIV/AIDS” [3]. For Aboriginal people living with or at risk of HIV/AIDS, the discrimination they experience can be compounded by their HIV status, their engagement in behaviours that put them at risk of HIV/AIDS, and/or membership in other marginalized groups (e.g. women, two-spirit people, sex workers, people who inject drugs) [22].

Numerous studies, including the Royal Commission on Aboriginal Peoples, have documented the historical marginalization of Aboriginal peoples in Canada. Aboriginal and non-Aboriginal scholars have suggested that the over-representation of Aboriginal people in HIV/AIDS cases in Canada must be seen within the historical context of colonization, “including forced removal from traditional lands and spiritual connection to the lands, cultural genocide and, in particular, the history of the residential school system” [23]. Aboriginal people are more likely to connect the prevalence of HIV/AIDS among Aboriginal populations to structural inequalities and colonialism than non-Aboriginal people [24]. The experience of colonization has significantly contributed to the poor health and socio-economic conditions currently experienced by Aboriginal peoples in Canada, including their vulnerability to HIV and AIDS.

Particularly marginalized Aboriginal populations, such as vulnerable women, youth, and gay, lesbian, bisexual, transgender and two-spirit people, may face additional forms of discrimination from Canadian society in general and within Aboriginal communities. While discrimination or homophobia may compel particularly vulnerable Aboriginal populations to leave their home communities [25;26], moving to an urban centre may lead to increased feelings of social and cultural isolation resulting from factors, such as poverty, racism, sexual exploitation, language barriers, unemployment, unstable housing, and related barriers in access to services. These factors can increase a person's likelihood of engaging in behaviours that put them at risk of HIV infection [25]. For APHAs, HIV/AIDS-specific organizations may lack culturally appropriate services for Aboriginal people, while Aboriginal-specific organizations may also lack culturally specific supports that meet the unique needs of First Nations, Inuit and Métis people. For example, an Inuk living in an urban centre may not wish to use a Native Friendship Centre, however, there may be no Inuit-specific cultural organizations available in the community for support [26].

You leave your community because it's not safe in your community anymore. It's hard probably to even get the approval of others—in your own family {...} And when you're Two-Spirit you're different and unaccepted and everybody in the family wants to make sure that that fact is hidden. The only way that you can be yourself is to leave the place {...}

- Two-spirit Aboriginal person [27]

{...} {Y}ou know when my brother was actually, I guess on his death bed and told me, like it was, it took me for a loop and it was a whole grief issue there, a loss issue there, I had known people who were on meds, I mean like my brother didn't even go on meds, and everything was a secret you know, and that goes to the stereotype where he being gay as well sorta moved from the reserve to the urban centers and tried to live a double life so to speak.

- Aboriginal person [28]

Gay, lesbian, bisexual, transgender and two-spirit Aboriginal people are vulnerable to homophobic discrimination and social marginalization within both their and non-Aboriginal communities which can increase the likelihood of engaging in behaviours that put them at risk of HIV infection [29]. "Isolation, exclusion and rejection by families, communities and society have a substantial negative impact upon [gay, lesbian, bisexual and transgender] people's sense of self, their ability to come out and self-affirm, their health and their capacity to locate appropriate and relevant health and social services" [30]. A study of 86 gay, lesbian, bisexual, transgender and two-spirit First Nations, Inuit and Métis people revealed that 81% had experienced homophobic gossip and 76% had experienced verbal abuse, while a significant minority had experienced physical assault (38%) and sexual assault (21%) [31]. Nearly half (46%) of the survey's participants were HIV positive. Gay, lesbian, bisexual, transgender and two-spirit Aboriginal people may also experience discrimination from both mainstream, gay- and trans-positive HIV/AIDS health service providers, and homophobia from Aboriginal-specific health service providers [30]. Experiences of homophobia from Aboriginal service organizations can contribute to feelings of isolation from the broader Aboriginal community [25]. Homophobic discrimination can result in feelings of social and/or cultural isolation which can contribute to Aboriginal peoples' engagement in behaviours that increase their risk of HIV infection, including sex work and illegal drug use [18;25;26].

APHAs may also experience a high burden of racial discrimination which can negatively impact their health and well-being. In studies comparing Aboriginal and non-Aboriginal people living with HIV/AIDS, APHAs experience increased mortality with an HIV diagnosis [32]; reduced access to medical treatment [33-35]; increased food insecurity [36]; and increased experiences of discrimination in accessing housing [37]. Racial discrimination and homophobia may also prevent some APHAs from accessing adequate health care [27;38]. The stigma experienced by APHAs can be exacerbated if they are also members of other marginalized groups, such as

women, two-spirit, gay, lesbian, bisexual or transgender, sex workers or people who inject drugs [22].

When people found out, they reacted very badly. It wasn't safe for me to stay. It's a small community. Everyone knows everyone. I am the first person in the community to test positive.

- HIV-positive First Nations woman [39]

It's the stigma that goes with it. It's not the death part. It's how you got it. You must be homosexual. You must have used IV drugs. You must have done something wrong. That's the fear for me, the rejection because of stigma.

- HIV-positive First Nations woman [39]

In addition, many APHAs also experience stigma and discrimination from within Aboriginal communities as a result of their HIV status, and “this has implications for both the person with HIV and for the community: the person becomes highly isolated and the community is less able to prevent the spread of HIV or to provide support for those who are ill” [40]. The 2006 Aboriginal HIV/AIDS Attitudinal Survey [41] found that Aboriginal people are more likely to hold negative beliefs or attitudes about people living with HIV/AIDS (PHAs) than the overall population. One-fifth of Inuit respondents (or 20%), 14% of First Nations living on-reserve and 11% of First Nations living off-reserve reported high levels of negative feelings directed toward PHAs, compared to 7% of the overall Canadian population. Just 6% of Métis respondents reported high levels of negative feelings. However, although Aboriginal people were generally more likely to hold negative beliefs or attitudes about PHAs, they were also more likely to believe that PHAs should have the same rights and freedoms as people who are HIV negative. Twenty percent of Inuit reported discriminatory feelings toward PHAs (the same percentage as the general population), while 16% of First Nations people and 8% of Métis reported discriminatory feelings. This implies that while some Aboriginal people hold unfavourable attitudes or beliefs about PHAs, this does not necessarily result in lack of support for the rights of PHAs. Many Aboriginal people also feel fearful of PHAs [41] – about

28% of Inuit, 23% of First Nations on-reserve and 18% off-reserve, and 16% of Métis felt this way. Factors associated with the Aboriginal public's discomfort with HIV/AIDS may include the assumption of association of HIV/AIDS with behaviours, such as casual or promiscuous sex, homosexuality or illegal drug use [1].

After time passed (which took years) they [community members] would look at him as a person and not a disease.

- Inuk [42]

I think a lot of their fear is that they're going to see somebody [at a local STD clinic] that they know. And even in the urban Aboriginal population, everybody still knows everybody who knows everybody.... It's still a smaller community.

- Aboriginal woman [43]

In Aboriginal populations, the fear of stigma associated with HIV/AIDS and related risk behaviours can be a barrier to accessing health care, including testing and treatment [43]. Concerns regarding confidentiality can affect Aboriginal people's willingness to seek HIV testing and social support to effectively manage an HIV diagnosis, and may also compel APHAs to migrate to urban centres to seek care and support [1]. CAAN notes that, “in small Reserves and isolated communities, it may become extremely difficult for members to conceal HIV/AIDS status, and even to receive information about managing the condition without making [their HIV positive status] known to others” [1]. The Aboriginal HIV/AIDS Attitudinal Survey reports that nearly 40% of First Nations, Inuit and Métis respondents agreed with the statement: “If I had HIV/AIDS, I would not want other people on my reserve/ in my community to find out about it”, while more than one-third agreed with the statement: “If I had HIV/AIDS, I would seek treatment off reserve/in another community so that the people I live and work with would be less likely to find out” [41]. Confidentiality and privacy for APHAs can also be a concern in the workplace, in personal relationships, when accessing medical services, such as HIV testing and counselling, and when participating in

the HIV/AIDS movement. In addition, “when an APHA’s privacy has been compromised, the consequences go well beyond the individual. The harmful effects can be felt by an entire community” [44] and the community’s reaction may dissuade others from seeking HIV testing or treatment.

I do as much as I can almost on a monthly basis... I guess it’s not for everybody, but I have a lot of good friends in the HIV community. Generally, being on committees and working in the HIV community helps me a lot; it helps me build a better life for myself.
- HIV-positive Aboriginal man [19]

To counter the negative effects of stigma and discrimination, the literature on HIV/AIDS and health determinants identifies social support networks as being particularly important for marginalized groups at high risk of contracting HIV and for PHAs. Social involvement and belonging can enhance the quality of life and extend the life of PHAs [3] and is associated with resilience and improved health among Aboriginal people [45]. In a study of 60 Aboriginal two-spirit men in Ontario, participants preferred to access services provided by Aboriginal AIDS service organizations rather than more general AIDS service organizations not targeted to Aboriginal people, citing social support as a key reason for doing so [21]. For some Aboriginal people, participating in the HIV/AIDS advocacy community and speaking about their lives with others can also contribute to improved quality of life [19].

There are some good examples of strong individuals who have gone back to their home communities and forced, basically the issue upon their community, coming back living with HIV. [In one community] they dealt with it in a traditional way by starting off by having a naming ceremony for her and then bringing in HIV/AIDS experts to provide all the necessary background information to all of the community and then the turn around being that the community fully supported this young woman staying in the community.
- Aboriginal person [28]

4.1.3 Income, Education and Employment

“Health status improves at each step up the income and social hierarchy. High income determines living conditions, such as safe housing and ability to buy sufficient good food. The healthiest populations are those in societies which are prosperous and have an equitable distribution of wealth. Education contributes to health and prosperity by equipping people with knowledge and skills for problem solving, and helps provide a sense of control and mastery over life circumstances. It increases opportunities for job and income security, and job satisfaction. And it improves people’s ability to access and understand information to help keep them healthy. Unemployment, underemployment, stressful or unsafe work are associated with poorer health. People who have more control over their work circumstances and fewer stress-related demands of the job are healthier and often live longer than those in more stressful or riskier work and activities” [46].

People with low incomes or living in poverty are more likely than those with higher incomes to be at risk for HIV infection, to have HIV, to progress from HIV to AIDS and to succumb to AIDS more quickly [3]. Aboriginal people have lower rates of high school completion and are less likely to obtain post-secondary training than the Canadian population overall [47]. Aboriginal people also experience lower rates of employment [48] and lower incomes than the general Canadian population [49], increasing the population’s vulnerability to HIV infection [3]. The Canadian Public Health Association notes that “the social consequences and economic constraints of living in poverty include exclusion, stigma, marginalization, inability to meet living needs or to participate in the community... These consequences limit the options and choices that individuals have in attaining economic security and a decent or adequate standard of living” [50].

For APHAs, low income and poverty can negatively impact quality of life, increase social isolation, reduce access to healthy food and quality housing, and increase the rate of HIV progression to AIDS [50;51]. Studies of people living with HIV/AIDS suggest that APHAs are more likely to have an income of less than \$10,000 a year [32;34] and have lower levels of education than non-Aboriginal PHAs [32;34;52;53]. A study that examined HIV-related deaths among PHAs in British Columbia revealed that Aboriginal people and those living in a lower-income neighbourhood were more likely to have died without accessing HIV treatment [54]. Another study that examined food insecurity and hunger among PHAs in British Columbia indicated that individuals experiencing food insecurity were significantly more likely to be Aboriginal, to have less education and to live in unstable housing than those who had secure access to food [36]. Many APHAs face considerable barriers to economic security, adequate food and shelter which can reduce quality of life and increase the rate of HIV progression to AIDS.

The development of effective medications that extend the lives of PHAs has resulted in new issues related to the effects of living with chronic illness and disability on employment [55]. The probability of finding employment is reduced for PHAs, which may be attributed to changes in life expectancy and reduced health status [56]. Additional challenges associated with employment for PHAs, including Aboriginal people, include determining whether to disclose HIV status and related issues of stigma and discrimination in the workplace; coordinating treatment regimens with work responsibilities and schedules; and dealing with HIV-related symptoms in the workplace, including the need to take time off work due to illness [44;57]. PHAs may also face the additional challenge of needing to access social assistance or disability plans at various times through the course of their illness as symptoms and health status change [57]. However, because employment has a positive effect on a person's physical, mental, emotional and social health, PHAs may view continued employment or returning to the workforce after a period of illness as symbolic of their improved health and hope for the future [57]. The forthcoming

Population-Specific HIV/AIDS Status Report: People Living with HIV/AIDS will examine these issues in greater depth.

4.1.4 Physical Environments

The physical environment is an important determinant of health that can impact the well-being of people living with, and at risk of, HIV/AIDS. This section will examine the unique HIV/AIDS risks for Aboriginal people due to their physical environments, including geographic isolation, housing instability and homelessness, and incarceration.

Geographic isolation

Many Aboriginal people face unique risks and barriers to good health as a result of the geographic isolation of their homes and communities. According to the 2006 Census, nearly half (47%) of all Aboriginal people in Canada live either on reserve or in a rural area, which includes remote areas, small towns, villages and other locations with a population of less than 1,000 [58].

It's hard. We're a long way from Vancouver, a long way from Toronto. HIV is seen as a big city illness, as a southern Canada illness. People here think they're immune somehow. The isolation can increase risk. There's a lot of unprotected sex here, also, of people sharing partners. When HIV comes in it can spread pretty rapidly.

- Community outreach worker, Whitehorse, Yukon [59]

Aboriginal people who live in remote communities may believe their location, far from urban centres, provides protection against the risk of HIV infection. However, although "residence in isolated areas may have protected Aboriginal peoples from urban problems like drug use, and from HIV/AIDS when it first appeared, this is no longer the case" [18]. A study of 262 street-involved young Aboriginal women in British Columbia found that there were few differences in terms of HIV risk factors (such as participation in sex work and injection drug use) experienced by those living in Vancouver, a large urban centre, compared with those living in Prince George,

a smaller northern city [60]. A study of the migration patterns of First Nations people from on-reserve communities to urban centres also indicates that issues associated with HIV/AIDS and related risk behaviours including illegal drug use are not limited to urban centres [61].

The geographic isolation and small size of many Inuit communities, in addition to “low reported rates of Inuit with HIV, have led to misconceptions about the disease [among Inuit] – that it is a southern and/or gay men’s disease or that Inuit, by virtue of geographic isolation, are protected from HIV” [62]. High rates of sexually transmitted diseases and teen pregnancy among Inuit youth in the north indicate the potential for the spread of HIV in Inuit communities [63;64]. In addition, rates of HIV among Inuit are likely under-reported [18;65] due in part to the lack of ethnic identifiers in HIV reporting in Ontario and Quebec [65], which could affect some Inuit living in urban areas outside the four Inuit regions. Furthermore, Inuit may also be at increased risk of HIV as a result of limited knowledge of the disease. The 2006 Aboriginal HIV/AIDS Attitudinal Survey [66] found that, of the three Aboriginal groups, Inuit were most likely to see HIV as a disease that does not affect them. Inuit may also lack information about HIV/AIDS compared to other Aboriginal groups; 89% of Inuit respondents had low to moderate knowledge about HIV/AIDS compared to 59% of First Nations and Métis with low to moderate levels of knowledge.

Access to services is the biggest barrier. You go to a community that is isolated, and you don't have access. You don't have a doctor. You don't have the medications. You may not have the knowledge. You may not have the ability. At least in the city we can go to the clinic or the hospital but in the small communities, you don't even have that.

- HIV/AIDS educator working with Aboriginal people [26]

Aboriginal people who live in remote and isolated communities can also experience decreased access to health and social services, as “small and isolated communities

generally lack health care professionals, transportation, and counselling services, and confidentiality is a greater concern” [18]. The lack of services such as harm reduction programs and social supports in smaller and remote communities may also contribute to the vulnerability of residents who are at risk of, and living with, HIV/AIDS [60]. A study examining access to family physician services for PHAs in Ontario identified Aboriginal people and those living in northern Ontario as having the most need for improved access to these services [67]. As a result of the lack of specialized care in smaller communities, First Nations people on reserve and Inuit who are living with HIV/AIDS may leave their home communities to access services that would not otherwise be available to them [18;65]. However, by leaving their home communities, APHAs may also experience difficulty accessing culturally appropriate care in urban centres [18]. Métis may also encounter barriers to accessing care due to a lack of culturally appropriate HIV/AIDS care; interventions that use a generalized approach to Aboriginal populations, which do not reflect their specific needs [68]; and the geographic isolation of some Métis settlements in the western provinces [69].

Housing and homelessness

Housing instability, including shelter use and homelessness is of particular concern for Aboriginal people at risk of, and living with, HIV/AIDS. Due to low income, poverty, and lack of adequate housing in small and remote communities and reserves, many First Nations, Inuit and Métis people in Canada have limited access to safe, affordable housing and instead live in neighbourhoods with limited access to services and greater incidences of violence. These environments can increase the risk of participation in activities that put someone at risk of HIV infection.

As discussed in Chapter 2, the number of homeless people in Canada is estimated at 150,000 to 300,000, and data indicate that Aboriginal people are over-represented in this population [70]. Point-in-time homeless population counts in cities across Canada reveal that Aboriginal people made up 16% of the homeless population of Toronto in 2006, 30% in Vancouver in 2005, 38% in

Edmonton in 2006, and 62% in Winnipeg in 2005 [71]. Homelessness is also an important issue for Inuit living in the north. The Government of Nunavut estimates that 39% of Inuit in the territory are unable to access acceptable housing [72].

The majority of the homeless population is not street-entrenched and lives in unstable housing, a term which refers to a range of living arrangements including shelters, "single-room occupancy hotels (SROs), transitional living arrangements ("couch surfing") and homelessness" [73]. Those who live in unstable or inadequate housing conditions are at greater risk for HIV infection due to the increased likelihood of engaging in HIV-related risk activities, such as survival sex and injection drug use. Similarly, housing instability and homelessness can also prevent persons living with HIV/AIDS from accessing consistent, appropriate care. In a study of 100 women engaged in sex work in Vancouver, of whom more than half were Aboriginal, 86% reported that they were currently experiencing or had experienced homelessness. Housing was also identified as a current need by one-third of the study's participants [74]. Another study of women engaged in street-level sex work found that the majority of women (82%) lived in unstable housing, 22% of whom had no fixed address or were homeless [75]. More than half of the participants in this study were Aboriginal. Studies on Aboriginal people who use noninjection and injection drugs also indicate that homelessness and/or unstable housing are significant issues for this population as well [23;76;77].

APHAs have been found to have higher experiences of housing discrimination than non-Aboriginal people [52]. A study of 605 people living with HIV/AIDS in Ontario (13% of whom were Aboriginal) revealed that experiences of housing discrimination were highest among Aboriginal participants. Nearly half of the APHAs in the study had experienced some type of housing discrimination; in comparison, 33% of the Caucasian PHAs had experienced housing discrimination, the lowest level in the study [37]. APHAs are also more likely to live in unstable housing [34;52;77] and experience food insecurity [36] than non-

Aboriginal PHAs. This dimension of social exclusion increases vulnerability to HIV and compromises the health of APHAs.

Prisons

As discussed in Chapter 3, Aboriginal people are over-represented in the Canadian prison population. The prevalence of HIV is higher among people in prisons than in the general Canadian population. In federal penitentiaries in 2006, 1.64% of people in prison were reported to be HIV positive [78]. The Canadian HIV/AIDS Legal Network notes that activities that put people at risk of HIV infection, including injection drug use, tattooing and high-risk sexual activity such as having multiple sexual partners, unprotected sexual intercourse, trading sex for drugs or other items, and having a sex partner who injects drugs, "often continue or may be initiated in prison, with potential consequences for HIV and [hepatitis C] transmission, particularly where access to information and prevention measures are limited or non-existent" [79]. Aboriginal people in prison who are living with HIV/AIDS may be ostracized by the larger Aboriginal community within the prison [80], which may present additional barriers to accessing HIV testing, care and treatment, while incarcerated.

HIV prevalence among new prison admissions is associated with a lifelong history of injection drug use [81;82]. Data also show that the majority of HIV cases among incarcerated individuals are prevalent on admission or are diagnosed at admission [82]. However, sharing non-sterile injection equipment in prison places people in prison who inject drugs at risk of acquiring HIV infection. Aboriginal people in prison are more likely to have substance-use issues than non-Aboriginal people. A survey of the federal prison population in 2000 found that 92% of Aboriginal people in prison (94% of First Nations, 92% of Inuit and 91% of Métis) had some or considerable need for substance-use interventions, compared to 70% of non-Aboriginal people in prison [83]. In Correctional Service of Canada's (CSC) 1995 survey of men in federal penitentiaries, 11% reported injecting drugs while in prison [84]. A 2003 study of

women in federal prisons found that 19% had injected drugs while in prison [85]. Some research has confirmed that some people who inject drugs continue to inject in prison despite the non-availability of sterile equipment [86]. Those who continue to inject drugs in prison are at risk for transmission of bloodborne infections, including HIV and hepatitis C.

The use of non-sterile equipment also presents HIV and HCV risks for people in prison who engage in tattooing. CSC's 1995 survey of people in federal prisons indicated that 13% of men had received a tattoo in prison [84], while a study of women in federal prisons found that 27% engaged in tattooing [85]. In addition, high-risk sexual activity represents an HIV risk for people in prison. According to CSC's 1995 survey of men in prison, 6% reported having had sex with another male in prison, while 4% of all respondents reported having sex with another person in prison without using a condom [84]. Another study of women in federal prisons indicated that nearly one-quarter (24%) had engaged in unprotected sexual activity while in prison [85].

In 2006, over half (52.1%) of new admissions to federal prisons and 26.4% of the general population in prison were tested for HIV [87]. As testing for HIV and other bloodborne and sexually transmitted infections in federal, provincial and territorial prisons is voluntary and only a proportion of people participate, it is not known whether the number of reported HIV cases represents the actual prevalence of HIV in prisons [88]. For people living with HIV, access to antiretroviral therapy (ART) is an important aspect of maintaining health. On average each month, 58.7% of HIV-positive people in federal prisons receive ART. The rate of accessing ART was slightly higher for women in federal prisons (60.5%) than for men (58.5%) [87]. The forthcoming *Population-Specific HIV/AIDS Status Report: People in Prison* will examine these issues in greater depth.

4.1.5 Personal Health Practices and Coping Skills

This section discusses several personal health practices that contribute to increased risk for HIV infection among Aboriginal populations, including unprotected sex, injection drug use, participation in sex work, and decreased access to HIV testing. Cultural reconnection and spirituality are identified as significant coping skills that increase the resilience of APHAs [16;17].

Sexual behaviours

Sexual risk factors for HIV infection, including unprotected sexual intercourse, are the same as for other sexually transmitted infections (STIs). As a result, individuals who engage in behaviours that put them at risk for STIs are also at increased risk for HIV infection. The 2002/03 First Nations Regional Longitudinal Health Survey found that study participants did not always use condoms during sexual activity. Several reasons for this were cited including: having a steady sexual partner; not wanting to use a condom or one's partner not wanting to use one; a feeling of safety such that a condom was not seen as necessary; and because pregnancy was desired [89].

I had slept with some people I probably shouldn't have, and it was unprotected, so I'd get really scared, and I'd go get it tested... because the lifestyle I had was not very safe.

- Aboriginal youth [90]

High rates of STIs and teen pregnancy among Aboriginal youth suggest inconsistent condom use within this population, which also indicates increased risk for HIV infection [13]. A study of 529 homeless and street-involved youth in British Columbia found that Aboriginal youth were more than 2.5 times more likely to be HIV positive than non-Aboriginal youth. This high rate of HIV infection among Aboriginal youth was linked to unsafe sexual practices rather than drug injection [91]. Another sexual health study among urban Aboriginal youth in Ontario found that just 38% of sexually active youth always used some form of contraception, and of those who did so,

just half (52%) used condoms. Twenty-six percent reported never using contraception, while 21% reported using it rarely or sometimes. "This data indicates that more than 50% of the sexually active [urban Aboriginal] youth are at risk of... contracting an STI" [92], including HIV. Among those who reported using condoms, the majority of male and female youth said that they did so to prevent contracting HIV [92]. However, research on condom use among Aboriginal youth suggests that there is a complex relationship between condom use, holding accurate knowledge about STIs (including HIV), and personal attributes such as assertive communication skills [93]. Knowledge of HIV transmission routes and prevention methods alone is not enough to reduce rates of HIV infection [14;93].

Me and [girlfriend] used protection, but if we were drunk we usually didn't.

- male Aboriginal youth [92]

In addition, consistent condom use can also be affected by alcohol or drug use. The 2002/03 First Nations Regional Longitudinal Health Survey indicates that almost 10% of First Nations participants aged 18 to 29 years living on-reserve identified being under the influence of alcohol or drugs as the reason for not always using condoms with sexual partners [89].

Though evidence indicates that Aboriginal populations in general are overrepresented in Canadian STI statistics, Inuit communities experience particularly high STI and teen pregnancy rates. Although Inuit-specific data for chlamydia and gonorrhoea are not available, data for Nunavut indicate high rates of both STIs. In 2003, the rate of chlamydia among residents of Nunavut was over 13 times the Canadian rate, while the rate of gonorrhoea was over 8.5 times the Canadian rate [94]. Pauktuutit Inuit Women of Canada [65] notes that, as of the year 2000, teen pregnancy rates were 2.5 times the national average in the Northwest Territories and more than four times the national average in Nunavut. A survey of Nunavut youth found that while the majority of participants (67% of males and 58% of females) reported that they always used condoms with sexual partners, 10%

of males and 20% of females reported never using condoms. In addition, 20% of respondents reported having been treated for an STI [95]. HIV prevention and education issues are made difficult due to certain Inuit cultural norms. For example, many Inuit feel discomfort talking about sex "... and there are often no Inuktitut words to describe sex and sexual health. Inuit traditionally did not discuss 'adult matters' which included sex or sexual matters with their children" [96]. Steenbeek *et al* note that "until recent times, contraceptives were unknown to Inuit people. As infant mortality rates were high, it was unlikely that women would have considered limiting their fertility. Another deterrent to contraceptive use was the heavy cultural emphasis placed upon bearing children..." [97]. These factors can increase the vulnerability of Inuit to HIV infection as a result of unprotected sexual intercourse.

Injection drug use

Injection drug use represents a significant vulnerability for Aboriginal people, as it is the main HIV exposure category for both Aboriginal men and women [81]. Aboriginal people have been over-represented in Canadian studies of people who inject drugs [98-101], although it is unclear whether this indicates the true picture of drug use within Aboriginal populations or other issues. Studies suggest that Aboriginal people who inject drugs may be more likely to become HIV-positive than non-Aboriginal people [76;77;102;103]. Aboriginal people who inject drugs are also less likely to be in addiction treatment than non-Aboriginal people [104]. Youth, including Aboriginal youth, who inject drugs face particular HIV-related vulnerabilities as they are more likely than older people who inject drugs to require help injecting, and "this behaviour, especially among youth, may increase vulnerability to both needle sharing and social networks and partnerships characterized by inequities in power" [98]. Aboriginal people who inject drugs have often experienced traumatic life events, such as sexual assault, including childhood sexual abuse, removal from their biological parents as children, engagement in sex work, and attempted suicide, which impact their vulnerability to HIV infection [23;73].

In addition to the HIV risks for people who inject drugs presented by needle sharing, there are additional risks associated with the use of injection drugs, including sexual risks. Studies of people who inject drugs indicate that condom use may be inconsistent, increasing the population's vulnerability to HIV infection. A study of people who inject drugs in Regina, of which the vast majority (87.2%) were Aboriginal, noted that the majority of respondents (68% of males and 70% of females) reported never using condoms with regular sexual partners [100]. A study of 910 MSM in British Columbia found that MSM who inject drugs were more likely to be Aboriginal than MSM who did not inject drugs. The study determined that MSM who inject drugs were more likely to report engaging in unprotected anal intercourse, a significant risk factor for HIV infection, than MSM who did not inject drugs [99].

Low rates of condom use are also reported among HIV-positive Aboriginal people who inject drugs. A study of over 1,400 people who inject drugs in Vancouver found that just 13% of younger (aged 13 to 24) HIV-positive participants and 28% of HIV-positive participants over the age of 24 reported using condoms with casual sexual partners. Over half (52%) of the HIV-positive participants in the study were Aboriginal [98].

At the time I was drinking and partying a lot. I was drunk at the time and you don't think about using condoms.
- female Aboriginal youth [92]

Sexual risks are also present for Aboriginal and non-Aboriginal people who use non-injection drugs and alcohol, which can also increase HIV risk by lowering inhibitions and increasing the likelihood of participation in practices, such as unprotected sex [26]. A study of 198 women engaged in survival sex work found that HIV infection was associated with intensive, daily smoking of crack cocaine [75]. Crystal methamphetamine (also known as "crystal meth"), which has been identified as an emerging issue in some Aboriginal communities, is a stimulant that can be injected, swallowed or inhaled through snorting or smoking. Because it increases sexual

arousal while reducing inhibition and judgement, crystal meth use can result in participation in high-risk sexual behaviours which place users at greater risk of HIV infection [105]. The link between drug and alcohol use and unprotected sexual activity among Aboriginal people is also highlighted in a study of Aboriginal youth living in urban areas, which reveals that "alcohol and drugs are a major factor in the sexual practices of youth, and in the high incidences of teen pregnancy" [92]. Aboriginal youth describe "how sex typically happens when there is 'partying', and that people [are] more likely to lose their inhibitions about sex when under the influence of alcohol or drugs" [92] which can also put youth at risk for HIV infection due to unprotected sexual activity.

Sex work

Participation in sex work and/or survival sex²² can increase the risk of HIV infection as a result of a variety of factors including unprotected sexual intercourse with clients or non-client partners, injection drug use and unstable housing. Literature suggests that Aboriginal women "constitute the majority of women engaged in visible, street-level sex work" in Canada [74;75]; however, it should be noted that the current research on sex work described in this report is concentrated on the province of British Columbia and may not be generalizable to the rest of Canada. In a study of 198 women engaged in street-level sex work in Vancouver, more than half (57%) self-identified as Aboriginal (47% were First Nations women, 9% were Métis and 1% were Inuit). Aboriginal women at the beginning of the study were more likely to be HIV-positive than non-Aboriginal women (32% versus 18%) [75]. Shannon *et al* note that "...substance-using women in street-level sex work experience multiple health and drug-related harms and are subject to heavy policing and high rates of violence and exploitation" [107].

22 Although current research is inconsistent in the use of the terms 'sex work' and 'survival sex', both terms are often defined as receiving money, shelter, food or drugs for sex [60;73;106]. However, the term 'survival sex' is exclusively meant to describe individuals engaged in sex work as a means for survival, while 'sex work' can refer to a freely chosen occupation. The research on sex work that is summarized in this chapter focuses on people who face multiple health risks and vulnerabilities.

A study of 46 women involved in sex work in Vancouver that examined the links between sexual violence, illegal drug use and HIV vulnerabilities among women engaged in sex work found that more than half of the participants (57%) self-identified as Aboriginal. Study participants described "... sex work as a means of daily survival and in particular, the role of dopesickness and the need to alleviate withdrawal symptoms that severely compromised their ability to control the situation and ensure the practice of HIV prevention behaviours" [106].

Frequent drug injection practices among women involved in sex work are a particular concern for HIV-related risks. A British Columbia study of 262 young Aboriginal women who use injection and non-injection drugs found frequent injection of cocaine was associated with recent involvement in sex work. The study's authors found this fact "... particularly concerning as the intense injection patterns associated with cocaine use amongst sex workers have been shown to lead to increased risk for... HIV transmission". Thirteen percent (13%) of the Aboriginal women in the study were HIV positive, while 42% had hepatitis C [60].

Research on Aboriginal women involved in sex work report varied rates of condom use with clients. A study of over 260 young Aboriginal women (aged 14-30) who use injection and non-injection drugs found that 90% of those who were involved in sex work reported always using condoms with clients [60]. However, another study of 198 women engaged in sex work in Vancouver (more than half of whom were Aboriginal) found that although the majority of women reported condom use with clients, 42% of HIV-positive participants and 29% of HIV-negative participants did not use condoms with clients [75]. Aboriginal women may also face HIV risks from inconsistent condom use with non-client sexual partners. The study of young Aboriginal women found that 83% of those who were involved in sex work had unprotected sex with regular, non-client sexual partners and 36% had unprotected sex with a casual (non-client) sexual partner [60]. The second study of women engaged in sex work found that 38% of the participants reported that they had

unprotected sex with non-client sexual partners – this included 50% of the participants who were HIV positive and 32% of those who were HIV negative [75].

Aboriginal men who inject drugs and engage in sex work are also at risk of HIV. A study of 910 MSM in British Columbia found that most MSM who injected drugs (72%) had traded sex for money or drugs in the previous year, compared to just 14% of MSM who did not inject drugs. MSM who injected drugs were more likely to be Aboriginal than MSM who did not inject drugs [99]. The rate of involvement in sex work was higher for MSM who injected drugs than for women who injected drugs described in another study in British Columbia, where 59% of the Aboriginal participants and 54% of the non-Aboriginal participants reported sex work involvement [76].

Aboriginal persons involved in sex work also report other HIV-related vulnerabilities including abuse during childhood, abuse while engaged in sex work and homelessness. A study of 100 women engaged in sex work in Vancouver revealed high self-reported rates of childhood physical (72%) and sexual abuse (82%), as well as high rates of physical violence (90%) and sexual violence (78%) while engaged in sex work. The majority of participants (72%) met the clinical criteria for post-traumatic stress disorder. More than half (52%) of the study's participants self-identified as Aboriginal, using terms including Native (24 persons), First Nations (2 persons), Native Indian (2 persons) and Métis (10 persons). Aboriginal women were more likely than non-Aboriginal women to report childhood physical and sexual abuse, verbal, physical and sexual abuse while engaged in sex work, and homelessness. Aboriginal women were also more likely than non-Aboriginal women to self-report the need for drug or alcohol treatment [74].

HIV testing

Oh, I get tested every 3 months for everything... Chlamydia, gonorrhoea, everything. From bottom to the top, everything... so I get my HIV testing as well... I like to get tested regularly. I'm a hypochondriac, so it's, like, you know [laughs], like, to know there's nothing wrong with me.
- female Métis youth [108]

Ensuring that people undergo HIV testing is a key component of reducing the spread of HIV and ensuring access to medical care for those who are HIV positive. Barriers to HIV testing for Aboriginal people include perceived lack of anonymity, lack of pre- and post-test counselling, feelings of shame, racial discrimination from health professionals and the fear of test results, as well as broader systemic barriers, including lack of trust in health care professionals and other service providers [26;43]. Studies examining rates of HIV testing among Aboriginal people report varied rates of testing. The 2002/03 First Nations Regional Longitudinal Health Survey found that 39% of First Nations women living on-reserve and 30% of First Nations men living on-reserve had undergone an HIV test in their lifetime. Young First Nations people aged 18-29 were most likely to have had an HIV test (45%), while those aged 60 and over were least likely to have been tested for HIV (14%) [89]. Other studies suggest varied rates of HIV testing among Aboriginal populations. A study of over 500 Aboriginal youth in British Columbia who used injection or non-injection drugs found that nearly three-quarters of participants reported having had an HIV test in their lifetime; of this total, 46% were tested at least once a year [109]. However, a cross-Canada study of over 3,000 people who inject drugs found that those who self-identified as Aboriginal were less likely to have had an HIV test in the last year than non-Aboriginal people [110].

Maybe [Aboriginal people] don't want to tell [the tester] exactly why they want that [HIV] test... [The tester] is full of judgements, and I think that's a real barrier {...} Puts me on the defensive. It makes me feel like I have to justify myself.

- Aboriginal woman [43]

Aboriginal youth may face a variety of issues when deciding whether or not to undergo HIV testing. A study of 413 Aboriginal youth aged 15 to 30 years old (57% status First Nations, 7% non-status First Nations, 21% Métis, 11% Inuit) identified the experiences of youth who had received HIV testing and the reasons that Aboriginal youth sought or avoided HIV testing and/or treatment for HIV. Just over half of the respondents had received an HIV test, and 13% had tested HIV positive. Characteristics associated with having been tested for HIV included being female, gay, homosexual or two-spirit, having had an STI and injection drug use. The most common reasons identified by the youth for accessing HIV testing was having sex without a condom (44%) or pregnancy (35%). While most of the youth who had accessed HIV testing said they had been treated with care (80%) and respect (77%) by health professionals, others reported that they had been treated with hostility (19%), fear (12%) and discrimination (11%). Youth expressed the need for sensitive, compassionate and non-judgemental care when accessing HIV testing. The youth identified several reasons for not seeking HIV testing, including the perception of being at low risk for HIV infection, believing that one had not had sex with an HIV-positive person, feeling indestructible, and fear of test results. Nearly 4 in 10 (38%) of the youth who tested positive for HIV waited for a period of time before accessing medical care following diagnosis. The length of the delay ranged from several months to seven years from the time of the person's HIV diagnosis. Six of the youth who reported being HIV-positive had AIDS when they were diagnosed. Reasons cited by the youth for delaying access to care for their HIV infection included fear of knowing the stage of their illness, addictions issues which limited their ability to focus on their personal health, and not wanting to live [108;111-113].

[Aboriginal women are] scared they're going to lose their kids [to Child Welfare, and] if they've already lost their kids, they're scared there's gonna be even more restrictions placed on them [by Child Welfare]. So if they disclose any [HIV risk] behaviours or they think they may be pregnant again, they don't even want to get [HIV] tested {...}
- Aboriginal woman [43]

Aboriginal women who are pregnant may face complex issues in deciding whether or not to accept prenatal HIV testing. An Alberta study, which examined factors that affected women's acceptance of routine, universal prenatal HIV testing, found that First Nations women were approximately twice as likely to decline HIV testing as non-First Nations women, especially those who were young (aged 20-24 years) and had a male health practitioner [114]. Other barriers to HIV testing for Aboriginal women include "anticipating that the tester may ask women questions about their risk behaviours... primarily because they fear being judged" [43]. In addition, Aboriginal women may avoid testing out of fear of losing custody of their children as a result of revealing risk behaviours or being diagnosed with HIV infection [43;115].

Attitudes about HIV/AIDS

That's what it was at the beginning. You know, I thought it was like instant death. I've been there. And as I begin to read books, research it myself that I realized that I could live years and years.
- HIV-positive Aboriginal woman [116]

The 2006 Aboriginal HIV/AIDS Attitudinal Survey found that, "of a range of factors examined, the fact that HIV/AIDS is a fatal disease is seen as having the greatest impact on the level of public discomfort with this disease" [41]. Seventy-two percent of First Nations people, 68% of Métis and 64% of Inuit reported that this fact had a strong impact on their feelings of discomfort with HIV/AIDS [41]. Research shows that Aboriginal youth are more likely than non-Aboriginal youth "... to hold a fatalistic view of their future and to blame their own community for high [HIV] infection rates" [117]. Fear of HIV/AIDS and

the view of the disease as a 'death sentence' among APHAs is frequently noted in the literature [1;22;118] and is an important factor in discrimination against APHAs within Aboriginal communities.

{...} I was only 21 and I got all these years ahead of me, I'm not going to see them and I just. I was scared yeah I was scared. I didn't know how to deal with it. May as well just kill myself now 'cause I'm already dead. That's the way I felt back then.
- HIV-positive Aboriginal man [22]

When I finally did test positive, it was really hard for me... I was in a daze for quite a while. I started drinking more. I didn't want to be sober because I didn't want to think about my disease, and I didn't want to think about dying and the whole AIDS thing.
- HIV-positive First Nations female youth [112]

As a result of the highly negative perception of HIV/AIDS, it is not surprising that many APHAs have a highly negative response to their initial HIV diagnosis, and may use substances, such as alcohol or drugs to cope with their feelings [19;112]. A study of 31 APHAs (24 First Nations people, 6 Métis and 1 Inuk) examined the process of receiving and learning to live with an HIV diagnosis. The study found that APHAs experienced a series of stages that led toward acceptance of the diagnosis, including initial social isolation from friends and family, suicidal thoughts or behaviours, and increasing use of substances [19]. The period immediately after an HIV diagnosis is particularly challenging, as APHAs were "vulnerable, susceptible to other diseases, and in danger of inflicting further harm upon themselves and others under the influence of drugs and alcohol" [19]. However, while some Aboriginal people may use drugs or alcohol initially to cope with their diagnosis, many eventually adapt to living with HIV [16;19]. APHAs may also identify positive outcomes as a result of their HIV status, such as an increased focus on their own health and well-being, a reduction in, or abstention from, substance use, participation in the Aboriginal HIV/AIDS community or events,

and reconnection with traditional Aboriginal culture and spirituality [16;17;19]. For this reason, some Aboriginal people may view HIV/AIDS as “the great teacher” [119].

If there were a cure tomorrow {...} it would be very hard for me to take it because I would be afraid to lose what I learned from having AIDS... That would be hard. Because I wouldn't want to let go of what AIDS has given me.

Like compassion, spirituality.

- HIV-positive Aboriginal man [120]

Spirituality and reconnection with traditional Aboriginal cultural practices and beliefs are often cited by APHAs as ways of adapting to, and coping with, HIV/AIDS [16], including the use of traditional healing practices such as Elder counselling, healing circles, traditional medicine, and attending Aboriginal community events [17]. For this reason, access to culturally competent care can be imperative to improving the physical and mental well-being of APHAs [17]. CAAN has published a qualitative study examining the meaning of culturally competent care (termed ‘relational care’) for APHAs, which provides wise practices for health care professionals working with this population. The study notes that “relational care encompasses the physical, social, emotional and spiritual dimensions of human connection” [121] between the caregiver and care recipient. Wise practices for providing relational care include creating a common understanding of the historical context of colonialism and its impact on Aboriginal peoples, building respectful, flexible, open and honest relationships between the caregiver and recipient, and “creating a safe space for APHAs to connect and support one another, one where they are assured of confidentiality and a non-judgemental atmosphere” [121].

The importance of incorporating cultural elements into programs and interventions directed at HIV/AIDS among Aboriginal people is strongly emphasized in the literature. APHAs frequently report the use of cultural resources and services, such as participation in ceremonies (such as sweat lodges, drumming, healing/talking circles), use of traditional medicines, care offered by Elders, and the use of traditional practices such as the medicine wheel,

to improve their quality of life and physical, mental, spiritual and mental health [20;69;118;120;122-124]. It is important to note that many APHAs hold beliefs other than traditional Aboriginal spirituality, such as Christianity, which can offer support and may sometimes be combined with traditional Aboriginal spirituality in adapting to, and living with, an HIV diagnosis [19;69;119].

It's helped me a lot. I'm a very spiritual person. I'm a Roman Catholic, but—like, I pray every night, but I also believe in the old—with the sweetgrass and the sweats, I agree with it; I totally agree with all that.

- HIV-positive Aboriginal woman [19]

Although there is currently no cure for HIV, there is a focus in the literature on healing and personal wellness that has “... more to do with a sense of peace and fulfilment than seronegativity” [120]. A holistic approach to health, focusing on the mental, emotional and spiritual aspects of a person’s life, in addition to physical health, is of particular importance for APHAs [125;126] as a means of “moving away from the ‘AIDS=death’ messages of the previous decade to promote a holistic understanding of the disease” [118]. A survey of 195 APHAs indicated that a variety of treatments and care services are used in addressing HIV/AIDS, including ART, traditional services and complementary therapies. While some APHAs choose not to use any HIV drugs or therapies [69], a large number of respondents (88%) reported that they used or needed primary health care services, such as doctors, pharmacies, hospitals and health centres. Approximately 60% of the study’s respondents reported using or needing traditional care services, such as Elder counselling, traditional medicine, ceremonies and healing circles, while nearly half (45.6%) used or needed complementary or alternative therapies such as massage therapy, medical marijuana and homeopathy [1]. Healing and wellness for APHAs may be achieved by connecting or re-connecting with one’s culture, which can result in a renewed focus on coping with past negative experiences [124] and improving one’s health for the future.

Towards the end, like the last two weeks, my brothers and sisters were still really naive about the disease. Can I hug him? {...} He was brought up by our family. He was like our little brother. He was like part of us. And there was still that ignorance [about his disease]. He longed to be touched; he longed to be held, to be kissed.

- First Nations woman [127]

A lot of people just didn't know what to do with all the loss—how to navigate through the actual death first of all and—I don't want to generalize—but a lot of Aboriginal people are in poverty, so even navigating to get coffins, go to the funeral home—becomes a problem. AIDS isn't the only barrier.

- Aboriginal person [128]

Due perhaps to the focus on personal health and wellness for APHAs, there is little literature available that considers the experiences of death and dying for APHAs, their families, friends and communities. Families and friends of APHAs who have died, as well as those involved in the broader Canadian Aboriginal HIV/AIDS movement who have lost multiple friends and colleagues, are all impacted by grief and loss [28]. In addition, HIV-related stigma and discrimination impact not only those who are living with HIV/AIDS and may not be accepted by family and community, but “those who are uninfected also experience a form of marginalization within their communities. These factors exist in addition to the already complex AIDS grief responses of bereaved community members” [128]. The importance of culture and spirituality is again identified as a key aspect of coping successfully with the grief and loss associated with the deaths of APHAs [28].

4.1.6 Healthy Child Development

“Healthy isn't just something you are, it is something you learn to be, and it is really hard to be healthy when there is no way to learn to be so” [129].

As discussed in Chapters 2 and 3, the Aboriginal population is younger than the non-Aboriginal Canadian

population [130]. Aboriginal people also tend to be diagnosed with HIV younger than non-Aboriginal people [81]. HIV/AIDS and determinants of health literature make little reference to healthy child development specifically, but do refer to early childhood experiences and their impacts on a person's vulnerability to HIV.

A history of childhood abuse, including sexual abuse, and family disruption is clearly associated with risk-taking behaviours, increasing the likelihood that people will engage in behaviours that put them at risk of contracting HIV [3;26]. For many Aboriginal people, the legacy of residential schools and cultural disruption has resulted in family breakdown [23], contributing to the over-representation of Aboriginal children under the protection of child and family services [131]. The ‘Sixties Scoop’, for example, refers to the dramatic increase in the number of Aboriginal children who were removed from their families and placed in the care of child welfare agencies beginning in the 1960s [132].

Among Aboriginal youth who use injection and non-injection drugs, those who were removed from their biological parents as children and placed into foster care are more likely to be HIV positive than those who grew up living with their biological parents [133]. Aboriginal youth who have experienced childhood sexual abuse are also more likely to have had a STI (52% versus 33%) [23], which is seen as a predictor for HIV infection [13]. Other studies demonstrate that Aboriginal youth who have experienced childhood sexual abuse are more likely to be female, to have hepatitis C and to be HIV positive than Aboriginal youth who have not been sexually abused [23;73]. In a study of people in federal prisons, a significant proportion of Aboriginal people had been through or had been in contact with the child welfare system, either through foster care, group homes or adoption. Almost two-thirds (63%) of Aboriginal people in the study had been through the child welfare system, compared to 36% of non-Aboriginal people in prison [134]. Many Aboriginal people in prison had also been in custody as youth (46% of Métis, 40% of First Nations and 18% of

Inuit offenders) [83]. The HIV-related risks associated with incarceration have been discussed previously in this chapter and in Chapter 3.

My mother and father drank. They were products of residential schools. I was the youngest. I was placed in a foster home... It's tough being an Aboriginal woman. I was part of an abusive relationship. What I saw in him is what I got from my family. I was sexually abused.
- HIV-positive First Nations woman [26]

The experience of physical and sexual abuse in childhood is also associated with increased participation in sex work [23;60], which enhances the risk of HIV infection. One study of 100 women engaged in sex work in Vancouver (of whom 52% were Aboriginal) revealed that the majority had experienced sexual abuse (82%) and physical abuse (72%) in childhood. Aboriginal women were more likely to report having experienced childhood abuse than non-Aboriginal women [74].

I started going to therapy... that's been a real big help, and there, I've been learning a lot more about myself and a lot more about a lot of things that happened to me, and why I drink so much because of the loneliness... 'Cause I never realized that I was still hurt from what was going on in the past. I drank all that pain away; for 10 years, I drank.
- HIV-positive Aboriginal man [19]

Children are highly valued in Aboriginal cultures [135;136]. Historically, "Aboriginal child-rearing did not condone the use of physical violence against children" [137] and other methods were traditionally used to instruct children. In traditional Inuit culture, children were allowed more independence than most Western households, encouraging the development of a child's ability to reason and make decisions, while discipline was carried out through verbal cues and teasing to correct inappropriate behaviour [135]. Métis Elders note that, "learning how to look after children is considered an important teaching. Each child is recognized as having a unique talent or special gift... [and] it is up to each of us to help children explore and

discover their talents or gifts" [136]. APHAs who are parents identify their children as a significant source of strength and meaning in their lives [20] and describe "... their love for their children and their desire to protect them from suffering; they often worried that their illness would cause undue burdens on their offspring" [19]. The survival of traditional knowledge of child-rearing is vital to ensuring resilience and healing for Aboriginal peoples. Chief Wayne Christian of the Splat'sin/Secwepemc Nation notes, "we must do whatever it takes to create a healing environment founded on our culture and traditions... If we believe that the children are our future, then the future is now" [138].

4.1.7 Biology and Genetic Endowment

There is currently no available evidence, which demonstrates that Aboriginal people are genetically predisposed to greater risks for HIV infection. A study of Aboriginal and non-Aboriginal people living with HIV/AIDS found that while non-Aboriginal participants lived longer than Aboriginal participants after initiating highly active antiretroviral therapy (HAART), the study identified no racial differences in the participants' physical responses to the treatment [139]. It is more likely that differences in mortality among Aboriginal and non-Aboriginal people are associated with non-biological determinants of health, such as the socio-economic disparities discussed in this chapter. However, issues related to the influence of biology and genetics need to be further investigated to fully assess their influence on HIV/AIDS prevention, diagnosis, care, treatment and support services for Aboriginal populations.

4.1.8 Health Services

The health system for Aboriginal people in Canada is divided between provincial, territorial and federal governments. Provincial and territorial governments provide universal insured health services to residents in their respective jurisdictions. The federal government provides some primary health care and referral services, as well as public health promotion, on First Nations

reserves and in Inuit communities, including initiatives to increase the knowledge and awareness of HIV/AIDS among health staff, youth, women, and community leaders on-reserve. The federal government also provides non-insured health benefits (including drugs, dental, vision care and medical transportation), to Registered Indians and eligible Inuit, such as ART for HIV-positive clients. In addition, insofar as Aboriginal people generally face disproportionately high levels of various health problems, the federal government provides health promotion and related programs to Aboriginal people in general, regardless of status, as a population with special health needs.

HIV/AIDS and health determinants literature notes that the assumption that most people have considerable faith in the health care system and seek its services may not hold for many of those at risk of HIV infection or living with HIV/AIDS. Further, it states that the health system itself is partly responsible for the poor health outcomes evident in these populations, as people often face barriers to accessing the care and treatment they need [3]. These issues are particularly relevant for Aboriginal people, who face considerable challenges regarding access to health services including primary and specialized care, physician and nursing shortages in small and isolated communities, and lack of culturally appropriate care [140]. Non-Registered Indians and Métis in addition may face financial barriers in accessing HIV/AIDS services, “as many therapies are not covered by medical or drug plans” [69] and these populations are not eligible for the Non-Insured Health Benefits Program.

As discussed in the previous section on physical environments, Aboriginal people face challenges regarding access to care as a result of the geographic isolation and small size of many communities, which may lack specialized services for HIV/AIDS. As a result, many APHAs must travel away from their home communities to urban centres for treatment and care [1;38;65]. In urban settings, Aboriginal people also face barriers to accessing treatment and care for HIV/AIDS. In studies comparing Aboriginal

and non-Aboriginal people living with HIV/AIDS, APHAs have also been found to be less likely to see their doctor or HIV specialist than non-Aboriginal people [52], to have experienced physicians treating their HIV/AIDS than non-Aboriginal people living with HIV/AIDS [32;34], and to leave the hospital against medical advice [141].

I find that being an Inuk living in a city that there is a lot of isolation and no matter what your health concern may be it can be very difficult to take the first step in receiving the medical attention required. Coming from a small community one becomes accepting of the lack of services and even after moving to an urban area it takes a lot of coaxing (for lack of a better word) to see a medical professional for the most common ailments.
- Inuk [42]

Furthermore, “in small centres, the stigma of HIV and fear of disclosure can prevent Aboriginal people from being tested for HIV or accessing HIV care. In larger centres, Aboriginal people may be deterred from seeking care for reasons that, indirectly if not directly, relate to discrimination and racism” [38]. A national study of 195 APHAs in Canada indicated that a cause of dissatisfaction with primary medical care and social services for approximately one-third of participants was due to experienced and/or perceived stigma and discrimination from service providers [1]. Gay, lesbian, bisexual, transgender and two-spirit Aboriginal people can face particular challenges in accessing either Western or Aboriginal-specific health care. Aboriginal people who are gay, lesbian, bisexual, transgender or two-spirit may face racial discrimination in accessing mainstream and gay- or trans-positive health services [27;30], and may experience homophobic discrimination from Aboriginal-specific health care providers [30] which can make accessing appropriate HIV/AIDS or other health care additionally challenging.

{...} he was a dentist in [small town] he basically referred me to another doctor. He says he doesn't deal with that kind of people.
- HIV-positive Aboriginal man [22]

Lack of access to appropriate care can have devastating consequences for APHAs, who experience increased mortality with an HIV diagnosis [32] and reduced access to medical treatment than non-Aboriginal PHAs [33-35]. A study of 892 APHAs and non-Aboriginal PHAs in British Columbia found that Aboriginal people were more likely to die from AIDS without ever accessing ART compared to non-Aboriginal PHAs [34], despite the distribution of HIV medications free of charge in that province.

Although injection drug use is the main route of HIV infection among Aboriginal people, studies suggest that Aboriginal people who inject drugs are less likely to access addiction treatment than non-Aboriginal people [104;142], and are also less than half as likely to use methadone maintenance therapy²³ than non-Aboriginal people [142].

To have an Aboriginal counsellor available to me at this time is very helpful, but to have more Aboriginal-centred centres would make it easier for a lot of other people I know who are living positive.

- HIV-positive Métis person [69]

The need for culturally appropriate health care services for Aboriginal people has been identified as an urgent issue for First Nations, Inuit and Métis [69;96;140]. As discussed in the previous section on *Personal Health Practices and Coping Skills*, many APHAs use or wish to access traditional cultural services as part of a holistic approach to adapting to, and living with, HIV/AIDS. In addressing this need for traditional services, it is important to note that, as Aboriginal peoples are not culturally homogenous, “simply staffing services with Aboriginal people and providing materials that are Aboriginal specific, do not in themselves constitute culturally relevant programs... Aboriginal peoples do not all share the same cultural beliefs and history” [1]. For example, Métis PHAs and HIV/AIDS service workers note that “there are no independent Métis-specific HIV/AIDS services in Canada.

Existing services are ‘inclusive’ of Métis PHAs and in some regions are customized to meet unique needs faced by Métis PHAs... Métis cultural identity is not necessarily reflected in traditional Aboriginal care and support services” [69]. Inuit living in some urban centres may not feel comfortable using a Native Friendship Centre, however, there may be no Inuit-specific cultural organizations available for support [26]. Access to culturally appropriate care for those living with, and at risk of, HIV/AIDS must include First Nations-, Inuit- and Métis-specific services, as approaches targeted to the general Aboriginal population do not reflect the distinct needs and realities of these populations in the context of HIV/AIDS.

4.1.9 Gender

Gender roles in Aboriginal communities prior to European contact were based on principles of equality [143;144]. The Royal Commission on Aboriginal Peoples notes that “in many Aboriginal nations, women could become warriors, hunters, healers or bearers of chiefly names or titles. But their contribution to the well-being of the community was typically through responsibilities specific to women, including marriage and child rearing. The fact that women did so-called women’s work did not necessarily mean that they had minor influence or low status” [132]. Colonialism has had a significant impact on the gender roles of both Aboriginal men and women as families and communities have adapted over time from hunter-gatherer or agricultural societies to industrial and urban economies [132]. The inequality and gender discrimination currently experienced by Aboriginal women is largely a result of “the imposition of European notions of women’s social position [which] resulted in the dispossession of Aboriginal women’s rights and the devaluation of women’s social roles” [26]. This legacy has had a significant impact on the health and socio-economic well-being of both Aboriginal women and men.

23 Methadone maintenance therapy is used to block the effects of symptoms of withdrawal from opioids (such as heroin) to reduce or eliminate drug injection in an individual [142].

Aboriginal women account for nearly half (48.1%) of all new positive HIV test reports among Aboriginal people. This is dissimilar from the non-Aboriginal population, in which just 20.7% of positive HIV test reports are among women. The main source of HIV infection among Aboriginal women is injection drug use, followed by heterosexual sex [81]. Women are biologically more susceptible to HIV infection through unprotected vaginal intercourse than men who engage in unprotected vaginal intercourse. The HIV/AIDS literature notes that women's biological susceptibility to HIV infection is exacerbated by social and economic circumstances, which are influenced by gender [3]. As Csete observes, "HIV/AIDS among Aboriginal women cannot be understood without reference to poverty, gender power relations, violence and discrimination, including systemic racism in the delivery of health services" [145]. The historic root of these issues is colonialism [146].

Early childhood development

Many Aboriginal men and women face multiple factors that increase their vulnerability to HIV infection, such as childhood abuse, including physical and sexual abuse. A study of 512 Aboriginal youth in British Columbia who use illegal (non-injection and injection) drugs found that 25% of male participants and 70% of female participants had experienced non-consensual sex in their lifetimes. The experience of non-consensual sex was found to be significantly associated with HIV infection among both males and females in this study [73]. Violence is an important factor that increases Aboriginal women's vulnerability to HIV infection [115]. Both Aboriginal women and men are about three times more likely than non-Aboriginal people to experience spousal violence; 24% of Aboriginal women and 18% of Aboriginal men have experienced spousal violence, compared with 7% of non-Aboriginal women and 6% of non-Aboriginal men. Among female victims of spousal violence, more Aboriginal women (54%) report severe²⁴ forms of violence compared with non-Aboriginal women (37%) [147]. Violence

contributes to Aboriginal women's vulnerability to HIV both directly and indirectly – directly through forced or coerced sexual intercourse and indirectly by reducing women's ability to negotiate safer sexual practices such as condom use [115]. The vulnerability of Aboriginal women to violence and abuse is impacted by the historical legacy of colonization, including multigenerational abuse in residential schools, racism, and the historic portrayal of Aboriginal women and girls as sexually available to men [148;149]. The overrepresentation of Aboriginal people in prisons and the high levels of physical and sexual abuse in many Aboriginal communities are also linked to the history of colonialism and residential school attendance, where traditional values and norms about male and female roles and sexuality were undermined [150;151].

Among Aboriginal women, the experience of non-consensual sex and/or childhood sexual abuse is linked to HIV vulnerability in numerous ways, including illegal drug use and sex work, as well as "powerlessness in intimate relationships and an inability to negotiate safer sex, even during consensual sex" [146]. Aboriginal women who use illegal (non-injection and injection) drugs and engage in survival sex work are often victims of sexual assault or childhood sexual abuse [73;98]. Women who experience sexual and physical violence may feel that their lives are worthless [115], leading to an increased likelihood that they will participate in risk behaviours including unprotected sex and drug use.

Since the day they found out I was HIV positive, its like I'm really—I mean its bad enough that I've already been a drug addict and an alcoholic and everything else, and I was working the streets and that. But now that I'm positive it's like, 'You! You're really a piece of garbage. You go sit over there and don't come near us. You can't come near my children 'cause my children might get it'.

- HIV-positive Aboriginal woman [152]

24 Severe and potentially life-threatening acts of violence in this study include being beaten, choked, threatened with or having a gun or knife used against oneself, and sexual assault [147].

Sex work

As discussed in the previous section on *Personal Health Practices and Coping Skills*, Aboriginal women are overrepresented in visible, street-level sex work, and are more likely to be HIV positive than non-Aboriginal women engaged in sex work [75]. As Shannon *et al* note, drug dependence and the pervasiveness of violence in the lives of women engaged in sex work reduce the ability of women to control their HIV risk reduction behaviours, such as insisting on condom use [106]. A study of Aboriginal youth in British Columbia who use illegal drugs found that 70% of female participants reported having been given food or shelter in exchange for sex, compared to less than 10% of male study participants [73]. Colonization, racism and sexism are identified as key contributors to the experience of predation of Aboriginal women by men, both Aboriginal and non-Aboriginal [148;149;153], experiences which contribute to the vulnerability of Aboriginal women to HIV infection by reducing their ability to assert control over their HIV-related risk behaviours.

Injection drug use

The main source of HIV infection among both Aboriginal women and men is injection drug use. People who inject drugs are at increased risk of HIV infection through the practice of needle sharing. As discussed above in the section on *Personal Health Practices and Coping Skills*, studies suggest that Aboriginal people are over-represented among people who inject drugs [98-101], and may be more likely to become HIV-positive than non-Aboriginal people who inject drugs [76;77;102;103]. Women who inject drugs may face additional HIV-related risks, as they are more likely to require help injecting drugs than men [154], reducing their control over the use of clean needles. While injection drug use increases the user's risk of HIV infection due to the potential for exposure to HIV through needle sharing, use of non-injection drugs (such as smokeable crack cocaine and alcohol), can also put people at risk of HIV infection by decreasing their ability to ensure safer sexual practices [75].

Gay, lesbian, bisexual, transgender and two-spirit people

This guy brought me there. He was asking for sex. I looked around and everywhere I looked there were cockroaches. He told me that he wasn't a pedophile... that he was a really nice guy and that he would like to help me.

- Transgender female Aboriginal youth [25]

[I want] support services for Two-Spirited people who [can go] where they feel welcome.

- Two-spirit Aboriginal person living with HIV/AIDS [1]

Gay, lesbian, bisexual, transgender and two-spirit Aboriginal people also face increased risks as a result of homophobic discrimination, and cultural and/or social isolation [29;155], which increase vulnerability to HIV infection. Gay, bisexual, transgender and two-spirit Aboriginal men may experience "family and community shaming, estrangement, and abuse, caused in large part by Aboriginal community homophobia" [7], while two-spirit women living with HIV/AIDS "have to face additional stigma because they are thought to be the least at risk (because of assumptions about their sexual activities and drug use)" [29]. Transgender Aboriginal people may experience various forms of discrimination as a result of their physical appearance, including harassment, arrest, violence [155] and reduced access to health care [30;155; 156]. A study of 75 transgender people in Manitoba and northwestern Ontario (27 of whom were Aboriginal) revealed high levels of mental distress and drug use among Aboriginal participants; 67% used alcohol, 59% used prescription medications such as antidepressants and 44% used illegal drugs such as marijuana and cocaine. Fifteen percent of the Aboriginal participants were HIV-positive, compared with 4% of non-Aboriginal transgender participants; an additional 8% of Aboriginal participants did not know their HIV status [156].

Motherhood

What I find for a lot of women who I talk to is that they are so busy taking care of everybody else's needs is that their own needs are at the bottom of life. Their health, their well-being, physical, mental, emotional and spiritual, doesn't count.

- HIV-positive First Nations woman [39]

Aboriginal women face barriers to accessing HIV testing and care which include "... cultural norms about disclosure [of HIV risk factors and behaviours] to outsiders, lack of internal motivation or readiness, feeling ashamed, perceived lack of anonymity, fear of testing HIV positive, and fear of being judged by their own people" [43]. As a result, Aboriginal women receive HIV testing later in the development of their HIV infection than non-Aboriginal women [43] and therefore may not receive appropriate care and treatment. Pregnant Aboriginal women may delay or refuse prenatal HIV testing due to fear of the consequences of disclosing HIV risk factors such as illegal drug use, including the fear of losing custody of their children as a result of this disclosure [115;157]. Research suggests that HIV-positive Aboriginal women have higher birth rates than non-Aboriginal HIV-positive women [53;158; 159]. As discussed in Chapter 3, although the vast majority of Aboriginal infants who are known to have been exposed to HIV in the womb have been confirmed to be HIV negative, Aboriginal women are overrepresented among cases of mother-to-child transmission of HIV [160].

I think for a lot of women, it is scary because when you find out [you're positive], you're responsible for the whole world. You're responsible for your children. You're responsible for your man. You're responsible for your home, for everything.

- HIV-positive First Nations woman [39]

I would like to have help with childcare for appointments. Sometimes people do not qualify for daycare yet they do not have the supports in place. HIV programs should coordinate appointments better for children and parents, especially for out of town patients.

- HIV-positive Aboriginal woman [157]

Aboriginal women living with HIV/AIDS face unique challenges due to racism and gender discrimination, and are "... more likely to be single parents, living below the poverty line and responsible for the health and well-being of their children, in addition to their own, with fewer resources" [161]. As a result of their roles as mothers and caregivers, Aboriginal mothers living with HIV/AIDS face unique challenges in caring for their families while maintaining their own health and well-being. The Native Women's Association of Canada notes that "the ability to provide basic needs – shelter, food and clothing – for herself and her family, particularly if she is the sole support parent of children, is a fundamental concern for a majority of Aboriginal women in Canada" [143]. As discussed in Chapter 2, Aboriginal women have a lower median annual income than Aboriginal men [49]. Aboriginal mothers living with HIV/AIDS often put the needs of their children first, compromising their ability to care for their own health and well-being [20;162]. Aboriginal women may face barriers to accessing services or attending medical appointments due to the unavailability of child care [20;157].

{...} The judgement was that if I was an HIV positive woman making a choice to have a child, I was treated differently than if I was just an innocent victim happening to find out that I was HIV positive.

- HIV-positive First Nations woman [39]

Aboriginal women living with HIV/AIDS may face additional discrimination and social stigma if they decide to have children after they have been diagnosed with HIV [39;163]. Aboriginal mothers living with HIV/AIDS also "... bear an additional burden of concern for the psychological and social effects of discrimination against their own children should their HIV status become known" [157]. They may worry about the effects of their illness on the well-being of their children, in some cases may keep their HIV status a secret from their children [19]. However, children are also a great source of love and strength for Aboriginal mothers living with HIV/AIDS and "... often provided value and meaning to their lives and can therefore buffer the experience of HIV and depression" [20].

4.1.10 Residential Schools

The residential school system in Canada profoundly affected the lives of thousands of First Nations, Inuit and Métis people who attended the schools, as well as those of their parents, children, grandchildren, and communities. The main period of residential school operation was from the late 19th century to 1969 [151], however, the last government-run residential school did not close until 1996 [164]. The residential school system was the product of a partnership between the federal government and the Roman Catholic, Anglican, United and other churches. The schools operated in every province and territory with the exception of Prince Edward Island and New Brunswick. In 1991 it was estimated that of the 105,000 to 107,000 former residential school students who were still living, 80% were status First Nations, 6% were non-status First Nations, 9% were Métis and 5% were Inuit [164].

It is apparent that cultural loss, social marginalization, multi-generational abuse, “shame, rage, lack of trust and engagement in negative coping patterns, including substance abuse, among others” [151] contribute to the vulnerability of Aboriginal people to HIV infection [73]. As stated in the Government of Canada’s apology for its part in the residential schools system, “two primary objectives of the residential school system were to remove and isolate children from the influence of their homes, families, traditions and cultures, and to assimilate them into the dominant culture. These objectives were based on the assumption [that] Aboriginal cultures and spiritual beliefs were inferior and unequal” [165]. In addition to the mental, emotional, spiritual and cultural damage inflicted by these goals, many students also experienced physical, sexual and psychological abuses while attending residential school [164]. Poor mental health, low self-esteem and substance-use are some of the outcomes resulting from the abuse experienced by many residential school survivors [151]—factors that contribute to HIV risk.

The impact of residential schools is felt not only by many of the people who personally attended the schools, but also by their children and grandchildren [166], resulting in “... the transmission of trauma from parent to child, creating ‘intergenerational’ [residential school] Survivors, some of whom are no less marked by the Legacy of Physical and Sexual Abuse than their forebears” [137]. The multi-generational impact of cultural disruption and abuse on First Nations, Inuit and Métis people is felt today, as Chief Wayne Christian notes:

The full effect of this legislated horror [of residential schools] is reflected in our communities’ high levels of youth suicide, HIV/AIDS, addiction, social dislocation, discrimination, human-rights violations, children in care of the state and poverty. Currently, levels of drug use on and off our reserves are of grave concern to our leadership. Many young people in our communities are addicted, suffering in isolation, and still grappling with the legacy of physical and sexual trauma that has been passed down from one generation to the next [138].

A study of 543 Aboriginal youth (aged 14 to 30 years) who use non-injection and injection drugs found significant associations between participants who had at least one parent who attended residential school, involved in the child welfare system and suffered sexual abuse [23]. Participants in the study who had been sexually abused were more likely to have had a sexually transmitted infection and to participate in activities that put them at risk of HIV, including involvement in sex work and having more than 20 sexual partners in their lifetime [23]. Sixteen percent of the participants in a study of 195 APHAs had attended residential school, while nearly half of the participants (48%) had a parent, grandparent or guardian who had attended residential school. Approximately 22% of these participants felt that their health had been impacted by the residential school legacy; the most commonly reported effects were poor mental health resulting from abuse, and increased participation in risk behaviours, such as unsafe sexual practices and addictions [1].

As discussed earlier in the section on *Healthy Child Development*, the cultural prohibition against child abuse in First Nations, Inuit and Métis cultures has been significantly undermined in many communities by the multigenerational effects of residential school attendance [137]. However, “people can counteract the effects of risk and promote resilience, either in themselves or their children” [137] through strategies such as social support, sharing one’s experiences with others, and spiritual and cultural connection. For example, the utilization of “... life-sustaining Aboriginal teachings, values, songs and dance have been identified as critically important to trauma recovery because they replace the psychologically destructive shame-based beliefs that were imposed on children in residential schools” [60]. Culturally relevant strategies for First Nations, Inuit and Métis people are key to effectively addressing the legacy of residential schools that increase the vulnerability of Aboriginal populations to HIV/AIDS, and to improving the quality of life for APHAs.

4.2 References

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CHAPTER 5 - Current HIV/AIDS Research

HIV/AIDS research in Canada extends to behavioural, biomedical, clinical, economic, epidemiological, legal and psychosocial fields of studies. Aboriginal HIV/AIDS research also includes community-driven research projects that examine issues that are identified by Aboriginal communities. Flicker *et al* note that “including communities most affected by HIV in the research process makes it more likely that results will be acted upon” [1] and the research will be responsive to the needs of these communities.

For example, the Canadian Institutes of Health Research (CIHR) HIV/AIDS Research Initiative includes a Community-Based Research Program, which works in partnership with CIHR’s Institute of Aboriginal Peoples’ Health. A key feature of the Community-Based Research Program is the involvement of Aboriginal communities and organizations in the design and implementation of research projects. This approach provides study populations with control of the research they are involved in and helps to disseminate the knowledge that has been created back to that community to assist them in addressing HIV/AIDS.

In addition, there are specific ethical guidelines available for research with Aboriginal populations. For instance, the principles of ownership, control, access and possession/protection are important in the field of Aboriginal HIV/AIDS research and indicate “that Aboriginal people have relinquished the notion of ‘being researched,’ and have taken up the call to become active participants in the research process” [2]. Work continues in this area to reflect the needs of First Nations [3;4], Inuit [5;6] and Métis communities [7]. In addition, CIHR has developed *Guidelines for Health Research Involving Aboriginal People* [8] which aim to facilitate the development of mutually beneficial research partnerships, resulting in ethical and culturally relevant research. Furthermore,

the Interagency Advisory Panel on Research Ethics (comprising CIHR, the Social Sciences and Humanities Research Council or SSHRC, and the Natural Sciences and Engineering Research Council or NSERC) is revising the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* which contains a chapter regarding research involving Aboriginal peoples [9].

A review of funded research specific to HIV/AIDS and Aboriginal peoples in Canada identified 49 separate research projects. Of these projects, the majority focus on APHAs, prevention, youth, injection drug use and other substance use, issues related to HIV/AIDS service provision, and enhanced Aboriginal community research capacity. See Appendix B for a complete list of research projects captured in this analysis.

In general, the research projects identified are conducting psychosocial and behavioural research, which will allow for the description of experiences and the identification of needs, issues, challenges and solutions by community members, and, in some situations, service providers. The general areas of investigation are as follows:

- Risk-taking behaviour and contributing factors;
- Barriers to accessing services;
- Strategies to enhance design and delivery of programs and services;
- Strategies for increasing access to programs and services; and
- Community research capacity development and research dissemination strategies.

5.1 Methodology

The information in this chapter was gathered from the following organizations: Canadian Institutes of Health Research (CIHR), the Canadian Association for HIV Research (CAHR), the Canadian Foundation for AIDS Research (CANFAR), and the Social Sciences and Humanities Research Council of Canada (SSHRC). It was assumed that research completed before 2006 would have been published and identified in the academic and grey literature review completed for the previous chapters of this status report. Therefore, projects were included that were either completed in 2006 or later, or are currently under development.

5.2 Research Analysis

This section offers an overview of current research (2006 to 2008) being undertaken on issues related to HIV/AIDS among Aboriginal peoples. Using the information presented earlier in the status report, this chapter attempts to assess whether currently funded research on the HIV/AIDS epidemic among Aboriginal peoples responds to identified needs and gaps.

Information in Appendix B includes research project titles, the names of investigators, the project abstract, dates, and the source of funding. In the following analysis, research projects are identified with a number (e.g. R1) corresponding to the project description in Appendix B.

5.2.1 Geographic distribution of research projects

The majority of the research projects do not identify a primary location for the research. Of the 22 projects that identify a location for the research, 8 are focused on British Columbia [R7-R10, R20, R24, R26, R35]; 6 of these projects focus on Vancouver and/or the Downtown Eastside neighbourhood in Vancouver, two projects also examine the Aboriginal populations in Prince George

and Kamloops, and one project examines Aboriginal communities in northern British Columbia.

The remaining 14 projects focus on Aboriginal populations in Alberta [R38], Saskatchewan [R23, R29], Ontario [R2, R6, R39, R47], Quebec [R4, R19], and the north [R1, R16, R44]. In addition, 2 projects focus on research capacity development in eastern Canada, including Labrador and Nunavut [R27], and western Canada, the Yukon and Northwest Territories [R28].

5.2.2 Research projects addressing prevention, care and treatment

There are 25 research projects which address the themes of prevention, care and treatment, representing 51% of the projects.

Prevention

Given the over-representation of Aboriginal people among new HIV infections, prevention is a key element of the response to HIV/AIDS in the Aboriginal population. There are 13 current research projects which focus on prevention. Of these projects, four are focused on prevention in First Nation communities [R4, R15, R16, R47], and one examines prevention among Inuit youth [R44]. Six of the projects address prevention issues among Aboriginal youth [R4, R11, R21, R31, R44, R46]. Two projects focus on barriers to prevention in high-risk populations: Aboriginal youth who inject drugs [R31], and Aboriginal women engaged in survival sex work [R26].

Access to care

The issue of access to health care is an important and complex determinant of health that can impact on the well-being of Aboriginal people living with, and at risk of, HIV/AIDS. There are 14 projects which examine the issue of access to care for Aboriginal people in the context of HIV/AIDS [R2, R3, R5, R6, R10, R13, R15, R19, R22, R26, R32, R34, R43, R44]. Two of these projects focus on access to care issues among First Nations people and communities [R6, R15]; none of the projects focus on the unique needs of Inuit or Métis people.

Ten of the research projects focus on issues related to service provision; seven of these projects focus on service provision for APHAs [R5, R6, R10, R22, R32, R43, R48]. Two of these projects focus on cultural competency among HIV/AIDS service providers in First Nation communities. Two research projects examine the impact of gender, culture and HIV status for Aboriginal women when accessing HIV/AIDS services [R43, R48]; one of these projects focuses on two-spirit women, a significant research gap in the current literature. Another project examines factors that promote well-being among APHAs who use substances, the impact of gender, culture and HIV status for Aboriginal women when accessing services, and the service needs of Aboriginal families impacted by HIV/AIDS.

Although stigma and discrimination have a significant impact on Aboriginal people living with, and at risk for, HIV/AIDS, only two projects specifically identify stigma and discrimination in the context of HIV/AIDS service provision as a focus of the research [R12, R48]. The significant impact of stigma and discrimination on APHAs suggests that more research is needed to determine best practices for addressing this issue.

Five projects focus on barriers to accessing services and issues related to HIV treatment [R2, R10, R19, R26, R38]. Themes addressed in the research include beliefs, attitudes, risk behaviours and barriers to prevention and treatment for Aboriginal women, experiences of APHAs including access to services, treatment outcomes, mental health and well-being, and maternity experiences of mothers living with HIV/AIDS. Three of these projects examine issues of access to care for Aboriginal women: barriers to prevention and treatment for Aboriginal women who are engaged in survival sex work [R26]; access to care and treatment for Aboriginal mothers who are HIV positive [R19]; and, knowledge, attitudes and experiences of Aboriginal women in Ontario regarding HIV and HIV risks [R2]. One project examined improving access to HIV services, education, screening and treatment for Aboriginal people in northern British Columbia

[R10]. One project examines the relationship between alcohol use among APHAs and access to care [R3].

Mental health

Two projects examine mental health among APHAs [R34, R49], a subject area with little research currently available. Both projects examine depression among APHAs, and consider depression in the context of the social determinants of health, “as it relates to the ongoing stigmatization of HIV/AIDS, social isolation, lack of knowledge of HIV and its treatment, alcohol and drug use, personal biographies involving abuse and family disruption, medication side effects and poverty” [R34].

5.2.3 Research projects addressing specific populations

Thirty-six of the current research projects address issues pertaining to specific populations, including First Nations and Inuit (none of the research projects focused on Métis); Aboriginal people living with HIV/AIDS; people who inject drugs; youth; women; and, two-spirit, gay, lesbian, bisexual and transgender people. Projects that focus on specific populations represent 73% of all current research projects.

HIV/AIDS and First Nations, Inuit and Métis people

Five of the research projects focus on First Nations communities [R4, R6, R15, R16, R47]. Two of the projects focus on First Nations communities in Ontario, one on the James Bay Cree of Quebec and another on the Tlicho First Nation communities in the Northwest Territories. Three of the research projects focus on prevention programs, while the other two projects focus on the interplay between culture and successful HIV/AIDS service provision in First Nation communities.

There are two research projects that focus on Inuit and the territory of Nunavut [R1, R44]. These projects work on building HIV/AIDS research capacity in Nunavut, and examine approaches to HIV/AIDS education, screening and treatment for Inuit youth.

None of the current research projects identified focus on Métis people.

Aboriginal people living with HIV/AIDS

There are 16 projects that focus on APHAs [R5, R6, R10, R12, R14, R19, R22, R32-R34, R37-R39, R43, R48, R49]. As discussed in the previous section on *Access to Care*, 7 of these projects focus on the needs of APHAs in the context of service provision.

The absence of adequate housing and homelessness can greatly impact the physical and mental well-being of people at risk of, and living with, HIV/AIDS. As discussed in the previous chapter, research suggests that Aboriginal people are over-represented among homeless populations across the country. Two current research projects are examining this impact and strategies to address issues related to housing and homelessness for APHAs [R37, R39]. Similarly, access to healthy and nutritious food is an important determinant of health for PHAs, but there is currently little data available that examines this link among APHAs. There is currently one study underway that examines food choice and perceptions of nutritional needs among Aboriginal people in the context of HIV/AIDS [R14].

There are a number of gaps in the focus of current research. For example, although First Nations, Inuit and Métis PHAs have unique needs and challenges, there was only one project which focused on First Nations PHAs and none of the projects focused on Inuit or Métis PHAs. Although Aboriginal women make up nearly half of all new HIV-positive test reports, only 4 of the projects focused on women living with HIV/AIDS [R19, R29, R43, R48]. Two projects addressed Aboriginal mothers living with HIV/AIDS [R19, R29]. Similarly, although nearly one-third of Aboriginal persons who are diagnosed with HIV infection are under the age of 30, none of the research projects focused on the needs of young APHAs.

As discussed in Chapter 4, research suggests that APHAs experience increased mortality with an HIV diagnosis than non-Aboriginal PHAs [10], and experience reduced

access to medical treatment [11-13]. One research study in northern Alberta is exploring outcomes of HAART among PHAs and APHAs [R38].

People who inject drugs

Injection drug use is the main exposure category for HIV infection for Aboriginal men and women. There are 7 research projects that focus on injection drug use and HIV/AIDS among Aboriginal people [R7-R9, R20, R24, R31, R35], 5 of which focus on Aboriginal youth who inject drugs. As research suggests that Aboriginal people are over-represented among persons who are co-infected with HIV and hepatitis C, it is encouraging that 4 of the 5 current research projects on injection drug use among Aboriginal people are examining prevention and vulnerability for both HIV and HCV infection [R9, R20, R24, R31].

Youth

Almost one-third of Aboriginal people who receive an HIV diagnosis are under the age of 30. There are 11 research projects focused on Aboriginal youth, comprising 22% of the research projects [R4, R7-R9, R11, R13, R20, R21, R31, R44, R46]. Seven of the projects focus on HIV prevention and examine themes such as barriers to HIV prevention among high-risk youth that inject drugs and other substances, factors influencing condom use among Aboriginal youth, and arts-based approaches to HIV prevention. One project focuses on First Nations youth [R4] and another on Inuit youth [R44]; none of the projects focus on Métis youth.

Women

There are 6 research projects focused on Aboriginal women and HIV/AIDS [R2, R19, R26, R29, R43, R48]. Although Aboriginal women make up nearly half of all new HIV-positive test reports among Aboriginal people, only 12% of the current HIV/AIDS research projects focus on Aboriginal women. Two of the projects examine the impact of gender in the context of HIV/AIDS service provision for Aboriginal women [R43, R48]. Two projects address issues related to motherhood in the context of HIV/AIDS [R19, R29], and 1 explores the knowledge,

attitudes and experiences of Aboriginal women regarding HIV and HIV risks [R2]. The remaining project examines barriers to HIV prevention and treatment among Aboriginal women engaged in survival sex work [R26].

Two-spirit, gay, lesbian, bisexual and transgender people

Only 1 research project focuses on this population [R48]. This project focuses on experiences of homophobia for two-spirit women accessing HIV/AIDS services. This project will begin to fill a significant research gap, as currently there is little available research that specifically examines two-spirit women's experiences regarding HIV/AIDS. However, the lack of current research projects on two-spirit, gay, lesbian, bisexual and transgender Aboriginal people is problematic given the multi-faceted impacts of homophobia and discrimination which can contribute to increased vulnerability in this population.

5.2.4 Resilience

The majority of available research on HIV/AIDS among Aboriginal people focuses on issues that increase the population's vulnerability to HIV and AIDS. As a counter-balance to this focus on vulnerability, there are several research projects that focus on and/or utilize Aboriginal community resilience, health and well-being to address issues related to HIV/AIDS [R16, R33, R42]. These projects focus on dimensions of health and wellness of people living with HIV/AIDS, and resilience in Aboriginal communities in responding to HIV/AIDS.

5.2.5 Community research capacity, research dissemination and knowledge transfer

There are 15 projects which focus on and/or contribute to increasing research capacity and knowledge translation for Aboriginal communities [R1, R7, R12, R13, R16-18, R22, R23, R27, R28, R36, R37, R40, R41]. These projects involve community partners in research projects and capacity building workshops, and focus on areas including design and implementation of research dissemination strategies; development of best practice guidelines;

promotion of cultural competence among academic researchers; systematic data synthesis; research networking; and ethical considerations for HIV/AIDS research in Aboriginal communities. Increasing community research capacity ensures that research is relevant to the needs of Aboriginal communities, thereby increasing knowledge translation for improved policy and programs.

5.3 Areas for Further Research

Though the following list should not be considered exhaustive, a selection of areas for further study identified in this chapter and by the Status Report Working Group includes:

- The unique needs of First Nations, Inuit and Métis people in relation to HIV prevention, care, treatment and response;
- HIV risks resulting from addictions other than injection drug use among Aboriginal peoples;
- HIV risk behaviours and access to prevention, care, treatment and support services for Inuit living in urban areas;
- HIV risks associated with housing instability (e.g. couch surfing) for Aboriginal peoples, in urban and rural/isolated locations;
- Impact of multi-generational trauma on HIV risk among Aboriginal peoples;
- HIV-related vulnerabilities of elderly Aboriginal people who may not perceive themselves to be at risk for HIV/AIDS;
- HIV risks associated with sex work/survival sex among transgender Aboriginal peoples;
- HIV-related risks for incarcerated and recently released Aboriginal peoples;

- Transition to sex work and HIV risks for Aboriginal peoples moving from rural to urban areas;
- The needs of two-spirit, gay, lesbian, bisexual and transgender Aboriginal peoples living with and at risk of HIV/AIDS;
- The needs of First Nations, Inuit and Métis women living with, and at risk of, HIV/AIDS;
- Wise practices in the design of interventions to reduce stigma associated with HIV/AIDS among Aboriginal peoples;
- The impact of literacy on vulnerability to, and resilience against, HIV/AIDS;
- Health outcomes of HAART among APHAs;
- Access to Elders for APHAs and ensuring Elders have knowledge of HIV/AIDS;
- The use of traditional medicines to address and treat HIV/AIDS by Aboriginal people;
- HIV co-morbidity (e.g. diabetes, sexually transmitted infections, tuberculosis, mental and physical disability) and the challenges of managing multiple conditions for APHAs; and
- The experience of death and dying for APHAs, their families and communities.

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CHAPTER 6 - Current Response to HIV/AIDS among Aboriginal Peoples

This chapter offers an overview of the strategies, coalitions, networks and organizations dedicated to the issue of HIV/AIDS among Aboriginal populations, as well as the programmatic response.

While this chapter provides a descriptive overview of a number of components of the response to HIV/AIDS among Aboriginal populations, due to methodological and data limitations it does not provide an in-depth analysis of this response in relation to information presented earlier in this report. In addition, while Chapter 4 of this report provided an in-depth examination of the determinants of health as they impact the vulnerability and resilience of Aboriginal populations to HIV/AIDS, due to the need to limit the scope of this project, this chapter provides an overview of only those strategies, coalitions, networks, organizations and projects which were specifically focused on HIV/AIDS among Aboriginal populations. It does not broaden this scope to include an examination of the response to the various determinants of health for Aboriginal populations.

6.1 Methodology

To obtain information on projects, networks, coalitions, committees, and strategies in place between 2006 and 2008 to address HIV/AIDS among Aboriginal peoples, information-gathering templates were circulated to federal, provincial and territorial officials through the following mechanisms: the Canadian Aboriginal AIDS Network (CAAN); the Federal/Provincial/Territorial Advisory Committee on AIDS (F/P/T AIDS); PHAC's national and regional HIV/AIDS program consultants; the Federal/Provincial/Territorial Heads of Corrections Working Group on Health; and Health Canada's Regional HIV/AIDS Sub-Working Group. Responses were received from all provinces and territories. In addition, projects funded by Toronto Public Health's AIDS Prevention Community Investment Program were also included in the analysis.

It is important to note that some projects, programs or initiatives, such as health care and social services delivered by provinces and territories, may not have been captured through the information-gathering methodology used in this report. In addition, data from some of Quebec's regional health authorities, which manage local community programs, were unavailable and we hope to address this gap in the future. Organizations are invited to contact PHAC's Centre for Communicable Diseases and Infection Control (www.phac-aspc.gc.ca) if they wish to see their work reflected in future status reports.

It is also recognized that while many programs and services serve Aboriginal clients in addition to other key populations, for the purposes of this chapter, only HIV/AIDS programs that explicitly focus on the needs for First Nations, Inuit and Métis clients are included.

6.2 Overview

Canada's response to HIV/AIDS has grown in scope and in complexity since the early days of the epidemic. Governments, non-governmental and community-based organizations, researchers, health professionals and people living with, and vulnerable to, HIV/AIDS are engaged in addressing the disease and the conditions that sustain the epidemic.

Through the *Federal Initiative to Address HIV/AIDS in Canada* [1], the Government of Canada monitors the epidemic through its national surveillance system; develops policies, guidelines and programs; and supports the voluntary sector (composed of national HIV/AIDS organizations, AIDS service organizations and community-based organizations) in the response to HIV/AIDS in communities across the country.

Provinces and territories are engaged in similar activities and, under Canada's Constitution, are primarily responsible for the provision of health and social services to people

living with, or, at risk for, HIV/AIDS²⁵. Organizations operate in all provinces and territories to reduce vulnerability to, and the impact of, HIV/AIDS and to provide diagnosis, prevention, care, treatment and support services to those most at risk. These organizations are funded by government and the private sector. Depending on the jurisdiction, regional or local public health authorities play a substantial role in addressing the epidemic. In some jurisdictions, community-based organizations are working through pre-defined structures to determine priorities and allocate resources. Communities and local health authorities, governments, front-line organizations, volunteers and affected populations are uniquely positioned to determine the appropriateness of the response [2]. In addition, the private sector is involved in the response to HIV/AIDS in Canadian populations, including corporations, pharmaceutical companies, churches and others.

6.3 Population-specific Strategies

This section provides an overview of existing Aboriginal-specific strategies to address HIV/AIDS on both the national and provincial/territorial levels. Given the over-representation of Aboriginal people in Canadian HIV/AIDS statistics, the existence of such strategies provides a foundation for action and indicates that this issue is a priority for national and provincial/territorial governments and organizations.

The *Federal Initiative to Address HIV/AIDS in Canada* [1] identifies Aboriginal people as one of eight key populations at risk of, or disproportionately affected by, HIV/AIDS²⁶. The initiative was developed at the same time as *Leading Together: Canada Takes Action on HIV/AIDS (2005-2010)* [3], a stakeholder-led document which

outlines a coordinated nationwide approach to HIV/AIDS in Canada. *Leading Together* also highlights the importance of community involvement in the response, as well as the need for sensitive and culturally appropriate services for people from different ethnocultural groups, including Aboriginal peoples.

The Canadian Aboriginal AIDS Network recently renewed its *Aboriginal Strategy on HIV/AIDS in Canada for First Nations, Inuit and Métis Peoples from 2009 to 2014* [4], which builds on the previous strategy *Strengthening Ties, Strengthening Communities* released in 2003 [5]. The renewed strategy identifies the following seven strategic areas for action to address the needs of Aboriginal people living with, and affected by, HIV/AIDS: holistic care, treatment and support; Aboriginal involvement in HIV/AIDS research; broad-based harm reduction approaches; capacity building; legal, ethical and human rights issues; partnerships, collaboration and sustainability; and prevention and awareness.

Pauktuutit Inuit Women of Canada, led by the Canadian Inuit HIV/AIDS Network (CIHAN) Steering Committee, launched the *Inuit Plan of Action for HIV/AIDS in 2002* [6]. The stakeholder-led document was developed in consultation with frontline workers, national and regional organizations and Inuit living with HIV/AIDS. The plan is aimed at Regional Inuit Associations and seeks to expand Inuit awareness of HIV/AIDS, increase education and prevention activities and promote partnerships that enable Inuit living with HIV/AIDS to access appropriate care, treatment and support. In addition to HIV/AIDS, the plan identifies hepatitis C as an emerging concern in Inuit communities.

Aboriginal-specific HIV/AIDS strategies currently exist in British Columbia, Alberta, Manitoba, Ontario, and Quebec.

In British Columbia, two strategies have been identified which specifically address Aboriginal people. *The Red Road, Pathways to Wholeness: An Aboriginal Strategy for HIV/AIDS in B.C.* [7] was released in 1999 and identifies a number of issues related to HIV/AIDS among Aboriginal

25 The federal government is also responsible for the provision of health care services to designated groups such as Aboriginal people residing on-reserve, the military and people incarcerated in federal prisons.

26 The other populations identified in the Federal Initiative are: gay men and other men who have sex with men; people who inject drugs; people in prison; youth at risk; women; people from countries where HIV is endemic; and people living with HIV/AIDS.

people, including determinants of health such as housing and access to health services, as well as service coordination and issues specific to Aboriginal people in prison. Another strategy focused on the northern part of the province, *An Aboriginal Strategy on HIV/AIDS for Northern British Columbia* [8], is an outcome of a 2005 meeting of Chiefs from northern communities, government officials and service organizations. The strategy focuses on leadership and political action; education and awareness; harm reduction; treatment and services; palliative care for APHAs; and research and evaluation.

The *Alberta Aboriginal HIV/AIDS Strategy* was a shared initiative between Health Canada and Alberta Health and Wellness. The period covered was 2001-2004 [9]. The strategy identified seven areas for strategic focus in the province, including building capacity and partnerships in Aboriginal communities; enhancing care and support services; increasing culturally appropriate resources; utilizing harm reduction practices; and enhancing epidemiological information on HIV/AIDS in Alberta's Aboriginal population. The model developed is known as the "Tree of Creation". Currently, Aboriginal HIV/AIDS facilitators have developed a community-driven strategy to address bloodborne pathogens and STIs entitled *Taking the Lead*.

While Saskatchewan does not have a provincial strategy on HIV/AIDS, in 2002 the Provincial Strategy Team on HIV, Blood-borne Pathogens and Injection Drug Use released a paper with recommendations for the development of a strategy to address the spread of blood-borne pathogens among people who inject drugs and their partners in Saskatchewan. The paper, entitled *At Risk: Recommendations for a Strategy on HIV, Blood-borne Pathogens and Injection Drug Use* [10] identifies Aboriginal people as a population at risk of infection and recommends culturally appropriate strategies to meet their needs.

Manitoba's strategy *As Long as the Waters Flow: An Aboriginal Strategy on HIV/AIDS* [11] is a component of the provincial AIDS strategy and has the following four goals: prevention and education, with a focus on mothers,

children and youth; care, treatment and support for APHAs; coordination of services; and research and evaluation.

The *Ontario Aboriginal HIV/AIDS Strategy* is a provincially-mandated HIV/AIDS service organization established in 1995 to provide outreach, prevention, education and support services to off-reserve Aboriginal people living with, and affected by, HIV/AIDS. *The Strategic Plan for the Years 2006-2011* [12] focuses on activities in the following areas: promoting awareness and preventing HIV among Aboriginal people at high risk of infection; providing care, treatment and support for APHAs, including long-term and palliative care; facilitating knowledge development and exchange for people affected by HIV/AIDS; addressing the determinants of health, including those that impact the quality of life for APHAs; focusing on key populations within the Aboriginal population, including women, children, youth, two-spirit people, people in prison and those who use substances; providing leadership; and reporting on the indicators listed in the Strategic Plan.

The First Nations of Quebec and Labrador Health and Social Services Commission's HIV/AIDS strategy, entitled *The Circle of Hope: The First Nations and Inuit of Quebec HIV and AIDS Strategy* [13] was created in 2000 at the request of the chiefs of the First Nations of Quebec and Labrador. The strategy aims to address the following five areas: knowledge; prevention; care and treatment; healthy communities; and coordination. Activities under the strategy include forums, training and conferences, development of educational materials (such as games, posters and booklets) and the creation of "The Circle of Hope" newsletter, which is published twice annually.

Regarding the international response, Canadian Aboriginal HIV/AIDS organizations participated in the development of the *Toronto Charter: Indigenous Peoples' Action Plan on HIV/AIDS* [14], which was presented at the 16th International AIDS Conference in Toronto in 2006. The Toronto Charter is intended to acknowledge the commonalities amongst Indigenous populations worldwide in terms of their vulnerability to HIV/AIDS, their right to control their

health, and their participation in the development of policies and programs that address HIV/AIDS.

6.4 Population-specific Networks, Coalitions and Advisory Bodies

This section provides an overview of existing national and provincial/territorial Aboriginal-specific networks, coalitions and advisory bodies that undertake a variety of activities, such as providing advice, advocacy, and undertaking research. Some of the networks and coalitions listed below also deliver programs. The existence of these organizations indicates the importance of working in partnership across community, organizational, government sectors to address HIV/AIDS among Aboriginal populations.

For the purposes of this report, a network or coalition is defined as an organization that has member organizations and/or individual members and was formed to represent the interests, goals or objectives of these member organizations at provincial, national or international fora. An advisory body is defined as an organization that provides advice on the development and/or implementation of strategies, policies and programs. Please see Appendix C for a list of these networks, coalitions and advisory bodies.

National networks, coalitions and advisory bodies

The National Aboriginal Council on HIV/AIDS (NACHA) provides strategic policy advice to the Public Health Agency of Canada and Health Canada on HIV/AIDS-related issues pertaining to the specific needs of First Nations, Inuit and Métis peoples under the *Federal Initiative to Address HIV/AIDS in Canada* [15].

The Canadian Aboriginal AIDS Network (CAAN) provides leadership, support and advocacy for Aboriginal people across Canada living with, and affected by, HIV/AIDS. Activities include publication of resources and fact sheets on HIV/AIDS issues for Aboriginal people, awareness

campaigns, and original research on the needs and realities of APHAs [16].

The Canadian Inuit HIV/AIDS Network (CIHAN) [17] was formed by Pauktuutit Inuit Women of Canada in 1999 to advise on the implementation of its HIV/AIDS programming. CIHAN raises awareness of HIV/AIDS among Inuit and provides an Inuit perspective on initiatives to address the disease. It is led by an advisory committee of representatives from Inuit regions, Inuit youth, Inuit living with HIV/AIDS and an Elder.

Provincial networks, coalitions and advisory bodies

Three networks and coalitions were identified in British Columbia. The Red Road HIV/AIDS Network [18] was created as part of the implementation of the province's strategy to address HIV/AIDS among the Aboriginal population, a document entitled *Red Road: Pathways to Wholeness, An Aboriginal Strategy for HIV and AIDS in B.C.* (described in the previous section). The Red Road HIV/AIDS Network provides skills building, presentations and resource materials for its membership, which includes APHAs, Aboriginal and non-Aboriginal ASOs, and Aboriginal community organizations. The network also publishes Bloodlines Magazine, which features the stories and experiences of APHAs. Renewing Our Response [19] is a coalition of ASOs in British Columbia that is reviewing the province's strategy to address HIV/AIDS among the Aboriginal population. The Northern Aboriginal HIV/AIDS Task Force was created to bring together Aboriginal leadership, youth and government organizations to develop a strategic approach to addressing HIV/AIDS in northern British Columbia.

All Nations Hope AIDS Network [20] is located in Saskatchewan. It provides education, prevention and support to Aboriginal people through workshops, training, networking, outreach services, and publishes a bi-monthly newsletter. The Network is involved in regional, provincial and national initiatives to voice issues and concerns pertaining to HIV/AIDS and Aboriginal people.

The Manitoba First Nations AIDS Working Group [21] aims to develop and enhance HIV/AIDS prevention by linking health programs, education, care, treatment and support for First Nations people in the province. Membership includes provincial tribal councils, health organizations, community representatives, regional representation from Health Canada–First Nations and Inuit Health Branch, APHAs and Elders. The Working Group meets quarterly to allow for skills building, networking and advocacy opportunities with other HIV/AIDS and First Nations health organizations.

The Ontario First Nations HIV/AIDS Education Circle is a network of First Nations HIV/AIDS educators and coordinators in Ontario created as a forum to share information, resources and personal support.

In Quebec, the First Nations and Inuit of Quebec Permanent Committee on HIV and AIDS [13] was created to develop and advise on the implementation of *The Circle of Hope: The First Nations and Inuit of Quebec HIV and AIDS Strategy* [13], developed by the First Nations of Quebec and Labrador Health and Social Services Commission. The Committee includes the program officers addressing HIV/AIDS in urban and First Nations communities, a person living with HIV/AIDS, Inuit, First Nations and Elder representation, a nurse, representatives from provincial NGOs, and representatives from provincial and federal departments and agencies including PHAC.

In the Atlantic provinces, Healing Our Nations Atlantic First Nations AIDS Network [22] provides support for APHAs and delivers workshops to teach Aboriginal communities about HIV/AIDS and support prevention efforts. The Atlantic Aboriginal HIV/AIDS Circle is a forum for stakeholders and staff working in HIV/AIDS in the Aboriginal community to share information, resources, skills, capacity building and personal support [23].

The Northwest Territories HIV and Hepatitis C Support Network [24] was formed in 2008 to ensure that Aboriginal and non-Aboriginal people are aware of, and have access

to, programs and services to support those living with chronic infectious diseases, including HIV/AIDS and other STIs, hepatitis C and tuberculosis. The network aims to develop programs to reduce the rate of infectious diseases; support people living with chronic infectious diseases including HIV/AIDS; and work to reduce discrimination associated with infectious diseases.

Regarding the international response, Canadian Aboriginal people working in the HIV/AIDS field participated in the Indigenous satellite sessions held at the AIDS 2006 and AIDS 2008 conferences in Toronto and Mexico City, respectively. A third Indigenous satellite session is planned as part of the AIDS 2010 conference in Vienna.

6.5 Program Analysis

This section describes the distribution of programs and projects addressing HIV/AIDS among Aboriginal populations across Canada. These projects were identified through the data-gathering process outlined in Section 6.1. Programs and projects are listed under the following headings: the response to HIV/AIDS among Aboriginal populations residing off-reserve; the response to HIV/AIDS among First Nations populations living on-reserve; and the response to HIV/AIDS among Aboriginal people in prison. This section also analyses to what extent the current response reflects the realities and needs of the population based on available evidence.

6.5.1 Response to HIV/AIDS among First Nations off-reserve, Inuit and Métis populations

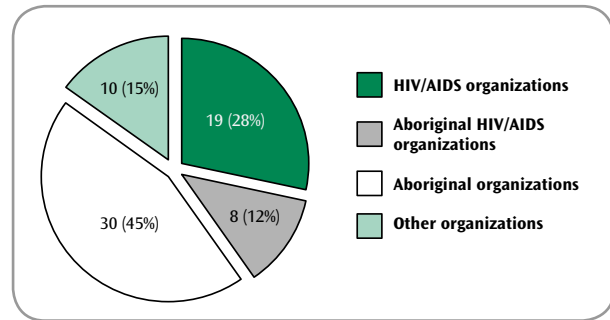
Various organizations are involved in the HIV/AIDS response among Aboriginal populations living off-reserve, including Aboriginal and non-Aboriginal HIV/AIDS organizations, friendship centres and other Aboriginal organizations not specifically focused on HIV/AIDS, public health units, and government departments. These organizations undertake a variety of activities to address HIV/AIDS among their client populations,

including providing HIV/AIDS information and resources to clients; presenting workshops and providing training; offering outreach to high-risk populations; organizing support groups for PHAs; providing referrals to health and social services; distributing condoms; exchanging or distributing needles; and holding community awareness-raising events such as health fairs or AIDS Walks.

PHAC provides support for community-based organizations to deliver local prevention, care and support services to Aboriginal people living with HIV/AIDS and those vulnerable to HIV infection through its community programming, including the Non-Reserve First Nations, Inuit and Métis Communities HIV/AIDS Project Fund (which focuses on reducing HIV incidence among Aboriginal populations), the Specific Populations HIV/AIDS initiatives Fund and the AIDS Community Action Program. A number of the projects identified in this section are funded through these programs.

The main focus of the data-gathering process was to identify time-limited projects (active between 2006 and 2008) that address HIV/AIDS among Aboriginal populations. Projects and the responsible organizations are listed in Appendix C. It is important to note that the analysis does not include those HIV/AIDS services that have been integrated into regular provincial or territorial health care and social services delivery activities. Figure 13 shows that 84 time-limited projects led by 67 organizations were identified in the data-gathering process. These organizations are grouped into four categories: HIV/AIDS organizations; Aboriginal-specific HIV/AIDS organizations; Aboriginal organizations which are not HIV/AIDS-specific; and other types of organizations, such as public health units, government departments, and NGOs with mandates outside of HIV/AIDS.

Figure 13: Project breakdown according to organization categories (n=67)



Geographic distribution of projects

Of the 84 time-limited projects reviewed, Quebec had 24% of the projects [A54-A73], while British Columbia had 19% [A4-A19], Alberta 16% [A20-A33], Ontario 12% [A44-A53], Manitoba 8% [A37-A43], and Saskatchewan 5%²⁷ [A34-A37]. The Northern territories [A79-A84] had 7% of the projects and the Atlantic provinces [A74-A78] had 6%. Projects that were national in scope made up 4% of the projects [A1-A3].

Populations within the Aboriginal population

Youth

Of the 84 projects reviewed, 24 (29%) projects identified youth as a target audience. Projects targeting youth were identified in every region in Canada. Given that almost one-third of Aboriginal people diagnosed with HIV infection are under 30 years of age, projects targeting this population are an important part of the response.

Nearly all of the projects (21 out of 24) identified information-sharing activities, such as presentations and workshops, as a key delivery tool. For example, some projects targeted youth in the school setting for information-sharing activities. *Chî Kayeh* [A64] a pilot sexual

²⁷ Note: One project [*Play It Safer Phase II Project*, project A37] spans Manitoba and Saskatchewan. This project is listed in both provinces in Appendix C.

health education program for high school students implemented in two James Bay Cree communities in Quebec, incorporates Cree values and traditions into lessons on healthy and unhealthy sexuality, teen pregnancy, and assertiveness skills.

A few projects specifically targeted high-risk Aboriginal youth. For example, the project *Na-Me-Res/Tumivut Aboriginal Homeless Youth HIV/AIDS Prevention Initiative: Towards an Urban Aboriginal Approach* [A51] implemented by the Native Men's Residence in Toronto, increases awareness of HIV/AIDS and promotes safer sex among street-involved Aboriginal youth in Toronto.

Other projects target high-risk youth as part of other high-risk populations, including people who inject drugs and high-risk women. For example, the project *Circle of Change: Reducing Harm* [A35] implemented by the Battlefords Family Health Centre in Saskatchewan included HIV/AIDS educational sessions for youth at a local correctional centre as part of the program. *The HIV/AIDS Labrador Project* [A77], which partners with the Newfoundland and Labrador AIDS Committee and Healing Our Nations Atlantic First Nations AIDS Network, delivers education and awareness, prevention, resources for referral to appropriate agencies and services, and support to Aboriginal populations at risk of HIV/AIDS, including high-risk youth.

Women

Aboriginal women represent nearly half of all new HIV infections among Aboriginal people. Of the 84 projects reviewed, 13 (15%) identified Aboriginal women as a target population [projects A1, A14-15, A35, A38-A39, A49, A52, A65, A69, A71, A74, A77]. Five of these projects identified facilitating access to care as a key part of the project, while another 4 projects focused on capacity building for Aboriginal women living with, and at risk of, HIV/AIDS.

Three projects focused on women living with HIV/AIDS, located in British Columbia and Alberta, without focusing exclusively on Aboriginal women. The project *Support Program for HIV Positive Women* [A14], implemented by Positive Women's Network in Vancouver, provides support to women living with HIV/AIDS who face multiple barriers (such as addictions, poverty, and racism) to accessing HIV/AIDS care, treatment and support, including Aboriginal women.

Two projects were identified that focus on female sex workers. The *Aboriginal Sex Worker Outreach and Education Project* [A49], implemented by MAGGIE's The Toronto Prostitute Community Service Project, provides culturally appropriate outreach, support and education to Aboriginal women living with, or at risk of, HIV/AIDS who are sex workers. The Quebec project *CatWoman Mauricie* [A71] implemented by *Sidaction Trois-Rivières*, provides HIV/AIDS information and encourages the adoption of safer sex behaviours among female sex workers who work in strip clubs and massage parlours as well as street-based sex work.

Two projects in Quebec focus on harm reduction and information-sharing activities for Aboriginal women who are escaping violence or abuse. The Native Women's Shelter of Montreal's *Harm Reduction* project [A69] seeks to improve Aboriginal women's access to HIV/AIDS diagnosis, care and treatment through workshops, a support group, cultural ceremonies, creation of a booklet on available resources for women in Montreal and by accompanying women to medical appointments. The project by Quebec Native Women entitled *Les femmes autochtones victimes de violence et Leur santé sexuelle... Vers une prise en charge [Aboriginal women, violence and sexual health... toward empowerment]* [A65] provides sexual health workshops for Aboriginal women who are residing in women's shelters, as well as staff at women's shelters located across Quebec.

People who inject drugs

As discussed in Chapter 2, injection drug use is the source of the majority of new HIV infections among Aboriginal men and women. Of the 84 projects reviewed, 11 (13%) focused specifically on injection drug use among Aboriginal populations [projects A1, A11-12, A18-19, A35-A36, A57, A59, A72, A77]. Programs targeting Aboriginal people who inject drugs include activities, such as HIV prevention education activities, drop-in centres, needle exchange programs, and outreach initiatives that often include a peer training component to facilitate outreach and build capacity in the target population. For example, the project *From a Whisper to a Song—Bridging the Peer Collective Together* [A19], developed by the Western Aboriginal Harm Reduction Society, delivers workshops, community forums, outreach, and peer-training aimed at Aboriginal people who inject drugs residing in Vancouver’s Downtown Eastside.

Some of the projects that focus on injection drug use also provide harm reduction education and interventions addressing sexual health. Positive Living North: No kheyoh t’sih’en t’sehena Society’s project *The Fire Pit: Fanning the Flames* [A12] is a cultural drop-in centre, which works to facilitate culturally appropriate prevention education regarding injection drug use harms and sexual health. The centre also facilitates access to HIV/AIDS diagnosis, treatment and care for Aboriginal people living with, and at risk of, HIV/AIDS in Prince George, British Columbia. In Saskatchewan, the Battlefords Family Health Centre’s project *Circle of Change: Reducing Harm* [A35] focuses on Aboriginal populations at high risk of HIV infection, including people who inject drugs. The project offers a women’s drop-in support group which focuses on reducing harm from injection drug use and increasing sexual health, and also offers outreach education to Aboriginal street-involved youth on injection drug use and sexual health.

On a national scale, the Canadian Aboriginal AIDS Network’s project *Culturally Appropriate Harm Reduction Program Development: Four Best Practice Approaches to Reducing Harm Associated with Injection Drug Use (and Other*

Substances) in Aboriginal Communities [A1] focuses on developing a culturally appropriate harm reduction model for injection drug use, which targets Aboriginal women, youth, people in prison and two-spirit men. The project delivers training to improve capacity among services providers on developing programming for these populations.

Gay, lesbian, bisexual, transgender and two-spirit people

Of the 84 projects reviewed, 9 (11%) of the projects focus on gay, lesbian, bisexual, transgender and two-spirit Aboriginal populations [projects A1, A10, A28, A30, A34, A44-A46, A48]. Projects addressing this population were located in British Columbia, Alberta, Saskatchewan and Ontario. The projects focused on the development and delivery of educational workshops and conferences for the target population and to service providers working with the population to increase their knowledge, cultural competency and reduce stigma and discrimination; and the creation of wise practice resources to inform the response to HIV/AIDS among the population. For example, the HIV Network of Edmonton’s project *Two Spirit Safe Communities Project* [A28] included education and sensitivity workshops and resources delivered to organizations working with two-spirit populations at risk of, and living with, HIV/AIDS to reduce stigma and discrimination for two-spirit populations, including two-spirit youth. In Saskatchewan, the project *A Journey of Healing, Aboriginal People Living with HIV/AIDS (APHAs) Joining the Circle, Two Spirit People Joining the Circle* [A34], implemented by All Nations Hope AIDS Network included the development of a training manual on harm reduction for two-spirit people and trained APHAs to deliver the training. The *2 Spirits Trans Project* [A45], implemented by 2-Spirited People of the 1st Nations in Toronto, included the development of a wise practices guide and project training sessions, which focused on identifying the needs of Aboriginal Trans people and honouring their experiences.

Aboriginal People living with HIV/AIDS (APHAs)

Of the 84 projects reviewed, 31 (37%) focused on APHAs [A4, A7, A9-A10, A13-A15, A16-A18, A20-A21, A29, A32-A34, A37-A38, A42-A43, A48, A53-A54, A56, A66, A60, A70, A74, A77, A81, A83]. These projects conducted activities to facilitate APHAs' access to HIV/AIDS diagnosis, care, treatment and support, and identified the specific needs of APHAs in the community. For example, a pilot project between PHAC, the Homelessness Partnering Strategy of Human Resources and Skills Development Canada and Nine Circles Community Health Centre in Winnipeg aimed to improve access to services and health outcomes for APHAs and prevent them from falling into homelessness [A43].

Projects addressing the needs of APHAs often included a capacity-building component to train them to provide HIV/AIDS prevention education to peers. For example, through its project *An Integrated Community-Based Response to HIV/AIDS* [A42], Nine Circles Community Health Centre in Winnipeg offers people living with HIV/AIDS skills development opportunities by training them as volunteers in the program.

One project of the Canadian Aboriginal AIDS Network entitled *Fostering Community Leadership to End HIV/AIDS Stigma and Discrimination* [A2] focused on stigma and discrimination. The project utilized social marketing techniques to create awareness and knowledge of HIV/AIDS among Aboriginal leadership to reduce stigma and discrimination experienced by APHAs.

First Nations-, Inuit- and Métis-specific projects

Of the 84 projects reviewed, 13 specifically focused on First Nations populations [A6, A8, A17, A22, A30, A32, A64, A74-A76, A78, A80, A84], four focused on Métis populations [A25-A27, A31] and two focused on Inuit populations [A3, A82].

First Nations-specific projects

Of the 13 projects targeted to First Nations populations, seven focused on First Nations youth [A8, A22, A30, A64, A76, A78, A84], four on First Nations people living with HIV/AIDS [A17, A32, A74, A80], and one on First Nations women [A74]. Projects for these target populations focused mainly on sharing information on HIV/AIDS. For example, in Alberta the *Athabasca Native Friendship Centre Society's project Astawinitan (Let's Put it Out)* [A22] included workshops held in elementary and secondary schools to increase students' knowledge and awareness of HIV/AIDS. The Hiiye'yu Lelum (House of Friendship) Society in Duncan, British Columbia developed youth-led workshops on HIV/AIDS, HCV and healthy sexuality through its project *Kwam Kwum Súli: Strengthening the Spirit* [A8].

Three of the First Nations-specific projects focused on HIV co-infection issues. For example, the *Tlicho Community Services Agency Hep C and HIV/AIDS Awareness Program* [A84] in the Northwest Territories aims to address high rate of STIs in the Tlicho region by holding workshops and distributing resources to isolated communities. In the Yukon, the Council of Yukon First Nations project *Bringing the HIV and Hepatitis C Risk Assessment Guidelines to Remote and Rural Northern Communities* [A80] included delivering workshops to raise awareness of transmission and prevention methods, promote harm reduction practices, and support APHAs and people living with HCV in northern rural remote areas.

In British Columbia, the British Columbia Ministry of Healthy Living and Sport is supporting a qualitative and quantitative analysis of the services relating to the current response to HIV/AIDS among Aboriginal populations within the province [A6]. This project, undertaken in partnership with the BC First Nations Health Council, the regional offices of both First Nations and Inuit Health and PHAC, and the Provincial Health Services Authority, will provide a planning resource to help address gaps and foster equitable coverage of services for Aboriginal people.

Métis-specific projects

All four of the Métis-specific projects took place in Métis communities in Alberta. HIV/AIDS needs assessments were undertaken in the communities of Buffalo Lake [A25] and Peavine [A31] to determine community needs around HIV/AIDS and related issues and identify approaches to address those needs. The other two projects, the *Grande Prairie Youth Wellness Project* [A27] and the *Eastern Métis Settlements HIV Cultural Camp* [A26], focused on sharing HIV/AIDS information with Métis youth through conferences and workshops that included cultural teachings, health information, the participation of Elders, and artistic activities.

Inuit-specific projects

Both of the Inuit-specific projects identified in this process were developed by Pauktuutit Inuit Women of Canada. The project *Ajjigjauningittuq: Addressing the HIV Needs of Inuit in Urban Centres* [A3] included a literature review of HIV prevention, diagnosis, care and support services currently available to Inuit living in urban centres and interviews with Inuit women and men to identify gaps in current services. The second project, entitled *Increasing Sexual Health Capacity and Building Supportive Community for HIV-Positive Inuit* [A82], included a needs assessment of Inuit sexual health needs to identify priorities for research and programming and to develop culturally appropriate HIV/AIDS workshops.

6.5.2 Response to HIV/AIDS among First Nations populations living on-reserve

Health Canada provides community programs in all First Nations communities located on reserve and primary care services in remote and/or isolated First Nations communities where these services are not provided by provincial or regional health authorities. Health Canada's HIV/AIDS program provides AIDS education, prevention and related services to First Nations on-reserve and some Inuit communities. The following information on HIV/AIDS programming provided on-reserve was gathered with the assistance of the Health Canada Regional HIV/

AIDS Sub-Working Group²⁸. It is important to note that this section does not include those HIV/AIDS services that are part of primary health care on reserve, such as HIV testing or treatment. This section focuses only on programs and services addressing HIV/AIDS prevention, care and treatment outside the scope of primary health care delivery.

The programmatic response to HIV/AIDS for on-reserve First Nations communities includes programs and activities that are delivered by communities, Aboriginal organizations, and governments. A wide variety of programs and projects addressing various cross-populations were captured in the information-gathering process, including activities, such as workshops and presentations, conferences, support and referrals, needle exchanges and the development of culturally-relevant HIV/AIDS resources.

General Prevention Activities

Many of the activities identified through the information-gathering process focus on prevention through awareness-raising and information-sharing, including presentations, workshops and conferences. First Nations communities across Canada are often provided with funding to implement their own projects to address HIV/AIDS and STI prevention, healthy sexuality, co-infections and other related issues. In addition, Aboriginal ASOs may provide information sessions to First Nations communities. For example, the Aboriginal ASOs Healing Our Nations in the Atlantic provinces, All Nations Hope AIDS Network in Saskatchewan and Healing Our Spirit in British Columbia all provide HIV/AIDS information sessions to First Nations communities in their respective regions. In Manitoba, Health Canada provides awareness presentations on STIs and bloodborne infections (such as HIV) to First Nations communities in the region. A conference was held for First Nations Community Health Representatives in Manitoba to increase knowledge and awareness of HIV/AIDS, STIs, tuberculosis and immunization at the community level.

²⁸ Information was not available for the Ontario and Northern regions.

In Alberta, all First Nations communities in the province participate in awareness campaigns that include information-sharing activities, such as community events, games, and information booths to promote safer sex.

Capacity and Resource Development

In addition to providing workshops and educational sessions to community members, several regions also identified the provision of training to staff of organizations who work with First Nations clients. In Quebec, a project was identified in which nurses who work in First Nations and Inuit communities were given training to improve the delivery of counselling and education on contraception and STIs to Aboriginal youth. In British Columbia, Chee Mamuk provides a five-day workshop for employees of Aboriginal or First Nations organizations to provide the knowledge and skills necessary to mobilize on HIV/AIDS and related issues in Aboriginal populations. Also in British Columbia, Red Road HIV/AIDS Network provides workshops to First Nations leadership regarding barriers to service on-reserve, including HIV/AIDS-related services.

The development of culturally-appropriate HIV/AIDS resources for First Nations was identified as an activity in some regions through the information-gathering process. The First Nations of Quebec and Labrador Health and Social Services Commission (CSSSPNQL) has worked with First Nations communities and Aboriginal organizations to create a brochure containing information on HIV/AIDS. In addition, the CSSSPNQL has published two editions of a newsletter (*Circle of Hope – Le cercle de l'espoir*) on HIV/AIDS, STIs, contraception and related issues. In British Columbia, the program “Star in Your Own Stories” allows Aboriginal youth to create their own positive sexual health campaign, including a DVD and promotional materials. In addition, the Red Road HIV/AIDS Network, an Aboriginal AIDS network in British Columbia, has a resource library that will mail HIV/AIDS-related resources to clients. First Nations youth in communities in Alberta have also developed DVDs with key messages on topics including HIV/AIDS, STIs, HCV, sexual health and drug use.

Women

Although women make up nearly half of all new HIV infections among Aboriginal people, few of the prevention/awareness-raising activities identified in the information-gathering process focus specifically on women. In Quebec, the Aboriginal organization Quebec Native Women provides HIV/AIDS workshops to women in the Innu language. In British Columbia, Chee Mamuk (an agency of the Provincial Health Services Authority) has created a project entitled “Around the Kitchen Table” which aims to empower Aboriginal women in remote communities by combining traditional teaching activities with HIV/AIDS education. In Alberta, a women’s gathering is held for all First Nations communities in the province. The gathering provides information on topics, including sexual health, HIV/AIDS, STIs, hepatitis C (HCV) and drug and alcohol use.

Youth

Taking into consideration the fact that the Aboriginal population is younger than the overall Canadian population and that nearly one-third of Aboriginal people diagnosed with HIV infection are under the age of 30 years, initiatives targeting the young Aboriginal population are an integral part of a comprehensive response. Projects targeting First Nations youth on-reserve were identified in Quebec, Saskatchewan and British Columbia. First Nations communities in Saskatchewan identified numerous projects and programs that focus on education and awareness among youth on issues, including HIV/AIDS, STIs, HCV, sexual health, the impact of drug and alcohol use on sexual behaviour, self-esteem and culture. Two communities have implemented a youth theatre group program, which presents a series of plays on HIV/AIDS, STIs and sexual health followed by a discussion. In British Columbia, Chee Mamuk has developed a program for First Nations youth entitled “Star in Your Own Stories” which engages youth to create their own positive sexual health campaigns focusing on HIV/AIDS, STIs, testing, and sexual health. In Alberta, a Youth Violence Prevention Tool Kit, which links violence among youth with HIV/AIDS, STIs and drug use, is used to train community workers to deliver presentations and workshops in their own

communities. Alberta Region also holds an annual five-day Youth Gathering for all First Nations communities in the province to train peer facilitators who will hold presentations on issues, including sexual health, HIV/AIDS, STIs, HCV and drug use in their own communities.

Injection Drug Use

Injection drug use is the main HIV exposure category for Aboriginal men and women. Several regions, including the Atlantic region, Manitoba and Saskatchewan report needle exchange programs in First Nations communities in the region. In Quebec, the organization Pikatemp offers screening and interventions to hard-to-reach populations at risk of HIV infection, including people who inject drugs. Members of the Abitibi communities in the region access the program. In Alberta, five First Nations communities participate in a program entitled Harm Reduction 101/ Leaving the Rez, which provides information and a tour of inner city programs, shelters, drop-in centres and medical centres to participants residing on- and off-reserve. The program addresses issues such as HIV/AIDS, STIs, tattooing and piercing, sexual health and drug use, including injection drug use.

Aboriginal People Living with HIV/AIDS

Many of the identified projects focus on HIV prevention, while few provide supports for APHAs living on-reserve. Healing Our Nations, an Aboriginal ASO in Atlantic Canada, provides support groups to APHAs. Although Aboriginal ASOs in other provinces provide supports to APHAs, these are not necessarily accessible for those residing on-reserve, particularly those living in rural and/or remote First Nations communities.

6.5.3 Response to HIV/AIDS among Aboriginal people in prison

As discussed in Chapter 4, Aboriginal people are over-represented in federal and provincial/territorial prison systems. For this reason, information was gathered on projects and programs implemented in federal, provincial and territorial prisons to address HIV prevention, substance use, as well as Aboriginal cultural programs, which may

contribute to reducing the vulnerability of Aboriginal people in prison and those who were formerly in prison to HIV infection. As discussed in Section 6.1, information for this section was gathered with the assistance of the Federal/Provincial/Territorial Heads of Corrections Working Group on Health. In addition, eight projects addressing Aboriginal people in prison were identified in the information-gathering process for Aboriginal populations living off-reserve. Some of these projects are also described below.

HIV Prevention

In federal penitentiaries, HIV prevention programming is offered through individual counselling or education sessions and from presentations offered by community-based organizations. The “Aboriginal Peer Education Course” trains Aboriginal people in prison to provide peer education and support on issues such as infectious disease and harm reduction. In Quebec, the project “Cercle de partage et sensibilisation” [A62], implemented by the First Nations of Quebec and Labrador Health and Social Services Commission (CSSSPNQL) provides culturally relevant HIV/AIDS prevention workshops to Aboriginal people in prison in federal institutions in the province of Quebec.

In provincial/territorial correctional facilities, HIV prevention programming generally falls into one of two models—individual counselling and/or education sessions, and presentations made by community-based organizations. In most cases, these services do not specifically target Aboriginal people. In the first program model, HIV counselling or education sessions are provided individually by public health nurses or other facility staff either at the time of intake or by request. In Alberta, a video on harm reduction entitled “Getting Out and Staying Safe” is available for all sentenced offenders in provincial correctional institutions for viewing prior to their release.

In the second program model, HIV education sessions are provided by community-based organizations, which make presentations to people in prison (i.e. Quebec, Ontario, Alberta). For example, through Ontario’s Native

Inmate Liaison Worker program, community-based organizations provide presentations on HIV/AIDS to people in prison. In Saskatchewan, the Battlefords Family Health Centre's project *Circle of Change: Reducing Harm* [A35] included HIV/AIDS educational groups targeting youth and adults in two correctional facilities in Saskatchewan. British Columbia is piloting a point-of-care HIV testing pilot in five correctional facilities. The project allows people in prison to request and receive rapid HIV testing including pre- and post-test counselling and education about HIV/AIDS from nursing staff.

A few projects were also identified that target previously incarcerated Aboriginal people for educational sessions on HIV/AIDS and other related health and lifestyle issues. The *HIV/AIDS Policy Development and Implementation for APHA Offender Transitional Services* project [A7], implemented by the Healing Our Spirit BC Aboriginal HIV/AIDS Society, included resource development and workshops to increase the knowledge of transitional staff and agencies working with Aboriginal people in prison and those formerly in prison to improve support for Aboriginal offenders impacted by HIV/AIDS in British Columbia. In Alberta, Kimamow Atoskanow Foundation's project *Full Circle* [A29] included the creation of culturally relevant materials to discuss sexual health and harm reduction practices both within and outside of the prison environment, and the facilitation of lifestyle adaptation sessions for persons who are currently or previously incarcerated.

Correctional Service of Canada (CSC) has a model for clinical discharge planning that ensures continuity in health care for offenders with HIV/AIDS by establishing linkages with Aboriginal communities, initiating contacts and making referrals to community resources to ensure access to services in a timely manner. CSC has also developed an Aboriginal Health Strategy, which will link health initiatives together and offer a holistic approach to the health and wellness of Aboriginal offenders. The strategy will increase the focus on the health needs of Aboriginal offenders, including HIV/AIDS.

Substance Use

As discussed in Chapter 2, a survey of people in federal prisons in 2000 found that 92% of Aboriginal people had an identified substance use problem at the time of admission [25]. The over-representation of Aboriginal people in Canadian prisons places Aboriginal people at particular risk of HIV infection through engagement in risk behaviours, including injection drug use [26].

CSC and some provincial/territorial prisons offer Methadone Maintenance Treatment. In federal penitentiaries, CSC offers two programs that address substance use among Aboriginal people in prison—the “Aboriginal Offender Substance Abuse Program” (AOSAP) for men, and the “Spirit of a Warrior” (SOAW) Program for Aboriginal women. The AOSAP is a high-intensity substance use program, which consists of 72 two-hour sessions over a 13-week period. The program is holistic and examines the physical, mental, emotional and spiritual elements of addictions. The program also includes cultural elements, such as ceremonial activities that are combined with current wise practices in substance use treatment. For Aboriginal women, the SOAW Program was specifically designed to address the violence prevention needs of high-risk Aboriginal women offenders. The program has recently been redesigned to also address substance use. SOAW focuses on alternatives to violence in childhood, adolescence and adulthood. The program consists of an in-depth intervention intended to reduce the risk to re-offend with violence; lower the risk of substance use relapse; improve family relations; enhance communication and coping skills; and adapt Aboriginal culture and spirituality into all aspects of behaviour and everyday life. Both programs are delivered by a trained Aboriginal Correctional Program Officer and an Aboriginal Elder. The design and delivery of Aboriginal-specific programs to address substance use in the federal prison system is important given the high number of Aboriginal people with substance use issues in prison systems and the implications for HIV infection due to substance use.

Most provinces and territories offer some form of substance use programming in their correctional facilities, with the exception of Quebec and Nunavut. However, only Ontario offers Aboriginal-specific substance use programming (“The Eastern Door” for Aboriginal men in prison, and “Understanding the Journey” for Aboriginal women in prison). Several provinces and territories offer general substance use programming which is not Aboriginal-specific. For example, New Brunswick correctional facilities offer access to Alcoholics Anonymous and Narcotics Anonymous programs, as well as access to programs offered by local community-based substance use centres. In Saskatchewan, substance use programming includes the “Offender Substance Abuse Pre-Release Program” (OSAPP) and methadone maintenance. Young offender facilities in Saskatchewan partner formally and informally with addiction services in the region to provide assessment, treatment, counselling and reintegration planning using a harm reduction model. The “Substance Abuse Management” (SAM) program is available to all people in British Columbia correctional facilities. SAM is an educational program based on harm reduction principles, which prepares people in prison for substance use treatment through 18 sessions delivered by correctional service staff.

Aboriginal Cultural Programming

Culture is identified as a significant promoter of mental, physical, emotional and spiritual well-being of Aboriginal people living with, and at risk of, HIV/AIDS. Federal penitentiaries and many provincial/territorial correctional facilities offer Aboriginal cultural programming.

Pathways units in federal institutions provide a healing and supportive environment for Aboriginal people who are committed to pursuing personal healing through traditional cultural approaches, including Elder services and other programs and interventions. Pathways units are located at men’s medium security and women’s institutions in all five of CSC’s regions. Healing lodges offer Aboriginal people culturally-based programs in a physical space that reflects elements of Aboriginal culture. Individualized programming, such as Elder teaching and

counselling, workshops and ceremonies, is delivered with a focus on healing and preparing for release into the community. There are eight healing lodges located across Canada, including seven men’s facilities and one women’s facility. Four of the healing lodges are run by CSC, while the other four are privately run by Aboriginal communities in an agreement with CSC. In addition to these two programs, the HIV prevention and substance use programs described in the section above on substance use are also Aboriginal-specific and offer a holistic approach based on the concept of healing.

The majority of provincial/territorial correctional facilities have some form of cultural programming specific to Aboriginal people. Several provinces offer considerable Aboriginal cultural programming, including Ontario, Saskatchewan, Alberta and British Columbia. Ontario programs address issues including substance use, criminality and other issues in the context of colonization (e.g. The Eastern Door for Aboriginal men, Understanding the Journey for Aboriginal women, Aboriginal Men’s Intensive Substance Abuse Program, Turning Full Circle Aboriginal Men’s Intensive Integrated program, The Healing Journey Aboriginal Women’s Intensive Program). In Saskatchewan, Aboriginal cultural programs for adults include individual counselling, spiritual and cultural events, talking circles, and a children’s visiting program that focuses on issues such as parental effectiveness, fetal alcohol spectrum disorder, literacy and anger management. In youth facilities, cultural programming includes traditional teachings; individual counselling; spiritual and cultural events; and reintegration programs in partnership with regional First Nations councils. British Columbia’s cultural programming includes cultural education, ceremonies, and counselling provided by Elders. In Quebec, Aboriginal people may access Elder services, however, this is determined individually and is not part of a larger cultural program. Ontario, Saskatchewan, Alberta and British Columbia also have some form of Native Liaison Worker or Native Program Coordinator program, a co-ordinator responsible for cultural programs and services for Aboriginal people, as well as the services of Elders. Yukon, Northwest Territories and Nunavut also offer cultural

programming to Aboriginal people in prison. In Nunavut, this programming includes a program that allows for the completion of traditional activities on the land, as well as a program to create traditional carvings.

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CHAPTER 7 - Conclusions

Aboriginal peoples—First Nations, Inuit and Métis—make up a unique segment of the concentrated HIV/AIDS epidemic in Canada. This is the first time PHAC has attempted to present evidence from a variety of sources in one document to better understand the impact of HIV and AIDS on Aboriginal populations. This status report does not include an exhaustive list of program, policy and research gaps, nor does it prescribe solutions to address existing gaps. However, it is hoped that the evidence provided in the report will be useful to governments, non-governmental organizations, public health officials, researchers, communities and others in informing the development of programs and policies addressing HIV/AIDS and issues related to the determinants of health of Aboriginal populations.

Surveillance data indicate that Aboriginal populations are over-represented in HIV and AIDS statistics in Canada. The main route of HIV infection among Aboriginal people is injection drug use. Compared to the non-Aboriginal population, Aboriginal women and youth are particularly affected by HIV/AIDS. Data completeness presents a challenge for Aboriginal populations because of limitations in data collection and reporting across provinces and territories. In addition, Aboriginal people may face additional challenges in accessing HIV testing, including fear of test results, feelings of shame, fear of racial discrimination from health care providers, and lack of pre- and post-test counselling, as well as broader systemic barriers, including lack of trust in health care professionals and other service providers.

This report confirms that HIV/AIDS within the Aboriginal population is closely linked to a variety of factors and determinants of health, which influence the population's vulnerability to HIV/AIDS. Research described in this report indicates that Aboriginal people experience higher rates of poverty, violence, harmful substance use, homelessness and incarceration—all factors which place the population at increased risk for HIV infection. The report also emphasizes the ongoing impacts of racism and the multi-generational legacy of residential schools as

key factors that impact on the vulnerability of Aboriginal people to HIV infection.

Barriers to accessing appropriate culturally sensitive health services and information remain an issue for this population. Racism, stigma and discrimination continue to affect the quality of life and health outcomes of Aboriginal people living with, and vulnerable to, HIV/AIDS. In addition, HIV/AIDS-related stigma and discrimination, including homophobia, within Aboriginal communities can reduce access to health care, including HIV testing, care and treatment, and reduce social and family support for APHAs.

This report has also confirmed the critical importance of culturally relevant approaches to HIV/AIDS prevention, care, treatment and support for Aboriginal populations. Evidence identifies cultural reconnection as an important source of strength and resilience for APHAs, and as an important aspect of successfully preventing HIV infection.

The literature also suggests that approaches to addressing HIV/AIDS among Aboriginal populations should be tailored to the unique cultural, linguistic and geographic needs and realities of First Nations, Métis and Inuit populations. More research and evidence will be required to identify and analyze culturally appropriate approaches to HIV/AIDS prevention, care, treatment and support which are specific to First Nations, Inuit and Métis populations, as well as the specific needs of cross-populations, including women, youth and two-spirit, gay, lesbian, bisexual and transgender Aboriginal people.

The evidence presented in this report clearly emphasizes the intersection of the determinants of health as key factors that impact on the vulnerability and resiliency of Aboriginal populations to HIV infection. These findings confirm the importance of partnerships among different sectors of society in addressing the issues surrounding HIV/AIDS among Aboriginal populations. The success of Aboriginal communities, community-based organizations, public health and social service agencies and other groups in lowering the number of new HIV infections in

this population and in improving the quality of life of APHAs is influenced by how well Canada as a country “addresses the factors that influence health, physical and social environments, which could facilitate decisions to achieve and maintain the highest state of health possible” [1]. Comprehensive, coordinated efforts will be required to address the broader health inequities that influence the vulnerability of Aboriginal people to HIV infection.

The response to HIV/AIDS among Aboriginal populations involves a wide array of organizations, communities and governments, which have built networks across the country and encouraged knowledge exchange and culturally relevant approaches to HIV/AIDS. Strengthening evaluation capacity will be important to determine whether current programs, interventions and activities adequately meet the prevention, care, treatment, and support needs of this population. As such, cross-sectoral and cross-jurisdictional activities to share best practices; to increase partnerships among a wider range of stakeholders; and better use evidence in the development of strategies and interventions should be fostered and encouraged.

Canadian stakeholders involved in addressing HIV/AIDS among Aboriginal populations have demonstrated strong collective will and leadership. Their unwavering dedication to increase HIV/AIDS awareness and to reduce stigma and discrimination has contributed to a growing recognition among this population that the epidemic cannot be ignored and that they must continue to lead this response. This report acknowledges their important role, their successes and their ongoing quest to get ahead of, and reverse the spread of, HIV/AIDS among Aboriginal peoples.

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Appendix A

1) Search terms

Note that words with an asterisk (*) are search terms with several possible endings.

Aboriginal	Alberta	Acquired immunodeficiency
Alaska	British Columbia	AIDS
Algonquin	Calgary	AIDS serodiagnosis
America	Canad*	APHA
American Indian	Colombie-Britannique	APHAs
American-Native-Continental-	Edmonton	HIV
Ancestry-Group	Halifax	HIV+
Autochtone	Haligonian	HIV infections
Blackfoot	Île-du-Prince-Edouard	HIV positive
Chippew*	Labrador	HIV seropositivity
Chipwe*	Manitoba	HIV seroprevalence
Cree(s)	Montreal	Human immune deficiency
Dene	New Brunswick	Human immunodeficiency
Eskimo	Newfoundland	Immunodeficiency/y
First Nation(s)	NFLD	D'immunodéficience (acquise;
Haida	Northwest Territor*	acquise humaine)
Indian	Nouveau-Brunswick	L'immunodéficience
Indigenous (Person or	Nouvelle Écosse	Infection
Persons; People or Peoples;	Nova Scotia	Prevalence
Population or Populations;	Nunavut	Sida
Community or Communities)	NWT	Syndrome
Innu	Ontario	VIH
Innus	Ottawa	VIH+
Inuit	PEI	VIH positi*
Iroqu*	Prince Edward Island	Virus
Listuguj	Quebec	
Malecite	Regina	
Maliseet	Saskatchewan	
Métis	Saskatoon	
Micmac	Terre-Neuve	
Mikmaq	Territoires du Nord Ouest	
Mohawk	Toronto	
Naskap*	Vancouver	
Native	Winnipeg	
Nisga*	Yukon	
North America		
Ojibw*		
Première nation		
Sekani		
Sioux		
Six Nations		
Status Indian		
Tlingit		

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- CINAHL (2001-November 2008)
- Global Health (2001-February 2008)
- Current Contents (2001-2008)
- MEDLINE (2001-2008)
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- PsychInfo (2001-2008)
- Social Policy and Practice (2001-October 2008)
- SCOPUS (2001-November 2008)
- OVID Embase (1980-November 2008)
- Bibliography of Native North Americans (2008-2009)

Appendix B

Research Projects Focusing on HIV/AIDS among Aboriginal Peoples

Project R1:

Title: *Aboriginal community-based research capacity-building initiative Canada: An initiative for Eastern Canada and Nunavut*

Principal investigators: Randy Jackson and J.K. Barlow, Canadian Aboriginal AIDS Network (CAAN)

Abstract: Under an existing CBR capacity-building project (now entering its sixth year of operation), CAAN Aboriginal Research Technical Assistant Program is part of a continuing strategic approach to address rates of HIV/AIDS infection and research capacity building needs in Aboriginal communities. Research technical assistants will address the original goals under this current initiative: (1) To provide support for the development of research skills within Aboriginal communities; (2) To promote cultural competence in research among professional and academic researchers undertaking work in collaboration with Aboriginal communities; and (3) To assist in the design of HIV/AIDS research that is both methodologically sound, culturally competent, respectful, and relevant. Specific objectives include: (a) Explore the development of both e-learning and virtual training opportunities in partnership with an appropriate academic institution (e.g., department and/or ACADRES) and another non-governmental organization (e.g., Ontario HIV Treatment Network and/or the Wellesley Institute or the Community-Based Research Centre) with a vision to implement an Aboriginal CBR certification process; (b) Build on our success with an Aboriginal-specific CBR journal focusing on continued dissemination activities, including publications and conference presentations; (c) Continue the implementation of CBR mentorship thereby providing support for the development of research skills; (d) Explore the feasibility of partnership activities in support of expanded CBR capacity-building to benefit the respective mandates of both CBRFs and Aboriginal RTAs; (e) Develop and offer a workshop focusing on Aboriginal research ethics; (f) Participate in a CAAN sponsored development grant focused on housing issues; and, (g) the RTA will work closely with members of our National Research Advisory

Committee as each of the above activities are developed and delivered.

Dates: April 2007 – March 2009

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Community-Based Research Facilitator (Aboriginal Stream)

Source: CIHR database

Project R2:

Title: *Advancing HIV services research: Expanding Andersen's health service utilization framework*

Principal investigator: Catherine Anne Worthington

Abstract: HIV services research and evaluation have shown that in order to be effective, HIV services need to be tailored to the specific contexts, cultures and locales of populations infected with, and at risk for, infection to HIV through collaborative research endeavours, particularly since many of these populations are vulnerable or marginalized. The goal of this five-year program of research, supported by a CIHR New Investigator award, is to conduct a series of collaborative and interdisciplinary research projects to improve HIV health services for specific groups. Two projects focus on services for those living with HIV, and two projects focus on services for vulnerable populations. The first project (funded by CIHR for 2003-2005) will provide rehabilitation and HIV professionals with information on the ways in which rehabilitation services could improve health care for those living with HIV. The second project (funded by SSHRC for 2003-2006) will provide HIV clinicians with information on ways to improve clinical research practices for HIV patients. The third research project (submitted to CIHR) will provide information to Aboriginal and HIV service providers on the knowledge, attitudes, experiences, and beliefs of Ontario Aboriginal women about HIV and HIV risks to assist in services development for this vulnerable population. The fourth research project (to be prioritized for funding by Health Canada for 2004) will provide a team of HIV and street youth agencies with information on the spectrum of street youth in Calgary, their HIV and health risks, strengths, coping mechanisms, and service needs. All of these projects are collaborative in nature with direct participation of service providers and/or

members of the populations under study to ensure knowledge exchange and timely uptake of research results.

Dates: July 2005 to June 2010

Funding Program: CIHR Clinical Research Initiative/ Institute of Health Services and Policy Research New Investigator Award

Source: CIHR database

Project R3:

Title: *Alcohol use by Aboriginal persons living with HIV/AIDS and its association with access to care and treatment*

Principal Investigators: Kevin Barlow; Colleen Dell

Co-investigators: John Egan; Nancy Gros-Louis; David Lee; Tracey Prentice; Lyanna Storm

Abstract: This proposal has been written to support CAAN's comprehensive research agenda which includes inquiring into health service delivery merits and issues regarding Aboriginal people with HIV/AIDS (APHAs) who use alcohol or are perceived to be using alcohol. Since 1997, CAAN has completed several research projects, many of which have been funded by the CIHR. In *Canadian Aboriginal People Living with HIV/AIDS: Care, Treatment and Support Issues* (Jackson & Reimer, 2005), prejudice was found to be prevalent among primary health care providers where APHAs are concerned. Recommendations by APHA participants point directly to ways in which access to and delivery of services can be improved. Therefore, the purpose of this grant proposal is to undertake research to determine the association between alcohol use and access to services from the perspectives of Aboriginal persons living with HIV/AIDS and service providers using a mixed methodology approach. In turn, these research findings, analysis and conclusions will be used to influence health service delivery, including cultural competency training for health care practitioners.

Dates: April 2008 - March 2011

Funding Program: CIHR Community-Based Research Program – Operating Grant (Aboriginal Stream)

Source: CIHR database

Project R4:

Title: *Analyse de l'implantation du programme Chiiyikiyaa pour la prévention du VIH et la promotion de la santé sexuelle des élèves de deux communautés de la région des Terres-Cries-de-la-Baie-James (Eeyou Istchee) [Analysis of the implementation of Chiiyikiyaa, a program to prevent HIV infection and promote sexual health among students in two communities in the Terres-Cries-de-la-Baie-James region (Eeyou Istchee)]*

Principal Investigators: Manon Dugas; Joanne Otis

Co-investigators: Marlene Beaulieu; Francoise Caron; Gaston Godin; Joseph Levy

Abstract: [translated from the original French] Adolescents in Aboriginal communities are at high risk of contracting HIV and other sexually transmitted infections (STIs) (Statistics Canada, 2005; Calzavara et al., 1998). A peer training program known as Chiiyikiyaa will be tested in two Terres-Cries-de-la-Baie-James communities (Waskaganish and Waswanipi). Under the supervision of a teacher, students in secondary IV will be asked to develop creative and educational activities around five themes. Later, these activities will be shared with younger students (secondary I and II). The themes are as follows: delaying sexual relations; communication; being sexually responsible; developing egalitarian relationships; and condom use. The proposed study will pursue the following objectives: (1) describe the degree to which the program has been implemented and the factors that have facilitated or obstructed implementation; (2) evaluate the process and structure of the program, as well as the achievement of its objectives; (3) develop measurement instruments to evaluate program effects; (4) lay the groundwork to transfer the program to other communities. A variety of qualitative and quantitative methodologies will be employed to analyse the implementation process over a three-year period. This study will make it possible to offer a relevant and culturally appropriate program in the longer term to adolescents in Terres-Cries-de-la-Baie-James. The project itself will contribute to efforts being made in Canada to prevent new cases of HIV infection, as well as the transmission of HIV among Aboriginal youth.

Dates: April 2006 - March 2009

Funding Program: CIHR Community-Based Research Program – Operating Grant (Aboriginal Stream)

Source: CIHR database

Project R4:

Title: *Analyse de l'implantation du programme Chiyiyiyaa pour la prévention du VIH et la promotion de la santé sexuelle des élèves de deux communautés de la région des Terre-Cries-de-la-Baie-James [Analysis of the implementation of Chiyiyiyaa, a program to prevent HIV infection and promote sexual health among students in two communities in the Terre-Cries-de-la-Baie-James region]*

Principal investigator: Ms. Mélanie Gagnon, Université du Québec à Montréal

Co-investigator: Joanne Otis

Abstract: [This research project is part of a larger project. See abstract above for project description.]

Dates: August 2006 - July 2008

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Master's Award (Aboriginal Stream)

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=1804>

Project R5:

Title: *Canadian Aboriginal cultural competence for HIV/AIDS health care providers*

Principal investigator: Kevin Barlow, CAAN

Co-investigators: Charlotte Loppie, Dalhousie University

Abstract: The cultural world views of Aboriginal peoples often warrant a unique approach with health care providers dealing with them. It is against this backdrop that this research addresses Aboriginal cultural competence in the context of HIV/AIDS health care. Some of the questions to be addressed are; the views of primary and community-based health care providers regarding culturally competent care in the context of HIV/AIDS, as well as the similarities and differences between the perception and practices of primary and community-based health care models. How do service providers influence the perceptions of Aboriginal peoples living with HIV/AIDS (APHA) regarding the quality of service? Using a community-based participatory action framework to answer these questions, we will

conduct twenty-four (24) interviews and four (4) focus groups with twenty-four (24) primary and twenty-four (24) community-based health care providers in four sites. With the publication of a 'good practice' manual, it is anticipated that service providers may come to a preliminary understanding of cultural competence resulting in an increase in client satisfaction and better health care outcomes for APHAs.

Dates: April 2005 - March 2008

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Operating Grant (Aboriginal Stream)

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=391>

Project R6:

Title: *Capacity building: Culturally sensitive training for staff and volunteers of First Nations' community organizations providing HIV/AIDS services*

Principal investigator: Basanti Bhaduri Majumdar

Co-investigators: Gina M. Browne; Amiram Gafni; Tracey L. Chambers, McMaster University; Jacqueline Gail, McMaster University

Abstract: Culturally sensitive education improves knowledge and awareness of HIV/AIDS, and decreases infection rates, stigma and fear within communities. Education of this nature, while making inroads in much of North America, often fails to recognize the specific needs of North American Aboriginals, who represent a rapidly growing proportion of HIV-positive tests. In Canada, many organizations exist to support Aboriginal people coping with HIV/AIDS; however, they lack resources to adequately care for clients who often live in remote areas. Staff and volunteers of such organizations can often feel unsupported and overwhelmed by their work. This project aims to train a group of staff and volunteers to strengthen these organizations. Working in collaboration, McMaster University, Union of Ontario Indians, 2-Spirited People of the First Nations, the Association of Iroquois and Allied Indians, Grand Council Treaty #3 and the Nishnawbe Aski Nation will combine resources to conduct a project examining the development, implementation and evaluation of a culturally sensitive

training program in HIV/AIDS for staff and volunteers of their respective organizations. Each group will contribute staff and volunteers to form a core group of trainees who will be trained in culturally sensitive HIV/AIDS prevention and education; the core group will then separate and each member will train others within their respective organizations. Findings from this project will be used to create a resource package that will provide education and training to future staff and volunteers of these organizations, enabling them to maintain a network of educators and trainers and build their capacity through mass education. Furthermore, this project can become a model for AIDS organizations in other provinces, demonstrating how to develop and use existing resources to increase awareness and reduce the spread of HIV/AIDS.

Dates: March 2005 - March 2006

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Capacity-Building Workshop (Aboriginal Stream)

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=671>

Project R7:

Title: *The cedar project leadership forum: Acknowledging the pain of our children*

Principal Investigator: Patricia Spittal

Abstract: The Cedar Project is an ongoing, CIHR-funded initiative addressing HIV and HCV vulnerability among young Aboriginal people who use drugs in three Canadian cities. It is the first and only study of its kind in North America. One of the most disastrous outcomes of the legacy of historical trauma among Aboriginal people has been a higher rate of HIV and other infectious diseases among young Aboriginal people who use drugs. Since the study's inception, an Aboriginal Partnership has led the Cedar Project. The Partnership has been planning "The Cedar Project Leadership Forum: Acknowledging the Pain of Our Children". Using funding from a CIHR-Institute of Aboriginal People's Health Meetings, Planning and Dissemination grant, this event will provide an opportunity for translating Cedar Project information and dialogue on the subject of healing multigenerational trauma among young Aboriginal people. Leadership

involved in the Partnership has committed to seek additional funding for the Forum. The Partnership has also emphasized the necessity of holding a preliminary meeting for knowledge transfer, planning, preparing and organizing the Cedar Project Leadership Forum. Part of the grant will be used to carry out this meeting. Meeting 1—Preparatory Gathering: With support from the grant, Cedar Project Partnership and Investigators will gather in Vancouver in September 2008. This preliminary meeting will allow the Partnership to carry out important organizational tasks in preparation for the Forum. Meeting 2—The Cedar Project Leadership Forum: In addition to funds raised by the Partnership, the remainder of the grant will go toward the Forum taking place in Vancouver, February 2009. This event will include voices of Aboriginal and non-Aboriginal leadership, Aboriginal youth delegates, law enforcement and justice, child welfare representatives, Aboriginal HIV/AIDS and health service organizations, health research scientists and other academics.

Dates: September 2008 - August 2009

Funder: CIHR Meetings, Planning and Dissemination

Grant: Knowledge Translation

Source: CIHR database

Project R8:

Title: *The cedar project: A comparison of the sexual vulnerabilities of young Aboriginal men and women surviving drug use and sex work in Prince George and Vancouver*

Principal investigator: Negar Chavoshi

Co-investigator: Patricia M. Spittal

Abstract: not available

Dates: May 2008 to April 2009

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Master's Award (Aboriginal Stream)

Source: CIHR database

Project R9:

Title: *The cedar project: Exploring HIV and hepatitis C vulnerabilities among young Aboriginal drug users in three Canadian cities*

Principal investigator: Patricia M. Spittal, St. Paul's Hospital; Martin Schechter

Co-investigators: Catherine Baylis; Russell Callaghan; Kevin Craib; Patricia Janssen; David Marsh; Akm Moniruzzaman; Christopher H. Sherlock; Mary Teegee; Christian M Wayne; Eric Yoshida

Abstract: HIV infection is spreading among Canada's Aboriginal people. The number of Aboriginal people living with HIV almost doubled during the prior 3-year period from 1996 to 1999. Although Aboriginal people make up only 4% of BC's population, they comprise more than 13% of all new HIV positive tests in BC, and half of all babies infected with HIV in the province. One of the major ways in which HIV is spreading among Aboriginal people is by use of injection drugs, such as cocaine and heroin. One recent study in Vancouver showed that Aboriginal people who injected drugs were getting HIV more than twice as fast as non-Aboriginal drug users. Aboriginal women seem to be at even higher risk. This collaborative study will work with large numbers of young Aboriginal people (aged 14 to 30) who use drugs in Vancouver, Prince George and Kamloops. The study will use the scientific methods of both epidemiology and anthropology. Its purpose is to understand the complex reasons underlying the increased vulnerability to HIV among young Aboriginal injection drug users. This research is critical and draws upon the collaboration of Aboriginal AIDS organizations whose input is crucial for this research to lead to preventive interventions that have a real impact.

Dates: October 2006 - September 2009

Funding Program: CIHR HIV/AIDS Research Initiative Operating Grant – Health Services/Population Health Stream

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=1852>

Project R10:

Title: *A collaborative approach to understanding and improving Aboriginal people's access to HIV services in Northern BC*

Principal investigator: Lesley A. Cerney

Co-investigators: Dara H. Culhane

Abstract: Overall declines in Canadian rates of HIV infection mask dramatic increases among vulnerable populations, such as Aboriginal women, youth, and

intravenous (IV) drug users. Scholars attribute the additional burden of illness among Aboriginal people to the legacy of colonialism and history of social marginalization. In a recent study Aboriginal women reported experiencing encounters with health providers as invalidating, which discouraged them from seeking health services. While colonialism continues to shape relationships between health providers and Aboriginal patients, we know little about how this legacy affects the delivery of HIV services. Specifically, how are differences in power experienced and negotiated in patient-provider relationships; how do Aboriginal people with HIV and their health providers experience the delivery of these services; and how can an understanding of Aboriginal people's experiences contribute to improvements in HIV policies and practices? This study uses ethnographic methods of participant observation, interviews and focus groups to examine these questions in the relationships between health providers and Aboriginal people with HIV. Patient-provider relationships will be observed during provision of HIV services. Parties will also be interviewed separately with attention to the experiences of Aboriginal women, youth and IV drug users. Participants will be engaged in discussing factors identified as barriers in accessing HIV services - to increase understanding between patients and providers. Development of a collaborative methodology will extend conventional approaches to participatory research by involving parties in analysis of data and in knowledge translation activities. Building on lived experiences of those most at risk for HIV, and those providing HIV services, this research will identify innovative new strategies for improving HIV policy and practice and for increasing access to HIV prevention, treatment and support services.

Dates: September 2007 to August 2012

Funding Program: CIHR Fellowship in the Area of Health Services/Population Health HIV/AIDS Research

Source: CIHR database

Project R11:

Title: *Colliding worlds: Looking behind HIV/AIDS discourse in public health campaigns and among Aboriginal youth*

Principal investigator: Jorge Laucirica, University of Ottawa

Abstract: not available

Dates: January 2006 - January 2009

Funder: SSHRC

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=1618>

Project R12:

Title: *Community consultations to design an intervention to reduce AIDS stigma*

Principal investigator: Judith E. Mill, University of Alberta

Co-investigators: Wendy J. Austin; Claudette Dumont-Smith; Nancy C. Edwards; Randy Jackson, CAAN; Lynne E. Leonard, University of Ottawa; Lynne M. Mclean

Abstract: Two community consultation workshops are proposed to build research capacity among community research partners by meaningfully engaging them in the design of an intervention to reduce AIDS stigma. The intervention will be based on findings from a CIHR-funded community-based research project, “The Influence of Stigma on Access to Health Services by Persons with HIV Illness” that is currently being conducted in Ottawa and Edmonton. During the research project persons living with HIV/AIDS (PHAs), Aboriginal persons living with HIV/AIDS (APHAs), and health professionals have been interviewed to examine the impact of stigma on access to health services. Workshops will be held in Ottawa and Edmonton and will include members of the research team and project advisory committees currently involved with the project, and decision-makers and health professionals from organizations in Ottawa and Edmonton not currently involved with the project. Following an overview of the key findings from the research, the workshop participants will be asked to assist with the development of the intervention. The development of best practice guidelines for the provision of health services to PHAs and APHAs will be an outcome of this process. The community consultation workshops will be held in the spring of 2006, in conjunction with another provincial meeting in Ottawa and Edmonton. The workshop will employ participatory learning strategies that rely on the direct involvement and recognized expertise of workshop participants.

Dates: January 2006 – March 2007

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Workshop (General Stream)

Source: CIHR database

Project R13:

Title: *Community solutions workshop: HIV testing and care for Aboriginal youth*

Principal investigator: Judith Ellen Mill, University of Alberta

Co-investigators: Chris Patrick Archibald, Surveillance and Risk Assessment Division, Public Health Agency of Canada (SRAD-PHAC); Randy Jackson, CAAN; Ted Myers, University of Toronto; Thomas Wong, Bureau of HIV/AIDS, STD and TB Health Canada; Catherine Anne Worthington, University of Calgary

Abstract: The purpose of the proposed two-day workshop is to build research capacity among our Aboriginal community partners by meaningfully engaging them in the design and implementation of dissemination strategies related to the findings of a CIHR-funded community-based research project “The Diagnosis and Care of HIV Infection in Canadian Aboriginal Youth”. Workshop participants will be asked to develop appropriate means for disseminating this information to their own clients and communities based on their knowledge of community needs and capacities. Guidance and technical assistance in designing dissemination strategies will be provided by the research team. Workshop participants will include the members of the research team, project advisory committee, and one representative from each of the Aboriginal community-based organizations who have assisted us in recruiting participants for our study and have been present at previous capacity-building exercises. These individuals include representatives from Inuit, Métis and First Nations groups and from communities in all geographic areas of Canada. The workshop will be held in conjunction with CAAN’s AGM in October 2005 ensuring that the maximum number of Aboriginal community members can attend. The workshop will employ participatory learning strategies that rely on the direct involvement and recognized expertise of workshop participants.

Their active participation and full engagement in the workshop will ensure that participants gain a better understanding of the processes involved in translating research findings into actionable interventions.

Dates: March 2005 - March 2006

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Capacity-Building Workshop (Aboriginal Stream)

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=693>

Project R14:

Title: *A cross-cultural analysis of HIV: Patterns of food choice behaviours and perceptions of nutritional needs in Aboriginal and non-Aboriginal families*

Principal investigator: Kristine Hoyak, University of Manitoba

Abstract: (not available)

Dates: January 2005 - January 2006

Funder: SSHRC

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=1587>

Project R15:

Title: *The cultural dynamics of care and service provision: HIV/AIDS prevention in First Nation communities*

Principal investigator: Sarah C. Fletcher, Brunel University (UK)

Co-investigators: Melissa Parker, Brunel University (UK)

Abstract: APHAs rarely receive adequate health services (Arnold, 2004 and BC Aboriginal HIV/AIDS Task Force, 1999). Among newly HIV-positive persons in BC, a disproportionately high number (16%) are Aboriginal (BC Stats, 2001). Given that existing prevention strategies have been unsuccessful in stemming HIV, Hepatitis C and addiction rates among Aboriginal people, research is needed to better understand how to effectively prevent the disease among these populations and reach out to those already affected. Cultural dynamics, including belief systems, individual and historical experiences, community relationships and traditional approaches to health have a strong impact on the way in which people access health services. Although research has been carried out examining the

cultural dynamics that come into play in African countries hardest hit by the AIDS epidemic, there has been a paucity of similar research undertaken in First Nations communities in Canada. By moving away from quantitative data collection and concentrating on creating an understanding of the contexts that impact the way in which Aboriginal people access health services, one can ensure that the results of the research can have the potential to directly benefit the communities involved. A close examination of the cultural dynamics related to the accessibility of health services, and the issue of “culturally appropriate” or “culturally sensitive” services could facilitate the development of more effective services for First Nations communities dealing with HIV and AIDS.

Dates: September 2005 - August 2007

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Master’s Award (Aboriginal Stream)

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=491>

Project R16:

Title: *Decision tool for evidence-based planning of AIDS prevention programs*

Principal investigator: Neil Andersson

Co-investigators: Jim Martin; Steven Paul Mitchell; Beverley J Shea; Cecilia Zoe-Martin

Abstract: Leadership among the Tlicho communities of NWT has chosen to make prevention of STIs and HIV a priority health issue. The Tlicho, however, still need to improve how they use evidence to create and implement programs that will be effective and sustainable. Simply put, there is too much existing information around STIs and HIV/AIDS for local community programmers to digest. We propose to identify, to develop and to refine effective and efficient methods to implement evidence-based STI and HIV prevention policy and planning in the Tlicho region through a community customized decision tool. First, we will examine the feasibility and effect of an accessible evidence base for the implementation of evidence-based STI and HIV prevention policy and programs relevant to the Tlicho and other Aboriginal communities. Secondly, we will conduct community-led customization of an existing knowledge translation and

decision tool. Thirdly, we will provide capacity-building opportunities for community researchers and decision makers on data synthesis and updating and use of the decision-support tool. The project will build upon an existing systematic review of HIV prevention done in South Africa, and an existing decision tool, created with planners from eight southern African countries. We will extend the systematic review to suit the Tlicho with an emphasis on culturally appropriate interventions, local resilience factors, and community strengths that contribute to STI and HIV prevention. The Tlicho will customize the decision tool for their own use, taking into account their own knowledge of what visual tools work best for the people who need to know and act upon the information. This will be done through a reiterative consultative process between the community representatives and the research team. We anticipate that development of prevention models and decision aids will be relevant to other communities and organizations such as CAAN and the Public Health Agency of Canada.

Dates: November 2008 to October 2010

Funding Program: CIHR Operating Grant: Knowledge to Action

Source: CIHR database

Project R17:

Title: *Enhancing dissemination: Including establishing an Aboriginal community-based HIV/AIDS peer-reviewed research (annual) journal, promoting a web presence and conference participation*

Principal investigator: Randy Jackson, CAAN

Co-investigators: Margaret Lynne Akan, All Nations Hope AIDS Network; Dina Epale, CAAN; Renée Masching, CAAN; Art Zoccole, 2-Spirited People of the 1st Nations

Abstract: The overall proportion of estimated HIV infections attributed to the Aboriginal community has been steadily increasing since the beginning of the epidemic in the early 1980s. These statistics clearly demonstrate the HIV epidemic among Canada's Aboriginal community is continuing to grow at an alarming rate. In fact, "each day one more Aboriginal person becomes infected with HIV" (CAAN, 2002). It is against this backdrop that in recent years, particularly under the Aboriginal Research

Program (Canadian Strategy on HIV/AIDS) and the Canadian Institutes of Health Research (Aboriginal Peoples Institutes and other Institutes), that there has been a notable increase in the scientific examination of the HIV epidemic as it impacts the Aboriginal community. However, there has not been a notable or similar increase in the number of research studies that present findings in academic journals (and electronic-based journals) or presentations at HIV/AIDS academic conferences by Aboriginal community-based researchers. For these reasons, and based on our review of the literature and of existing resources, CAAN (in collaboration with identified partners) has developed this proposal for dissemination funding under the Aboriginal Research Program (Health Canada, Canadian Strategy on HIV/AIDS) to assist members to share the findings of their research studies. The overall goal of this proposed project is to enhance dissemination of Aboriginal community-based HIV/AIDS research using a variety of methods. As such, this plan has five objectives. 1. To establish an Aboriginal community-based HIV/AIDS research journal. Produced on an annual basis, this peer-reviewed journal will provide opportunities to researchers in Aboriginal HIV/AIDS community-based research to (paper-format) publish their findings for broader dissemination. 2. To promote an electronic presence (using existing resources) of Aboriginal community-based HIV/AIDS research (based on the paper-format academic research journal). 3. To provide technical assistance to groups and individuals who conduct Aboriginal HIV/AIDS research to develop abstracts, formulate presentations and access scholarship funding assistance to present findings at various conferences including, but limited to, the Canadian Association of HIV/AIDS Research and at International AIDS Conferences, etc. 4. To address sustainability issues, beyond this initial funding request, as they relate to the research (paper-format) journal. 5. To evaluate and assess the impact of this enhanced dissemination plan.

Dates: April 2004 - March 2006

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Operating Grant (Aboriginal Stream)

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=580>

Project R18:

Title: *Ethical considerations in Aboriginal HIV/AIDS research: An Aboriginal CBR capacity building workshop*

Principal investigator: Kevin J Barlow

Abstract: The proposed workshop will provide training related to both ethical considerations and navigating the formal ethics review process when conducting Aboriginal community-based HIV/AIDS research. Training will offer practical applications of Aboriginal and Indigenous research principles identified in a growing body of literature emphasizing a 'new' Aboriginal-defined approach to research. Furthermore, in CAAN's role as a leader in Aboriginal Community-based HIV/AIDS research, we are continuing to operate in a proactive manner offering training that will be of value for our membership and academic partners as the field of researchers expands. This workshop will specifically provide participants with guidelines beyond the protection of individual 'subjects' to an equal focus on doing good for the community. This one-day intensive workshop will take place in conjunction with CAAN's annual general meeting and skills-building forum. Invited participants will have basic knowledge in community-based research and may be involved in or considering developing their own research initiatives where ethical considerations are paramount. The workshop will therefore be designed to meet the needs of community members, including interested academic partners.

Dates: March 2008 to March 2009

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Capacity-Building Workshop (Aboriginal Stream)

Source: CIHR database

Project R19 :

Title: *Expérience de maternité et traitements antirétroviraux parmi des femmes vivant avec le VIH/sida d'origine autochtone, Haïtienne, Africaine et québécoise [experience of motherhood and antiretroviral treatment among Aboriginal, Haitian, African and Quebec women living with HIV/AIDS]*

Principal investigator: Isabelle Toupin, Université du Québec à Montréal (UQAM)

Co-investigators: Joanne Otis; Mylène Fernet

Abstract: In Canada, and particularly in Quebec, so far, there have been few studies on representations of anti-retroviral therapies for HIV and their impact on the daily lives of women living with HIV. There have been even fewer studies on African, Haitian and Aboriginal women in a migration environment (Gallant, 2000; Lévy et al., 2000; Rogers et al., 2000; Sendi et al., 1999). Little consideration has been given to the experience of motherhood, which appears to be central in establishing a relationship to living with HIV, adhering to treatment and ensuring secondary prevention. There are few studies on understanding the experiences of women living with HIV/AIDS and receiving antiretroviral treatment, especially how they relate to their children (desire for children, pregnancy, childbirth, motherhood, mother-to-child transmission). This study will contribute to the advancement of knowledge, which is currently limited. Once the study is completed, we can identify strategies for secondary prevention of HIV/AIDS. We can also better understand the issues involved in adhering to antiretroviral treatment in the ethnic and cultural milieus targeted by the project.

Dates: September 2006 - August 2009

Funding Program: CIHR Doctoral Research Award in the Area of Health Services/Population Health HIV/AIDS Research

Source: <http://www.hivresearch.ca/index.asp?navid=17&csid1=1855>

Project R20:

Title: *Exploring HIV and hepatitis C related vulnerability among young drug users in British Columbia: A multi-disciplinary perspective*

Principal investigator: Patricia M. Spittal

Abstract: HIV infection is spreading among Canada's Aboriginal people. Although Aboriginal people make up only 4% of BC's population, they comprise more than 13% of all new HIV diagnoses in BC, and half of all babies infected with HIV in the province. One of the major ways in which HIV is spreading among Aboriginal people is by use of injection drugs such as cocaine and heroin. One recent study in Vancouver showed that Aboriginal people who injected drugs were getting HIV more than twice as fast as non-Aboriginal drug users. Aboriginal women

seem to be at even higher risk. Moreover, Hepatitis C infection is spreading even more rapidly than HIV among Aboriginal people through the same route of transmission. This study will involve large numbers of young Aboriginal people (aged 14 to 30) who use drugs in Vancouver and Prince George. The study will use the scientific methods of both epidemiology and anthropology to understand the complex reasons underlying the increased vulnerability to HIV and Hepatitis C among young Aboriginal injection drug users. Only when we collectively understand why this happens, can urban, rural and reserve Aboriginal communities design and implement interventions that can stop and reverse these terrible epidemics.

Dates: July 2005 – June 2010

Funding Program: CIHR New Investigator Award in the Area of Gender and Health Research

Source: CIHR database

Project R21

Title: *Factors influencing condom use among Aboriginal youth*

Principal investigator: Karen Maria Devries, London School of Hygiene and Tropical Medicine

Co-investigators: Caroline Free, London School of Hygiene and Tropical Medicine

Abstract: Aboriginal youth in Canada suffer from higher rates of sexually transmitted infections, including HIV/AIDS, than the rest of the population. One effective way to lower individual risk of contracting STIs is use of the male condom. In order to effectively promote condom use, factors which influence condom use among diverse ethnic groups must be identified. My systematic review of existing research indicates that condom use models generally are less applicable to ethnic minority youth and that studies of condom use among Aboriginal people are mostly of poor quality and test few potentially predictive factors. The purpose of my remaining PhD research is to identify important predictors of condom use among Aboriginal youth. Data from a large health survey will be analyzed to determine which factors are predictive of condom use among Aboriginal youth. Interviews with Aboriginal youth will be conducted to further examine the contexts in which condom use does and does not

occur. The findings of these studies will be useful to researchers, service providers and policy makers, in the development of appropriate condom promotion programs in Aboriginal groups.

Dates: April 2005 - November 2006

Funding Program: CIHR Doctoral Research Award in the Area of Health Services/Population Health HIV/AIDS Research

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=474>

Project R22:

Title: *Factors in service provision that promote well-being for Aboriginal peoples living with HIV/AIDS who report substance use: A research capacity building exercise*

Principal investigator: J. K. Barlow, CAAN

Abstract: This participatory development proposal focuses on alcohol use, the growing rate of HIV infection in Aboriginal communities and a possible negative impact on access to treatment. This is a logical extension of CAAN's research capacity-building program and strategic approach to addressing HIV/AIDS in Aboriginal communities. Building on the results of CAAN's recently completed participatory action research study; this development project would provide the opportunity to further explore an emerging issue that may lead to addressing gaps in knowledge specific to alcohol use and Aboriginal peoples in the context of HIV/AIDS. Grounded in a partnership between CAAN, members of the Aboriginal community and social science researchers the development project would facilitate learning together in a process governed by the principles of OCAP. The rationale driving this CBR capacity-building project is that by addressing the disproportional effects of HIV in Aboriginal communities, a project involving community partners in research capacity building exercises may lead to increased research competence and knowledge production contributing to a solid evidence-base for policy and program development.

Dates: April 2006 - March 2007

Funder: CIHR HIV/AIDS Community-Based Research Program – Catalyst Grant (Aboriginal Stream)

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=1789>

Project R23:

Title: *A gathering of support: Developing an Aboriginal grassroots research network on HIV/AIDS*

Principal investigator: Margaret L. Akan; Carrie Anne Bourassa

Co-investigators: Roxanne Boekelder; Mary Rucklos Hampton; Ron Scott Horsefall; Randy Jackson; Kim McKay-McNabb

Abstract: All Nations Hope AIDS Network is the only Aboriginal AIDS Service Organization in the province of Saskatchewan; yet, Saskatchewan has one of the highest urban Aboriginal populations in Canada. Within this urban Aboriginal population rates of HIV/AIDS are significant, 48.9% of positive HIV test reports in 2004-2005 are of Aboriginal ancestry (Saskatchewan Health, 2005). Some research has been done to identify the population size and demographics of this group, but no long-term, comprehensive studies have been undertaken at this time. Further, this data does not offer guidance in terms of programming and outreach, and also does not highlight, explore, or speculate on the relationships between substance use and HIV/AIDS. Given the incidence and prevalence of substance use within the province, an informal network has been working collaboratively to determine how it might best unite efforts to address local issues. This group is interested in moving forward with a community-based research approach to more closely examine Aboriginal peoples' experiences with substance use and HIV/AIDS in Saskatchewan. Presently, there are some informal networks that include members from academic institutions, health service providers, AIDS service organizations, and APHAs. Currently, it seems appropriate to attempt to bring these informal networks together to determine if it is possible to formalize partnerships and begin working toward establishing a research direction and approach to explore and identify better ways of addressing the issues. However, at this time, no formal partnerships or commitments have been established and, therefore, the purpose of this development application is to facilitate the establishment of the formal partnerships necessary to develop a community-based research project, which addresses community-identified needs as they relate to Aboriginal people, substance use, and HIV/AIDS.

Dates: April 2008 – March 2009

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Catalyst Grant (Aboriginal Stream)

Source: CIHR database

Project R24:

Title: *HIV and hepatitis C transmission networks in a cohort of injection drug users in Vancouver's downtown eastside: How structure and context matter*

Principal investigator: Sheila P. McCarthy, University of British Columbia

Co-investigator: David M. Patrick, BC Centre for Disease Control

Abstract: Our research plans are to map and analyze the spread of HIV and hepatitis C virus in injection drug users from Vancouver's poorest neighbourhood. Mapping the spread of the viruses is accomplished through DNA fingerprinting, which identifies similar and matching viral strains from blood samples. Similar and matching strains link individuals in networks that are then analyzed for common characteristics, such as age, sex, race/ethnicity, as well as risk behaviours (e.g., needle sharing, sex trade work) and shared hangouts (e.g., bars, hotels, shelters). We expect to find that injection drug users have formed networks with similar others through which common infections are spread. This finding may help explain, for example, why Aboriginal race/ethnicity is a significant predictor of HIV even when other risk behaviours are ignored. Additionally, we expect to uncover complex interconnections through shared hangouts. In other words, we expect that certain hangouts draw similar people, facilitate introductions, leading to syringe-sharing and unprotected sexual activity which spread disease. Our goal is to provide information that helps to (1) predict future spread of HIV and hepatitis C within and between networks, for example, by monitoring the size, activities, and contexts (e.g., hangouts) of, as well as connections between, networks involved in injection drug use; (2) tailor intervention and prevention strategies that counteract the negative effects of network relationships and contexts (e.g., hangouts), for example, by influencing key members or placing peer leaders in networks to encourage and support risk-reduction behaviours; and (3) direct funds and other

resources to those groups, be they street youth, women, and/or Aboriginal persons, disproportionately affected by the spread of disease, for example, by offering screening, treatment, counselling, and other supportive services to improve health and well-being.

Dates: September 2005 – August 2008

Funding Program: CIHR Doctoral Research Award in the Area of Health Services/Population Health HIV/AIDS Research

Source: CIHR database

Project R25:

Title: *HIV prevention in Canada: A meta-ethnographic synthesis of current knowledge*

Principal Investigators: Jacqueline Gahagan; Randy Jackson

Co-investigators: Barry Adam; Margaret Dykema; Judith Mill; Tracey Prentice

Abstract: Over the last 25 years Canadian researchers, policy makers, and non-governmental organizations have made significant strides developing our understanding and responding to the impact of HIV/AIDS, particularly through qualitative research efforts. Yet, there has been a lack of attention to integrating findings into a cohesive synthesis. This has important implications for future knowledge, development needs and for the utilization of qualitative research in HIV prevention practices and policy development. This research synthesis grant proposal was developed with a goal to systematically review the published qualitative evidence focused on HIV prevention health systems and to compare experiences across select populations. To support evidence-informed decision-making in three broad areas, the objectives of this proposal are: 1) to comparatively assess qualitative understanding of (a) HIV prevention for specified groups affected by HIV/AIDS in Canada and (b) where specific knowledge of prevention needs may be lacking; 2) to provide useful information and recommendations where research findings may not be well integrated into work undertaken at a federal/provincial policy level or at the local practice implementation level by providing information related to the effectiveness of prevention initiatives; and 3) to improve effectiveness and efficiency

of the research response with respect to research areas and researcher roles. To accomplish the goal and objectives, research team members are proposing a participatory meta-ethnographic method to guide a structured systematic review of findings that will include an initial scoping exercise to select appropriate literature, conducting a quality appraisal of relevant studies for inclusion in a synthesis of HIV prevention research, and a main interpretive review guided by a meta-ethnographic approach informed by both a gender-based and Indigenous research perspectives.

Dates: February 2008 - January 2009

Funding Program: CIHR Knowledge Synthesis Grant

Source: CIHR database

Project R26:

Title: *HIV risk behaviours and barriers to prevention and treatment among Aboriginal women engaged in survival sex work*

Principal investigator: Kate Shannon, BC Centre for Excellence in HIV/AIDS

Co-investigators: Mark Tyndall, University of British Columbia

Abstract: Women engaged in survival sex work in Vancouver's Downtown Eastside (DTES) are particularly marginalized and face multiple vulnerabilities including violence, predation, and increased likelihood of engaging in high-risk sexual and drug-related harms. In addition, the illegal and clandestine nature of sex trade work in Canadian cities increasingly renders street-entrenched women to the outskirts of society, limiting their access and uptake of supportive health services. While Aboriginal people represent approximately 4-5% of the total population of British Columbia, women of Aboriginal ancestry account for over 50% of survival sex workers in the DTES. The proposed research, through a cyclical process of community consultation and active peer participation, will explore the dynamics of HIV risk behaviours among women sex workers; barriers to HIV prevention and treatment unique to Aboriginal women; and inform the development of an HIV prevention and care model. Given the historically oppressive nature of research in this population, a collaborative and participatory research

approach through an urban drop-in centre will be highly valuable in providing women sex workers a true voice in HIV prevention and care. The social context of these women's lives present multiple barriers that place them at high risk for HIV transmission, including power dynamics of pimps, dates, and intimate partners in safe sex negotiation, the cycle of addiction and survival sex, ongoing violence and sexual assault, entrenched poverty and high levels of mobility between rural reserves and the DTES. Using social mapping, focus group discussions, and structured interviews, this study will explore HIV risk behaviours and obstacles through the key themes of mobility, violence and addiction. The participatory approach engaging peers at all levels will provide capacity building, as well as foster community ownership and leadership in this research.

Dates: September 2005 - August 2008

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Doctoral Research Award (Aboriginal Stream)

Source: <http://www.hivresearch.ca/index.asp?navid=17&csid1=828>

Project R27:

Title: *HIV/AIDS community-based research program research technical assistants (eastern Canada)*

Principal Investigators: Randy Jackson

Co-investigators: Kevin Barlow

Abstract: CAAN is developing this proposal as part of its strategic approach to address recommendations from *The Community Based HIV/AIDS Research Environmental Scan: Final Report* (2002). In 2002, CAAN undertook this environmental scan, an initial step in developing community-based research capacity. The following are the strategy's goals: to provide support for the development of research skills within Aboriginal communities; to promote understanding among professional researchers working in Aboriginal communities; and to design HIV/AIDS research that is methodologically sound, culturally appropriate, respectful and relevant. The proposed Research Technical Assistant for Eastern Canada, including Labrador and Nunavut, would address these goals.

Dates: April 2005 - March 2007

Funding Program: CIHR Community-Based Research Program – Community-Based Research Facilitators (Aboriginal Stream)

Source: CIHR database

Project R28:

Title: *HIV/AIDS community-based research program research technical assistant (western Canada)*

Principal Investigators: Randy Jackson; Kevin Barlow

Abstract: CAAN has developed this proposal as part of its strategic approach to address recommendations from *The Community Based HIV/AIDS Research Environmental Scan: Final Report* (2002). In 2002, CAAN undertook this environmental scan, an initial step in developing community-based research capacity. The following are the strategy's goals: to provide support for the development of research skills within Aboriginal communities; to promote understanding among professional researchers working in Aboriginal communities; and to design HIV/AIDS research that is methodologically sound, culturally appropriate, respectful and relevant. The proposed Research Technical Assistant who would be responsible for Western Canada, the Yukon and Northwest Territories would address these goals.

Dates: April 2005 - March 2007

Funding Program: CIHR Community-Based Research Program – Community-Based Research Facilitators (Aboriginal Stream)

Source: CIHR database

Project R29:

Title: *HIV/AIDS, maternal health and motherhood: Health-related behaviours, programming implications and narrative constructions*

Principal investigator: Pamela J. Downe

Co-investigator: Sylvia Abonyi, Karen Lawson, Jennifer Poudrier

Abstract: This three-year, community-based research will identify and analyze the interrelationship between women's experiences with motherhood and Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). In 2006 AIDS Saskatoon identified mothers

as a significant and growing constituency among those who access their services but for whom no programs were specifically designed. Twenty-one months of community-based collaboration with 17 organizations and university researchers led to the development of three research objectives: (1) To identify the interrelationship between motherhood and HIV/AIDS; (2) To assess how motherhood affects health-related behaviours of women accessing the services of AIDS Saskatoon; (3) To determine and build capacity to enhance the HIV/AIDS-related services that are identified positively by research participants. Adopting a narrative-based approach, this research is participatory in design and will be guided by AIDS Saskatoon and a 14-member Community Advisory Committee. This project will involve the participation of Aboriginal and non-Aboriginal women who identify as mothers in two sets of interviews, a photovoice project, a two-phase programming analysis, and focus groups. Given that the increasing rates of HIV/AIDS among women are occurring primarily in those of childbearing age and that fewer than 4% of the organizations registered with the Canadian AIDS Society offer maternal health programs, this research will have far-reaching significance for the health and well-being of Aboriginal and non-Aboriginal women who have children and who are living with, affected by, and/or vulnerable to, HIV/AIDS.

Dates: April 2008 to March 2011

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Operating Grant (General Stream)

Source: CIHR database

Project R30:

Title: *Implementation of a community-based approach to HIV/AIDS prevention in an Aboriginal community*

Principal investigator: Melanie Dawn Ross, University of Victoria

Co-investigators: Lisa M. Mitchell, University of Victoria

Abstract: not available

Dates: September 2005 - August 2007

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Master's Award (Aboriginal Stream)

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=796>

Project R31:

Title: *Investigating barriers to prevention and willingness to participate in a behavioural intervention to reduce HIV and Hepatitis C risk behaviours among high risk youth*

Principal investigator: Caroline L. Miller

Co-investigators: Charles J. Frankish

Abstract: My MSc thesis, to be conferred in November 2002, investigated the prevalence and incidence of HIV and Hepatitis C among young injection drug users.

The results were high prevalence and exceedingly high incidence rates for both viruses. Those at highest risk were female and Aboriginal youth engaged in both drug- and sex-related risks. Prevention of these viruses requires a response that incorporates drug and sexual vulnerabilities, that is gender and culturally appropriate and one that is developed in collaboration with the community, youth and Aboriginal peoples. The current proposed PHD seeks to build on this knowledge and to first, conduct a research project with drug dependent youth and community members to investigate the barriers to accessing current prevention modalities such as clean needles and condoms and second to investigate the willingness of the youth to participate in a behavioural intervention to reduce HIV and Hepatitis C risk behaviours. This research will inform policy around current and future directions for HIV and Hepatitis C prevention measures. The information gained can inform the development of interventions for drug dependent youth. Finally, the goal of the research is for immediate effects around educating and empowering youth to care for their health and that of their peers.

Dates: April 2003 – March 2006

Funding Program: Frederick Banting and Charles Best Canada Graduate Scholarships – Doctoral Award (CIHR)

Source: CIHR database

Project R32:

Title: *Life experiences of Aboriginal families living with HIV/AIDS: A qualitative inquiry*

Principal investigator: Kim McKay-McNabb, University of Regina

Co-investigators: Mary Rucklos Hampton, University of Regina

Abstract: HIV/AIDS has been described as an epidemic in our Aboriginal communities and we must focus on our communities to start our healing journey. *Life Experiences of Aboriginal Families and HIV/AIDS: A Qualitative Inquiry* has been guided by my motivation to assist creating a better understanding of HIV/AIDS within our Aboriginal communities. The proposed research will build on my years of experience as a First Nations researcher working with the community to address the needs of Aboriginal families living with HIV/AIDS. In Aboriginal communities, it is common for the family constellation to be composed of immediate, extended and adopted family members and that concept of families will be used in the study. Conducting research with Aboriginal families and HIV/AIDS is a sensitive topic that requires establishing relationships of trust with Aboriginal families. The proposed qualitative study will use grounded theory methods to analyze in-depth interviews with Aboriginal families living with HIV/AIDS. Results will enhance our understanding of culturally specific health care needs of Aboriginal families. The goal of this research is to contribute to our limited knowledge of appropriate prevention of this growing epidemic. My collaboration with local, provincial and national Aboriginal AIDS networks will ensure utilization of my findings.

Dates: September 2005 - August 2008

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Doctoral Research Award (Aboriginal Stream)

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=685>

Project R33:

Title: *The lived experiences of health and well-being among Aboriginal people living HIV/AIDS: Beyond a deficiency model*

Principal investigator: Tracey Prentice, University of Ottawa

Co-investigators: Carol A. Amaratung; Denise Spitzer; Randy Jackson, CAAN

Abstract: In partnership with CAAN and its member organizations, this community-based participatory research (CBPR) project will focus on the 'health' of APHAs. The study responds to published commentaries from Indigenous/Aboriginal researchers and CAAN research with Aboriginal women that highlights the need for stories and images of health and wellness among APHAs. The predominance of the 'deficit model' and the focus on pathogenesis (the origins of illness) in Aboriginal HIV/AIDS research has created an overall picture of suffering, disease, and dysfunction in Aboriginal and APHA communities that is neither a true or complete representation of the APHA experience. Such representations are misleading, disempowering, and de-motivating. The proposed research seeks to counterbalance the above by exploring the lived experience of health and well-being among APHAs through community-led focus groups and participant observation at formal and informal gatherings of APHAs. The specific research questions this project will address are: (1) how do APHAs understand and experience health and wellness in the context of living with HIV/AIDS? (2) What factors contribute to health and wellness among APHAs? (3) What role, if any, does culture play in the way APHAs understand and experience health and wellness? (4) What role, if any, does sex and/or gender play in the way APHAs understand and experience health and wellness? Consistent with principles of CBPR and ownership, control, access and possession (OCAP), community-led focus groups will provide opportunities for capacity building and facilitate community ownership and leadership in this research. In addition, partnering with CAAN and its member groups at local and provincial levels will ensure that findings from this research are fully utilized and contribute to the development of more responsive and culturally appropriate supports and services.

Dates: September 2007 – August 2010

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Doctoral Research Award (Aboriginal Stream)

Source: CIHR database

Project R34:

Title: *Mental health and wellness among Aboriginal people living with HIV/AIDS*

Principal investigator: Roy Cain, McMaster University

Co-investigators: Randy Jackson, CAAN; Kevin J. Barlow, CAAN; Judith Ellen Mill, University of Alberta; Evan Collins, AIDS 2006 Toronto

Abstract: This project will examine depression among Aboriginal men and women living with HIV (APHAs), an area of inquiry that has received very little research attention. Mental health concerns were recently identified as a priority concern of the membership of CAAN. Our research team has conducted preliminary research that identifies depression as a particularly important concern of APHAs. Our initial work suggests that depression relates to the ongoing stigmatization of HIV/AIDS, social isolation, lack of knowledge of HIV and its treatment, alcohol and drug use, personal biographies involving abuse and family disruption, medication side effects, and poverty. To examine such issues in greater detail, we propose to conduct 75-85 in-depth semi-structured interviews with APHAs in urban centres across Canada (Vancouver, Regina, Winnipeg, Toronto, Halifax). The study will examine respondents' experiences with depression, what they do about these feelings, and the ways in which their feelings of depression may influence how they manage their health and their HIV infection. By analyzing how the experience of depression among APHAs is influenced by a broad range of social and psychological factors, the project will contribute to the development of more responsive and culturally appropriate supports and services.

Dates: April 2005 - March 2007

Funding Program: CIHR Operating Grant – Urban Health (Community-Based)

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=434>

Project R35:

Title: *Migration patterns and impact of HIV-related risk behaviour among Aboriginal versus non-Aboriginal injection drug users (IDUs): Experiences from the Vancouver Injection Drug Users Study (VIDUS)*

Principal investigator: Beth Stephanie Rachlis, University of British Columbia

Co-investigators: Robert Stephen Hogg, BC Centre for Excellence in HIV/AIDS

Abstract: In Canada, injection drug users (IDUs) are a high-risk group for HIV transmission. Although little is known about the extent HIV/AIDS has had on our Native communities, recent research suggests that Aboriginal populations are overrepresented in the epidemic. Colonization, racism and poverty predispose Aboriginal groups to addiction and substance abuse. In 2002, 53.3% of Aboriginal AIDS cases where exposure was known, were attributed to injection use. Aboriginal IDUs are Canada's fastest growing HIV-infected population. IDUs are a mobile group, travelling easily between towns but drawn to big cities where there is freedom and access to drugs. Studies outside Canada indicate a link between migration and HIV transmission, particularly among IDUs and sex workers. The Vancouver Injection Drug Users Study (VIDUS) was initiated in 1996 and monitors HIV transmission among the 1400 IDUs enrolled. Aboriginals make up 25% of this cohort. Using this population, this research seeks to map migration patterns among Aboriginal and non-Aboriginal IDUs to determine if there is an association between travel and changes in risk behaviour. If there is a link, viral spread through mobile IDUs could penetrate smaller communities, including Native reserves. These areas have been previously unaffected by HIV and lack key resources needed to intervene and respond to the epidemic.

Dates: September 2005 - August 2006

Funding Program: CIHR Institute of Infection and Immunity Master's Award

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=776>

Project R36:

Title: *A national Aboriginal health training initiative at the University of Alberta*

Principal Investigator: Malcolm King

Co-investigators: Brenda L Cameron; Lynden Crowshoe; Nancy L Gibson; Ann C Macaulay; Kim D Raine; Ellen L Toth; Cora J Voyageur; Dennis A Wardman; Cornelia G Wieman; Jose G Zayas

Abstract: Not Available

Dates: October 2001 - September 2007

Funding Program: CIHR Aboriginal Capacity and Developmental Research Environments (ACADRE) Grant

Source: CIHR database

Project R37:

Title: *A national Aboriginal persons living with HIV/AIDS (APHA) housing strategy: Development of team infrastructure, approach, and capacity building*

Principal investigator: Kevin J Barlow, Sean B Rourke

Co-investigators: Margaret L Akan; Kenneth Clement; Monique Yvette Fong; Saara Greene; Charlotte Jayne Loppie; Laverne E Monette; Tracey Prentice; Ruthann Tucker; Catherine Anne Worthington

Abstract: CAAN and the Ontario HIV Treatment Network (OTHN) proposing a participatory development grant process that adopts a mixed methods research approach focused on housing needs among Aboriginal communities in Canada. The goals of the project include: (1) Further develop team infrastructure and approach through research to build on the seminal work in HIV housing and health in Ontario; and (2) Working in tandem with the Aboriginal Research Technical Program, to provide support for the development of research skill within Aboriginal communities. Specific objectives under these goals include: (1) Connect with provincial/territorial Aboriginal HIV networks to increase awareness and capacity to address the link between housing and health for Aboriginal people living with, and at risk of, HIV infection; and (2) Identify and work with academic researchers to develop culturally appropriate research that explores HIV and housing situations that improves access to the most appropriate support services; and (3) Develop a grant application were findings promote effective, appropriate housing programs, and directions that reflect the diverse needs of the Aboriginal HIV/AIDS community in Canada. Team members will be trained in research methodology and participate in activities that promote cultural competence in research.

Dates: March 2008 to March 2009

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Catalyst Grant (Aboriginal Stream)

Source: CIHR database

Project R38:

Title: *The patterns of use and outcomes of highly active anti-retroviral therapy (HAART) among AIDS patients treated by the northern Alberta HIV program*

Principal investigator: Leah J. Martin, University of Alberta

Co-investigators: Leslie D. Saunders; Stan C. Houston

Abstract: The recent introduction and use of an HIV/AIDS drug therapy combination, called HAART, has resulted in reduced AIDS-related morbidity and mortality [Hogg et al. CMAJ 1999;160:659-65]. However, we know little about the effectiveness of HAART among inner-city AIDS patients in North America. In Northern Alberta, all persons diagnosed HIV+ are referred to the Northern Alberta HIV Program (NAHIVP) for treatment; most of these patients are inner-city residents who deal with numerous social issues in addition to their illness. The purpose of our research is to learn more about the combinations of HAART drugs that NAHIVP patients are prescribed, and to evaluate the effectiveness of their therapies, especially in terms of patient quality of life. Improving our understanding about which HAART drug combinations are associated with the most successful outcomes will help physicians to prescribe more effective treatments. We expect that more effective treatments will improve the quality of life for the vulnerable AIDS population in Northern Alberta.

Dates: April 2005 – March 2008

Funding Program: CIHR Doctoral Research Aware in the Area of Health Services/Population Health HIV/AIDS Research

Source: CIHR database

Project R39:

Title: *A prospective study to explore the impact of housing support and homelessness on the health outcomes of people living with HIV/AIDS in Ontario*

Principal investigator: Saara Greene; Ruthann Tucker

Co-investigator: Steve Byers; James Roland Dunn; C. Dale Guenter; Stephen Wesley Hwang; Jay Koornstra; Laverne E. Monette; Lea April Narciso; Sean B Rourke; Michael Sobota

Abstract: Security and quality of housing are important determinants of health, although its impact remain poorly understood. There is little information about the housing status of people living with HIV/AIDS (PHAs) in Ontario; about the housing-related supports that are required by PHAs to ensure safety, health and dignity; and the effect of housing situation on health and on health and social service utilization. We propose to expand and enhance the work of a two-year study (start Apr. 2005) that explores the housing status and issues for PHAs, to achieve the following main objectives: 1) understand factors that affect housing status of PHAs; 2) understand quality of housing, level of housing security, and related supports that impact on the mental and physical health of PHAs; 3) understand how these factors impact the access to and utilization of health and social services; and 4) highlight similarities and differences between particular groups of PHAs including Aboriginals, ethnic minorities, women, sexual minorities, youth, and ex-prisoners regarding their experiences of housing and homelessness. Our overarching hypothesis is that good housing quality and security are important factors contributing to the mental and physical health of PHAs, and to their access to health and social services. We also hypothesize that good quality and security of housing decrease unnecessary health and social service utilization, and results in cost savings. Finally, we hypothesize that there are risk factors, including demographic characteristics and health status, that play a role in the housing and homelessness of PHAs. We will collect both qualitative and quantitative data in a longitudinal, province-wide study design in which PHAs will be followed for up to three years. Changes in housing status will be observed, along with factors that play a role in these changes, and outcomes resulting from these changes.

Dates: April 2005 to March 2008

Funder: CIHR HIV/AIDS Community-Based Research Program – Operating Grant (General Stream)

Source: CIHR database

Project R40:

Title: *Qualitative data analysis: Aboriginal CBR capacity-building workshop*

Principal investigator: Randy Jackson, CAAN

Co-investigators: J. Kevin Barlow, CAAN

Abstract: CAAN has proposed to train community-based researchers in qualitative data analysis using N6 and Atlas TI. Given the increasing numbers of Aboriginal people with HIV/AIDS and the relatively few number of Aboriginal researchers, training in research is needed. In CAAN's *Community Based HIV/AIDS Research Environmental Scan: Final Report* (2002), this national coalition of Aboriginal groups that addresses HIV/AIDS identified enhancing the direct research experience of Aboriginal community-based research as a priority. In keeping with Aboriginal oral traditions, data is often collected using semi-structured interviews making training in N6 and Atlas II necessary for Aboriginal researchers in today's technology-driven world. The two-day workshop for 15 to 20 participants would take place in October 2005 in conjunction with CAAN's annual general meeting in Regina, Saskatchewan.

Dates: March 2005 - March 2006

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Capacity-Building Workshop (Aboriginal Stream)

Source: <http://www.hivresearch.ca/index.asp?navid=18&cscid=582>

Project R41:

Title: *Researching back to life: Supporting an Aboriginal response to HIV/AIDS through community-based research*

Principal investigator: Randy Jackson, CAAN

Abstract: not available

Dates: April 2007 to March 2008

Funder: OHTN

Source: <http://www.hivresearch.ca/index.asp?navid=17&cscid=2293>

Project R42:

Title: *The role of resiliency in responding to blood borne viral and sexually transmitted infections in Indigenous communities*

Principal investigator: Neil Andersson, CIET Canada
Co-investigators: Chris P. Archibald, Surveillance and Risk Assessment Division Public Health Agency of Canada (SRAD-PHAC); Clive Aspin; Rachel Atkinson; J.K. Barlow; John Daniels; Vanessa Davies; Nigel Dickson; Sandra Eades; Andrew Grulich; Randy Jackson, CAAN; Rhys Jones; John Kaldor; Chris Lawrence; Lisa Maher; Kathryn Panaretto; Garrett Prestage; Mihi Ratima; Beverley J. Shea; Maurice Shipp

Abstract: not available

Dates: July 2005 – June 2010

Funding Program: CIHR International Collaborative Indigenous Health Research Partnership Grant on Resilience

Source: CIHR database

Project R43:

Title: *Sexual violence, HIV/AIDS and Aboriginal women*

Principal investigator: J Kevin Barlow, CAAN; Charlotte J. Loppie

Co-investigators: Gail Valaskakis; Cornelia Wieman

Abstract: Using a combined visual/in-depth interview methodology, CAAN will focus attention on the issue of sexual violence in the context of HIV/AIDS service provision. This exploration will ask the following research questions: (1) How do women represent and then interpret the impact of sexual violence on their lives in the context of HIV/AIDS through visual means? Visual methodology is a unique approach to research often used to explore difficult concepts that people may be unable to verbalize. (2) How does gender, culture and HIV/AIDS status manifest itself for Aboriginal women when accessing services? (3) What cultural tools or methods are being utilized by Aboriginal women living with HIV/AIDS to manage their health? (4) What policy/program implications arise when considering issues of sexual violence, gender, culture and HIV/AIDS?

Dates: April 2006 - March 2009

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Operating Grant (Aboriginal Stream)

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=1790>

Project R44:

Title: *Strengthening community-based approaches to HIV/AIDS education, screening, and treatment among Canadian Inuit youth*

Principal investigator: Jeanette Doucet; Jacqueline C Gahagan; Aideen Frances Reynolds; Audrey Steenbeek

Co-investigator: Chris Patrick Archibald; Pitsulala Sarah Lyta

Abstract: This project will begin to explore the complex interplay between culture, youth health, and gender empowerment regarding HIV/AIDS risk within Inuit communities, and determine research priorities for a multi-year study. There is an urgent need for a clearer picture of the dynamics and epidemiology of HIV risk among Inuit in Canada. Current Inuit HIV data tends to get lost among Aboriginal or broader Canadian statistics and under-represents the true situation for Inuit in Canada. This research seeks to contribute to this understanding and hopes to guide the development of sustainable community based participatory options for HIV/AIDS interventions that are sensitive to the challenges of health promotion and health care provision in Northern communities. The project employs a community-based research methodology involving direct participation from Inuit organizations and community members. Moreover, on account of the barriers related to testing in small remote communities (lack of anonymity, stigma and discrimination, lack of access to care upon receipt of a positive test, lack of AIDS Service Organizations in the North), this community-based research methodology provides an important opportunity to build capacity for health care providers and to improve access to education, testing (anonymous testing with pre- and post-test counselling), diagnosis, care, treatment and support.

Dates: April 2007 to March 2008

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Catalyst Grant (Aboriginal Stream)

Source: CIHR database

Project R45:

Title: *A systematic review of evidence linking sexual violence and HIV/AIDS*

Principal investigator: Beverley J Shea

Co-investigator: Neil Andersson; Chris Patrick Archibald; Kevin J Barlow; Candyce Hamel; Ari Ho-Foster; Tara Horvath; Gail Kennedy; Jorge Oscar Laucirica; Jessie McGowan; Deborah Milne; Steven Paul Mitchell; George Anthony Wells

Abstract: Despite the growing knowledge of evidence on HIV/AIDS, very little is known about the relationship between interventions for the prevention of sexual violence and HIV/AIDS. Individuals who are HIV+ report experiencing violence directly attributable to their being sero-positive. To date, there is no published high quality systematic review summarizing this body of knowledge. This project will 1) systematically review and meta-analyze all studies conducted on interventions for the prevention of sexual violence and HIV/AIDS, 2) translate the findings and develop recommendations for their use by integrating decision makers into the review process and 3) develop materials based on the findings for policy making and for front line HIV/AIDS and sexual violence prevention. Research Plan: The title for this review is registered with the Cochrane Review Group on HIV/AIDS of the Cochrane Collaboration. We will follow the methods established by the Cochrane Collaborative Review Group on HIV Infection and provided by Cochrane Collaboration Handbook for Systematic Reviews of Interventions. A protocol for the review will be submitted defining *a priori* the search strategy and data sources, the selection criteria, the methods of analysis. Integrated throughout the research, beginning with formulating the research problem, are decision makers from the Public Health Agency of Canada and CAAN who will help shape the review by providing guidance on the policy relevance, political context of the review, the inclusion criteria, and prioritizing outcomes for analysis; assist with interpreting the findings for use by addressing the strength and the applicability of the evidence, considerations, such as costs and current practice, and clarification of any trade-offs between the expected benefits, harm and cost of intervention; develop and

implement an end-of-grant translation plan to ensure the findings are accessible and useful.

Dates: October 2008 to September 2009

Funding Program: CIHR Knowledge Synthesis Grant

Source: CIHR database

Project R46:

Title: *Taking Action: Using arts-based approaches to developing Aboriginal youth leadership in HIV prevention*

Principal investigator: Sarah Flicker; Randy Jackson

Co-investigator: Jeanette Doucet; June Ann Larkin; Claudia Mitchell; Tracey Prentice; Jean-Paul Resoule; Melanie Mae Rivers

Abstract: Aboriginal youth are overrepresented in the Canadian HIV epidemic. Arts-based approaches to engaging youth in health promotion activism have been effective locally and globally. With this in mind, several community partners and academic researchers have collaboratively developed this research grant application. The goal of this study is to engage Aboriginal youth in HIV prevention leadership using art-based approaches. Specific objectives include: (1) Explore how Aboriginal youth link structural inequalities with individual risk, HIV and Aboriginal culture(s) using art-based methodologies; (2) Investigate the efficacy of art-based methods models of engagement (e.g., hip-hop, video/photographic documentary, popular theatre, music and/or dance, etc.); (3) Build youth capacity to address HIV issues in their local communities; (4) Develop and disseminate community-specific "by youth for youth" HIV prevention and support materials; and (5) Create a national digital repository of "by youth for youth" HIV prevention materials. Embedded and underlying each of these goals and objectives, is respect for the principles of Ownership, Control, Access and Possession (OCAP). The research team will partner with six local communities in different regions of the country to co-sponsor "Taking Action" workshops. These will each have HIV educational and cultural production components where participants will be afforded opportunities to develop projects that unpack the links between structural inequalities, individual HIV risk, and Aboriginal culture(s). Post-workshop, participating youth will be interviewed individually

and asked to reflect on key knowledge gained and how their artistic productions are embedded in structural realities. Interviews and media will be qualitatively analyzed for thematic content. Results will be disseminated in academic and community-accessible formats.

Dates: April 2008 to March 2011

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Operating Grant (Aboriginal Stream)

Source: CIHR database

Project R46:

Title: *Taking Action: Using arts-based approaches to developing Aboriginal youth leadership in HIV prevention*

Principal investigator: Ashley Heaslip

Co-investigator: Sarah Flicker; Suzanne Jackson

Abstract: [This research project is part of a larger project. See abstract above for project description.]

Dates: September 2008 – April 2009

Funder: CIHR Community-Based Research Program – Master's Award (Aboriginal Stream)

Source: CIHR database

Project R47:

Title: *Testing a model of HIV/AIDS prevention in Ontario First Nations communities*

Principal investigator: Basanti Majumdar

Co-investigators: Gina M. Browne; Tracey L. Chambers; Jacqueline Gail Roberts, McMaster University; Amiram Gafni, McMaster University

Abstract: Approximately 17-26% of all new HIV infections in Canada occur in Aboriginal populations, demonstrating a clear need for HIV/AIDS prevention in these communities. Prevention strategies may be directed toward all levels of a community, but in order for them to succeed, interventions need to occur at biological, behavioural and socio-cultural levels. In addition, Aboriginal prevention campaigns need to be sensitive to the unique needs of Aboriginal populations. This project aims to design a research proposal to evaluate a culturally sensitive HIV/AIDS prevention model that was developed in an earlier study by McMaster University and the Union of Ontario Indians (UOI). The UOI HIV/AIDS prevention model represents the relationship between the PHA and their community, and illustrates the

prevention supports and needs of affected communities. The model is circular in nature; the circles of the wheel reflect the cyclical nature of life, a prominent concept in First Nations' philosophy. The four major dimensions of life - emotional, physical, mental, and spiritual - are integrated into the model to demonstrate that HIV/AIDS affects all facets of life. In the project, a core group of participants from select Aboriginal organizations will collaborate to develop a proposal that will test the prevention model, while addressing issues relevant to HIV/AIDS prevention and education in Ontario First Nations communities. Capacity will be built within these organizations to develop independent proposals in areas of concern to their communities, so Aboriginal people can be the leaders of further research efforts to improve the health of First Nations communities in Ontario.

Dates: March 2005 - February 2006

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Catalyst Grant (Aboriginal Stream)

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=672>

Project R48:

Title: *Two-spirit women's experience of homophobia in the context of HIV/AIDS service provision*

Principal investigators: Kevin Barlow, CAAN; Janice L. Ristock

Co-investigators: Shari L. Brotman, McGill University; Laverne E. Monette, Ontario Aboriginal HIV/AIDS Strategy; Joyce G. Seto; Randy Jackson, CAAN

Abstract: Adopting a community-based research design, CAAN is pursuing a qualitative study of two-spirit women's experience of homophobia in the context of HIV/AIDS service provision. This study builds on a recent CAAN survey where trends are highlighted to asking more in-depth research questions: (1) when two-spirit women access care and homophobic discrimination is encountered, how do two-spirit women subjectively experience such situations? How do they understand the intersection between their identities as two-spirit, HIV/AIDS and as women? (2) What is the impact of homophobia and heterosexism in terms of access to HIV/AIDS services? In other words, how do two-spirit women respond and what are the reasons

they provide that guide their decision-making process? (3)
What are the best practice and policy features necessary to mitigate homophobia in service provision from this population's perspective? Underpinning the study, respecting principles of OCAP is essential to maximizing any potential benefit.

Dates: April 2006 – March 2009

Funding Program: CIHR HIV/AIDS Community-Based Research Program – Operating Grant (Aboriginal Stream)

Source: CIHR database

Project R49:

Title: *Understanding and responding to depression among Aboriginal people living with HIV/AIDS*

Principal investigator: Roy Cain, McMaster University

Co-investigators: Evan Collins, AIDS 2006 Toronto; Judith Ellen Mill, University of Alberta; Kevin Barlow, CAAN; Randy Jackson, CAAN

Abstract: not available

Dates: April 2005 - March 2006

Funder: OHTN

Source: <http://www.hivresearch.ca/index.asp?navid=18&csid1=982>

Appendix C

C

1) Population-specific Networks, Coalitions and Advisory Bodies

National

- National Aboriginal Council on HIV/AIDS [www.phac-aspc.gc.ca/aids-sida/fi-if/national-eng.php]
- Canadian Aboriginal AIDS Network [www.caan.ca]
- Canadian Inuit HIV/AIDS Network [www.pauktuutit.ca/hiv/about_us]

British Columbia

- Red Road HIV/AIDS Network [www.red-road.org]
- Renewing Our Response
- Northern Aboriginal HIV/AIDS Task Force

Saskatchewan

- All Nations Hope AIDS Network [www.allnationshope.ca]

Manitoba

- Manitoba First Nations AIDS Working Group [www.mfnawg.ca]

Ontario

- Ontario First Nations HIV/AIDS Education Circle

Quebec

- First Nations and Inuit of Quebec Permanent Committee on HIV and AIDS [www.cssspnql.com/eng/sante/vih-sida.htm]

Atlantic

- Healing Our Nations Atlantic First Nations AIDS Network [www.hon93.ca]
- Atlantic Aboriginal HIV/AIDS Circle

North

- Northwest Territories HIV and Hepatitis C Support Network [www.nwthhsn.ca]

2) Organizations Involved in the Delivery of Programs and Time-Limited Projects (2006-2008) Addressing HIV/AIDS among Aboriginal Populations Residing Off-Reserve

National

Canadian Aboriginal AIDS Network [www.caan.ca]

- **Project A1:** Culturally Appropriate Harm Reduction Program Development: Four Best Practice Approaches to Reducing Harm Associated with Injection Drug Use (and Other Substances) in Aboriginal Communities
- **Project A2:** Fostering Community Leadership to End HIV/AIDS Stigma and Discrimination

Pauktuutit Inuit Women of Canada [www.pauktuutit.ca]

- **Project A3:** Ajjigijaunningittuq: Addressing the HIV Needs of Inuit in Urban Centres

British Columbia

Boys and Girls Club of Williams Lake and District

[www.bgcwilliamslake.com]

- **Project A4:** Reducing Harm – Developing Community Capacity to Prevent the Spread of HIV/AIDS in Williams Lake and Area

Chee Mamuk Aboriginal Program, British Columbia

Centre for Disease Control [<http://www.bccdc.ca/prevention/Cheemamuk/default.htm>]

Columbia-Shuswap HIV/AIDS Resource Project (C-SHARP)

- **Project A5:** Prevention Education

Communicable Disease and Addictions Prevention, BC Ministry of Healthy Living and Sport

[www.gov.bc.ca/hls/index.html]

- **Project A6:** Inventory Project

Dr. Peter AIDS Foundation [www.drpeter.org]

Healing Our Spirit BC Aboriginal HIV/AIDS Society

[\[www.healingourspirit.org\]](http://www.healingourspirit.org)

- **Project A7:** HIV/AIDS Policy Development and Implementation for Aboriginal People Living with HIV/AIDS Offender Transitional Services

Hiiye'yu Lelum (House of Friendship) Society

[\[www.hiiyeyu.shawbiz.ca\]](http://www.hiiyeyu.shawbiz.ca)

- **Project A8:** Kwam Kwum Súli: Strengthening the Spirit

Northern Aboriginal HIV/AIDS Task Force

[\[www.nwtgroup.com/hivtaskforce.html\]](http://www.nwtgroup.com/hivtaskforce.html)

Okanagan Aboriginal AIDS Society [\[www.aaas.ca\]](http://www.aaas.ca)

Pacific AIDS Network Society

[\[www.pacificaidnetwork.org\]](http://www.pacificaidnetwork.org)

- **Project A9:** A Coordinated Community Response to HIV/AIDS in BC

Pacific Community Resources Society [\[www.pcrs.ca\]](http://www.pcrs.ca)

- **Project A10:** Project ID – Fraser East Gay, Two Spirited and Men Who Have Sex with Men Needs Assessment

Positive Living North: No khèyoh t'sih'en t'sehena Society [\[www.positivelivingnorth.ca\]](http://www.positivelivingnorth.ca)

- **Project A11:** The Choice is Yours: Interactive Targeted HIV/AIDS Education
- **Project A12:** The Fire Pit: Fanning the Flames

Positive Living North West Society [\[www.plnw.org\]](http://www.plnw.org)

- **Project A13:** Health Promotion for People Living with, Affected by and At-Risk for HIV and HIV/HCV Co-Infection

Positive Women's Network [\[www.pwn.bc.ca\]](http://www.pwn.bc.ca)

- **Project A14:** Support Program for HIV Positive Women
- **Project A15:** Women's Initiatives for Support and Education (WISE) Project (with YouthCO AIDS Society [\[www.youthco.org\]](http://www.youthco.org))

Red Road HIV/AIDS Network Society [\[www.red-road.org\]](http://www.red-road.org)

- **Project A16:** Bloodlines Magazine

Vancouver Native Health Society [\[www.vnhs.net\]](http://www.vnhs.net)

- **Project A17:** Positive Outlook Program (POP)
- **Project A18:** Towards Aboriginal Health and Healing: Reducing Disparities in HIV Treatment and Care through Community-Based Initiatives

Western Aboriginal Harm Reduction Society

- **Project A19:** From a Whisper to a Song Bridging the Peer Collective Together

Alberta

AIDS Calgary Awareness [\[www.aidscalgary.org\]](http://www.aidscalgary.org)

- **Project A20:** Spirit Helpers Program

Alberta Native Friendship Centres Association

[\[www.anfca.com\]](http://www.anfca.com)

- **Project A21:** Alberta Aboriginal HIV/AIDS Online Resource Centre

Athabasca Native Friendship Centre Society

[\[www.anfca.com/athabasca.html\]](http://www.anfca.com/athabasca.html)

- **Project A22:** Astawinitan (Let's Put It Out) HIV/AIDS Awareness Campaign

Canadian Red Cross Society [\[www.redcross.ca\]](http://www.redcross.ca)

- **Project A23:** Tipi of Courage Phase II
- **Project A24:** Youth Leadership through the Arts

Eastern Métis Settlements

- **Project A25:** Buffalo Lake Métis Settlement Community Needs Assessment
- **Project A26:** Eastern Métis Settlements HIV Cultural Camp

City of Grande Prairie

- **Project A27:** Grande Prairie Youth Wellness Project

HIV Network of Edmonton (HIVE)

[www.hivedmonton.com]

- **Project A28:** Two Spirit Safe Community Project

Kimamow Atoskanow Foundation

[www.treeofcreation.ca]

- **Project A29:** Full Circle

Opokaa’sin Early Intervention Society

[www.opokaasin.org]

- **Project A30:** Knowing Our First Nation Two Spirited Youth

Peavine Métis Settlement

- **Project A31:** Peavine Métis Settlement Community Needs Assessment

Pee Kis Kwe Tan “Let’s Talk” Society

- **Project A32:** HIV: Are We Reaching the Needs of the Wabasca Community

Shining Mountains Living Community Services

[www.shiningmountainslcs.ca]

- **Project A33:** Reducing Barriers

Saskatchewan

All Nations Hope AIDS Network

[www.allnationshope.ca]

- **Project A34:** A Journey of Healing, Aboriginal People Living with HIV/AIDS (APHAs) Joining the Circle, Two Spirit People Joining the Circle

Battlefords Family Health Centre

- **Project A35:** Circle of Change: Reducing Harm

Kikinahk Friendship Centre [www.kikinahk.com]

- **Project A36:** Kikinahk Sexual Health and Drug Use Awareness Program

Play It Safer Network (located in northern Saskatchewan and Manitoba)

[www.playitsafer.ca]

- **Project A37:** Play It Safer Phase II Project

Saskatoon HIV/AIDS Reduction (of harm) Program

(SHARP)–Saskatoon Tribal Council [www.sktc.sk.ca]

Manitoba

Kali Shiva AIDS Services

- **Project A38:** Positive Women’s Program

Ka Ni Kanichihk “Those Who Lead”

[www.kanikanichihk.ca]

- **Project A39:** Aboriginal Women Responding to the AIDS Crisis

Manitoba Health and Healthy Living, Public Health

Division [www.gov.mb.ca/healthyliving]

- **Project A40:** Healthy Sexuality Action Plan
- **Project A41:** STI Public Health Nurses in Corrections

Nine Circles Community Health Centre

[www.ninecircles.ca]

- **Project A42:** An Integrated Community-Based Response to HIV/AIDS

Nine Circles Community Health Centre, Public Health Agency of Canada (PHAC) and Human Resources and Social Development Canada (HRSDC)

- **Project A43:** Horizontal Pilot project for Aboriginal Homeless People Living with HIV/AIDS

Play It Safer Network (located in northern Saskatchewan and Manitoba)

[www.playitsafer.ca]

- **Project A37:** Play It Safer Phase II Project

Ontario

2-Spirited People of the 1st Nations

[www.2spirits.com]

- **Project A44:** 2 Spirits HIV/AIDS Outreach Prevention
- **Project A45:** 2 Spirits Trans Project
- **Project A46:** Services and Projects Development Program

AIDS Bureau, Ontario Ministry of Health and Long-Term Care [www.health.gov.on.ca]

- **Project A47:** Community-Based AIDS Education and Support Program (CBAESP)

AIDS Committee of Guelph and Wellington County [www.aidsguelph.org]

- **Project A48:** Wellington and Grey-Bruce Rural Prevention / Outreach Program

MAGGIE'S The Toronto Prostitutes' Community Project [www.maggiestoronto.com]

- **Project A49:** Aboriginal Sex Worker Outreach and Education Project

Native Child and Family Services of Toronto [www.nativechild.org]

- **Project A50:** Aboriginal AIDS Prevention Outreach project

Native Men's Residence [www.nameres.org]

- **Project A51:** Na-Me-Res/Tumivut Aboriginal Homeless Youth HIV/AIDS Prevention Initiative: Towards an Urban Aboriginal Approach

Ontario Aboriginal HIV/AIDS Strategy [www.oahas.org]

Ontario Federation of Indian Friendship Centres [www.ofifc.org]

- **Project A52:** Awakening the Spirit

Wabano Centre for Aboriginal Health [www.wabano.com]

- **Project A53:** Walking the Healing Path

Quebec

Actions Sida Côte-Nord [www.ascn.qc.ca]

- **Project A54:** Des ACTIONS... le SIDA... la CÔTE-NORD... notre CAUSE! [AIDS Action... North Shore... our cause]
- **Project A55:** Pour une Côte-Nord en santé sexuelle [For sexual health on the North Shore]

Bureau local d'intervention traitant du sida [www.blits.ca]

- **Project A56:** Trajectoire de Vie [Life path]

Bureau régional d'action SIDA [www.lebras.qc.ca]

- **Project A57:** Coordination du volet Éducation à la prévention [Coordination of the Prevention Education component]

Centre Associatif Polyvalent d'Aide Hépatite C [www.capahc.com]

- **Project A58:** Sentinelle bleue [Blue sentry]

Val-d'Or Native Friendship Centre [www.caavd-vdnfc.ca]

- **Project A59:** Projet de lutte au VIH/sida chez les personnes vulnérables de la communauté autochtone de Val-d'Or [HIV/AIDS prevention project aimed at vulnerable persons in the Aboriginal community of Val-d'Or]

Centre des R.O.S.E.S. de l'Abitibi-Témiscamisque [www3.cablevision.qc.ca/centredesroses]

- **Project A60:** Coordonateur (trice) au Soutien des PVVIH/Sida [Support coordinator for persons living with HIV/AIDS]
- **Project A61:** Projet SEXExplorer [SEXploration project]

First Nations of Quebec and Labrador Health and Social Services Commission [www.cssspnql.com]

- **Project A62:** Cercle de partage et sensibilisation [Sharing and awareness circle]
- **Project A63:** Rencontre, partage et réseautage : un organisme, une communauté à découvrir [Meeting, sharing and networking: an organization and a community to discover]

Cree Board of Health and Social Services of James Bay [www.creepublichealth.org]

- **Project A64:** Chî kayeh: A Sexual Health Education Curriculum

Quebec Native Women [www.faq-qnw.org]

- **Project A65:** Les femmes autochtones victimes de violence et Leur santé sexuelle...Vers une prise en charge [Aboriginal women, violence and sexual health... toward empowerment]

Groupe d'entraide à l'intention des Personnes Séropositives et Itinérantes (GEIPSI)

- **Project A66:** Poste de directeur [Director position]

Le Miens (Mouvement d'Information, d'Education et d'eNtraide dans la lutte contre le Sida) [www.lemiens.com]

- **Project A67:** Et si on parlait de santé sexuelle - Structure bénévole en prévention du VIH et des ITSS par les pairs [Let's talk about sexual health – volunteer structure in peer-focused HIV and STBBI prevention]
- **Project A68:** Programme éducation-prévention [Education/prevention program]

Native Women's Shelter of Montreal [www.nwsm.info]

- **Project A69:** Harm Reduction

Regroupement des centres d'amitié autochtones du Québec [www.rcaaq.info]

- **Project A70:** Mobilisons notre support! [Let's mobilize our support!]

Sidaction Trois-Rivières [www.sidaction-troisrivieres.ca]

- **Project A71:** CatWoman Mauricie

Services intégrés de dépistage et de prévention des ITSS [www.csssuroit.qc.ca/services/sidep]

- **Project A72:** Centre d'accès au matériel d'injection [Safe injection centre]
- **Project A73:** Stratégie québécoise de lutte contre les ITSS [Quebec strategy to combat STBBIs]

Atlantic

Healing Our Nations Atlantic First Nations AIDS Network [www.hon93.ca]

- **Project A74:** Finding Our Voices

- **Project A75:** Leading the Response: Building Prevention Capacity
- **Project A76:** The Voices of Our Youth: Youth Leading Youth Through Peer Mentoring

Labrador Friendship Centre [www.lfchvgb.ca]

- **Project A77:** HIV/AIDS Labrador Project

Native Council of Prince Edward Island [www.ncpei.com]

- **Project A78:** Hep'd Up on Life

North

Blood Ties 4 Directions Centre (YT) [www.bloodties.ca]

- **Project A79:** Yukon, Youth Outreach and Volunteer Events Program

Council of Yukon First Nations (YT) [www.cyfn.ca]

- **Project A80:** Bringing the HIV and Hepatitis C Risk Assessment Guidelines to Remote Rural Northern Communities Project

Fort Providence District Education Authority (NWT)

- **Project A81:** Healthy Choices Lead to a Healthy Community

Pauktuutit Inuit Women of Canada [www.pauktuutit.ca]

- **Project A82:** Increasing Sexual Health Capacity and Building Supportive Communities for HIV-Positive Inuit

Status of Women Council of the Northwest Territories (NWT) [www.statusofwomen.nt.ca]

- **Project A83:** Community HIV/AIDS/Hep-C Prevention and Awareness Project

Tlicho Community Services Agency (NWT)

[www.tlicho.ca]

- **Project A84:** Tlicho Community Services Agency Hep C and HIV AIDS Awareness program



