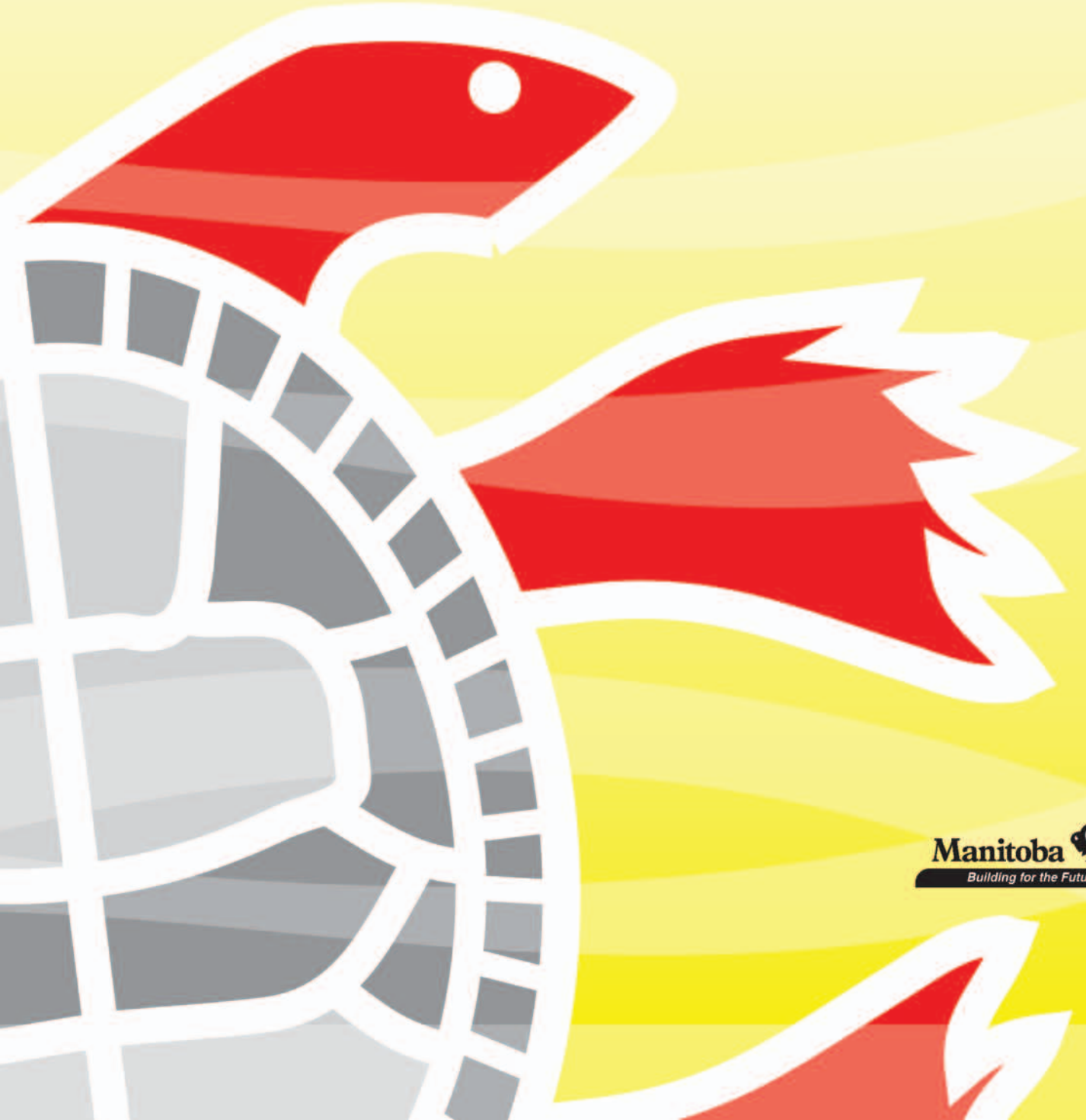
AS LONG AS THE

Waters Flow

An Aboriginal Strategy on HIV/AIDS

A Component of Manitoba's Provincial AIDS Strategy



Manitoba

Building for the Future

As Long as the Waters Flow: An Aboriginal Strategy on HIV/AIDS *draws its title from the many rivers and lakes in Manitoba that have provided Aboriginal people with a means of survival through hunting and fishing. The interconnectedness of these waterways also provided a vital mode of transportation and communication that continues to exist today.*

It recognizes the traditional Aboriginal view that Aboriginal people have a spiritual connection with water, an element that cleanses, purifies and is essential for existence. It is also a metaphor for the role that the blood plays in the human body. An Aboriginal strategy on HIV/AIDS is then a holistic strategy that both addresses the interconnected issues leading to risky behaviour and HIV infection, and also seeks to restore balance. In this sense, the Aboriginal strategy on HIV/AIDS is also part of a broader convergence of two separate healing traditions, as it seeks to find a place for traditional approaches.

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As Long as the Waters Flow *– this statement was made in the negotiations for treaties both in the United States and Canada. The full statement reads, "As long as the sun does shine, the waters do flow and the grass does grow, the treaties will be upheld." The Indigenous negotiators understood that the fire represented the existence of the men of our nations and as long as the sun traveled the sky; that fire acknowledged and taught the men of our nations; as long as the water flows from the women of our nations in the child bearing process there will be a future; and as long as the hair of Mother Earth, the sweet grass grows there will be medicine to take care of our families. According to this understanding, our leaders negotiated that the treaties were to be upheld for this length of time In other words, our people will stand as long as the men of our nations exist in union with the women of our nations to bring forward children and that as the creation family continues, the grass will continue to make us a place for our homes in the nest of the medicines of Mother Earth.*

The teaching and translation of "as long as the waters do flow" holds a truth for Indigenous people about the sacred creation of life. Once, before we were interrupted, the water that flowed from a woman's amniotic sac [membrane that surrounds a baby in the uterus] would announce to the community that a member of the next generation was getting ready to come to this physical world. It was this same water that washed the pathway or birth canal to allow a cleansed entry to this realm. The older women of the community or village handled the water that flowed from the mother carefully in prayer. During the water ceremony, these wise women of the village would look in the water to show them how best this child might be raised and taught. The gifts, talents, and life potential would be revealed and these women would offer guidance for the direction and parenting needed to help the new member of the family best maximize their potential and presence on the earth. In this way, their entrance to the world community from the beginning would be a celebration of honour and truth. (Laramee 2004)

Introduction

This strategy is being released during a time of important change in the history of the HIV/AIDS epidemic. Public education programs have been successful in reducing the incidence of HIV/AIDS infection in the group at highest risk when the epidemic first surfaced in Manitoba, namely gay men. However, rates of infection are increasing in other risk groups. In Manitoba and in Canada, Aboriginal people are over-represented among persons with HIV infections, and this over-representation is growing. As evidence in this document demonstrates, Aboriginal people in Manitoba appear to be 10 times more likely than non-Aboriginal people to contract HIV/AIDS. This fact makes it clear that the HIV/AIDS epidemic has not run its course.

To complicate matters, even as the nature of the epidemic has changed, Canadians have become more complacent about the disease. There is a perception among some that HIV/AIDS can be cured; it cannot. In particular, young people hold a number of misconceptions about HIV/AIDS that place themselves and others at risk. Paradoxically, this complacency exists alongside equally incorrect perceptions about the risks that people with HIV/AIDS present to others, leading to discrimination and isolation (Canadian Strategy on HIV/AIDS, 2003).

The human immunodeficiency virus (HIV) is a viral infection that can be transmitted by both unprotected sexual activity and blood, usually through the sharing of needles and other equipment used for the purposes of injecting drugs or body piercing/tattooing. Acquired immunodeficiency syndrome (AIDS) is a severe disease that represents the late clinical stage of HIV infection. In the absence of anti-retroviral therapies, about 90 per cent of HIV-infected individuals develop AIDS; between 80 and 90 per cent die within three to five years of an AIDS diagnosis. However, the routine use of highly active anti-retroviral therapies (HAART) in Canada has significantly delayed the number of deaths from AIDS (Chin, 2000).

HIV infection is preventable, but only when steps are taken to recognize and address the social and cultural issues in which the illness has become embedded. On its own, the health care system cannot halt this epidemic; nor can any single provincial government. HIV/AIDS does not respect political boundaries, constitutional divisions of power or the distinctions between professional disciplines. HIV/AIDS prevention will require co-ordinated action from a wide range of government, professional and community-based

organizations, each of which must assume a measure of responsibility in responding to HIV/AIDS. Truly effective strategies will emerge from an ongoing dialogue on how to create strong and healthy communities and will extend far beyond the traditional boundaries of medicine and public health.

As Long as the Waters Flow: An Aboriginal Strategy on HIV/AIDS is intended as a timely contribution to this important public dialogue. As a component of Manitoba's provincial AIDS strategy, it provides leadership and direction to key stakeholders – government, the regional health authorities, Manitoba communities and Aboriginal peoples – as they respond to the continuing evolution of HIV/AIDS in the province's Aboriginal communities. The work of a lengthy period of community consultation and research, this report highlights the effects of HIV/AIDS in the Aboriginal community in Manitoba, and the continued threat it presents.

This strategy concludes with a series of guides for action that complement the strategic goals first put forward in the 1996 Manitoba AIDS strategy. These guides for action are based on both the information that emerged during the community consultations and the latest statistical evidence. Manitoba Health encourages all organizations and communities affected by HIV/AIDS to examine these guides for action in light of their capacity, strengths and assessed needs; and where appropriate, to incorporate them into their planning and programming. This is not a one-way street: Manitobans are encouraged to view this document as a benchmark to assess the actions of Manitoba Health as it seeks to meet its responsibilities to address one of the most serious public health issues of our time.

HIV/AIDS

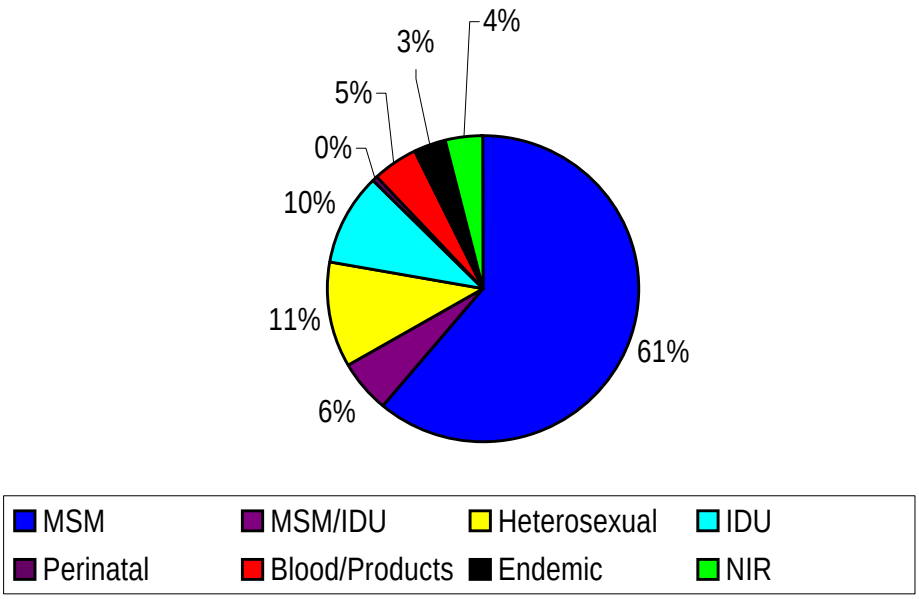
The human immunodeficiency virus (HIV) is a viral infection that can be transmitted through unprotected sexual intercourse, needle sharing, perinatal transmission (from an expectant woman to the fetus), breastfeeding (from an infected mother to her baby) and occupational exposure. HIV causes acquired immunodeficiency syndrome (AIDS), a chronic, progressive and fatal illness that leaves HIV-infected people vulnerable to fatal opportunistic infections and cancers. As the infection progresses, quality of life decreases and reliance upon others for the necessities of daily living increases.

The first case of HIV was reported in Manitoba in 1985. From 1985 to 2002, 986 cases of HIV/AIDS were reported. In any discussion of HIV/AIDS, it is essential to underline that the numbers refer only to reported cases. Though medical professionals are required by law to report diagnosed cases, not everyone who has HIV is likely to have undergone testing, due to a number of factors. First, despite the fact that HIV/AIDS testing is conducted in a confidential manner in Manitoba, concerns about stigmatization can discourage at-risk individuals from undergoing tests. Secondly, HIV/AIDS is often asymptomatic – meaning it shows no symptoms for many years – and as a result, the time lapse between infection and diagnosis may be upwards of 10 years. Finally, growing complacency about HIV/AIDS may reduce the number of individuals with HIV/AIDS who undergo testing. For these reasons, the statistics should be viewed as an under-representation of the actual number of persons infected with HIV.

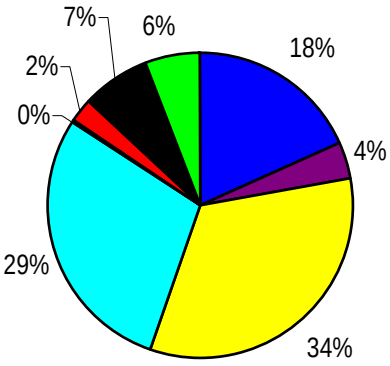
From 1985 to 1996 there were 574 newly diagnosed cases of HIV in Manitoba (513 males and 61 females). As shown in Figure 1 (page 6), 61 per cent of these cases were men who had sex with men (MSM) and 10 per cent were injection drug users (IDU). The period from 1997 to 2002 saw a dramatic shift in diagnosed cases according to risk category. The proportion of newly diagnosed HIV cases (412 in total; 283 males and 129 females) attributed to men having sex with men decreased by more than 42 per cent, down to 19 per cent of all cases. The proportion of new cases accounted for by injection drug users increased by almost 10 per cent, to 19 per cent of all cases. The greatest increase in at-risk populations was for those who reported heterosexual activity with persons at risk of HIV. Specifically, seven per cent of the incident HIV cases from 1985 to 1996 were among males, and an additional four per cent among females, who reported heterosexual activity with persons at risk of HIV. During 1997 to 2002, more than 21 per cent of newly diagnosed HIV cases reporting heterosexual activity with persons at risk of HIV were among males, with an additional 13 per cent among females.

Figure 1. Distribution of Risk Factors Among Newly Diagnosed HIV Positive Cases, 1985-1996 and 1997-2002

1985-1996



1997-2002



The Manitoba Strategy

Manitoba's Provincial HIV/AIDS Strategy

Manitoba's provincial HIV/AIDS strategy (1996) set out a provincial overview of HIV/AIDS-related needs and issues. The strategy adopted the following three goals:

- to reduce the spread of HIV infection;
- to provide a continuum of compassionate prevention, care, treatment and support programs for persons at risk of, and infected with/affected by HIV/AIDS; and
- to facilitate the planning, delivery and evaluation of all programs and efforts to ensure they are guided by a healthy public policy.

The provincial AIDS strategy articulated a set of principles (see Appendix One) and adopted the following priorities:

- prevention and education;
- care, treatment and support;
- co-ordination of services;
- recognizing the special needs of Aboriginal people; and
- research.

The spread of HIV/AIDS is reduced when individuals change their personal behaviour. To promote such change, public health authorities seek to identify individuals at high risk and to offer ways to protect them and reduce the risk. However, social and economic environments have a significant impact on people's health and life choices (Evans, 1994). The resilience, competence and coping skills of individuals are affected, for example, by the quality of their childhood environments (Mustard, 1996). Measures that seek to control the underlying determinants of incidence in a population as a whole, addressing such factors as poverty, lack of education, high unemployment and access to health care, are referred to as population prevention measures (Rose, 1988). Effective prevention efforts are those that will target both individual behaviors and the social environments that create them.

Many health determinants, such as education, housing and poverty, lie outside the responsibility of Manitoba Health. Recognizing this, the provincial HIV/AIDS strategy

made a commitment to "…address the issues and needs of all Manitobans through intersectoral collaboration, planning and provision of all services, including those directed at the prevention, care, treatment and support of HIV/AIDS (Manitoba Health, 1996). (See Appendix Two for a complete listing of the determinants of health.)

The 1996 provincial strategy identified the need to develop a complementary strategy to address HIV/AIDS issues affecting Aboriginal people, resulting in this document. The publication of *As Long as the Waters Flow* represents the latest step in the ongoing implementation of this strategy.

The Provincial Sexually Transmitted Diseases Control Strategy

In 2001, Manitoba issued its *Sexually Transmitted Diseases Control Strategy*. The STD control strategy associated the following risk factors with the spread of STDs:

- early age of first intercourse;
- multiple sex partners;
- non-use of condoms during sexual encounters;
- men having sex with men;
- sharing of injection drug equipment;
- the use of shooting galleries; and
- the use of cocaine.

Other markers that have been suggested to increase the risk of acquiring an STD include:

- lack of accessible and culturally appropriate health services;
- lack of anonymity in obtaining condoms and/or clean needles;
- transience;
- homelessness;
- poverty;
- having less than a high school education;

- prostitution;
- history of childhood abuse;
- early childhood low socio-economic status;
- marginalization of injection drug users and sex-trade workers; and
- unstable housing arrangements.

The STD control strategy concluded that successful prevention measures must operate on three levels:

- the primary level – preventing infections through behaviour interventions, harm reduction and programs that address the determinants of health;
- the secondary level – early detection and treatment; and
- the tertiary level – early access to effective health care and social support (Manitoba Health, 2001).

The Aboriginal strategy on HIV/AIDS employs many of these tools in identifying policies and developing guides for action.

An Aboriginal Strategy

HIV/AIDS and Aboriginal People in Manitoba

Prior to 1999, the ethnicity of individuals who tested positive for HIV was not reported to Manitoba Health. From 1999 to 2002, the average rate of positive HIV diagnoses for Manitobans self-reporting as Aboriginal was 64 per 100,000 for males, and 53 per 100,000 for females. These figures are in stark comparison to the rates of 4.5 and 3.5 per 100,000 for all other males and females, respectively. They show that Aboriginal people appear to be more than 10 times more likely to be diagnosed with HIV/AIDS than non-Aboriginal people. (The term "self-reported Aboriginal" refers to individuals who have tested positive for HIV in Manitoba and have chosen to report their ethnicity as Aboriginal on the Provincial Notification of HIV Infection form.) For the reasons identified previously, these data should be considered to be under-representative of the true proportion of Manitobans of Aboriginal ancestry with HIV.

As seen in Figure 2, these rates among Aboriginal peoples have fluctuated differently for males and females. From 1999 to 2002, the rate for Aboriginal females saw a 25 per cent decrease, while the rate for Aboriginal males increased by 17 per cent during the same period. It should be noted that these fluctuations do not necessarily indicate long-term trends, and thus may not reflect a sustained shift in populations at risk. However, they are important from prevention, control and care perspectives and require further monitoring and assessment.

Figure 2. Rate of Newly Diagnosed HIV Positive Cases by Self-Reported Ethnicity in Manitoba, 1999 - 2002

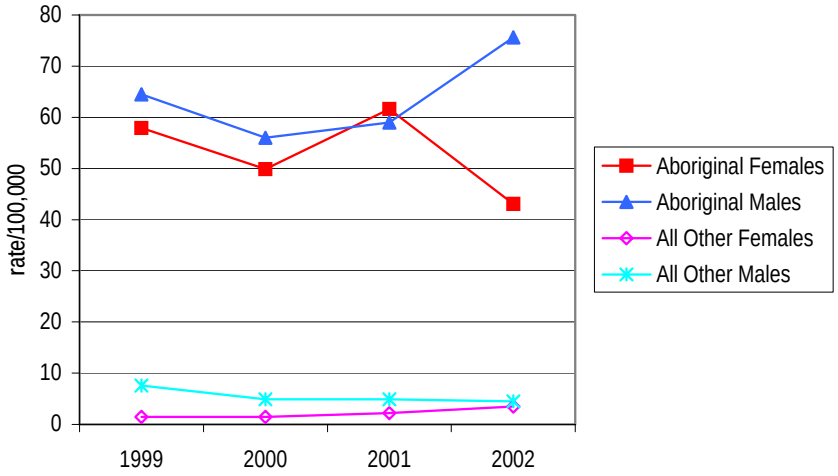
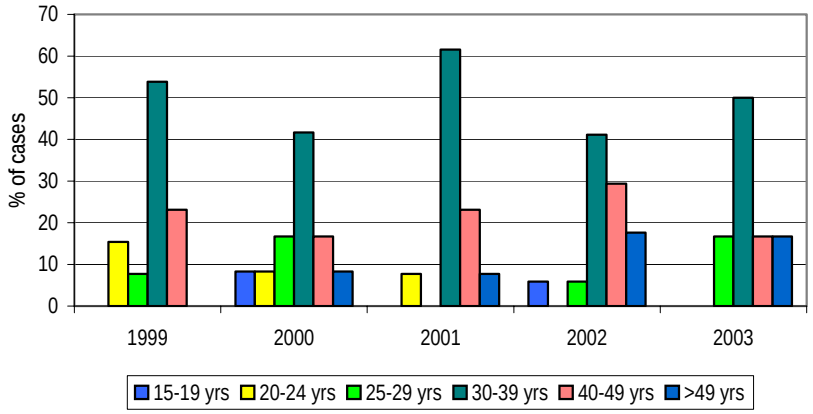


Figure 3 (page 12) shows the age distribution of HIV-positive cases in Manitoba from January 1999 to June 2003 for both males and females. Although the proportions vary from year to year, the majority of Aboriginal males testing HIV positive has consistently been in the age 30-39 group, accounting for 40 to 60 per cent of all cases. Comparatively, there have been very few males in the age 15-19 or 20-24 categories testing HIV positive.

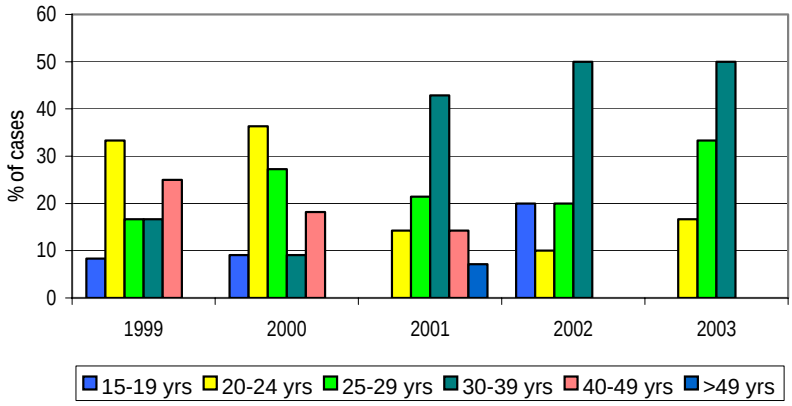
A very different picture emerges for females. While the last few years have witnessed an upsurge in the proportion of 30-39 year olds testing positive, women between the ages of 25 and 29 years account for 20 to 30 per cent of all female cases. Due to the often lengthy time lapse between infection and testing, this evidence suggests that 15-29 year old females and 20-29 year old males constitute two of the largest groups at risk for infection.

Figure 3. Age Distribution of Newly Diagnosed HIV Positive Cases for Self-Reported Aboriginal Persons in Manitoba, January 1999 - June 2003

Males



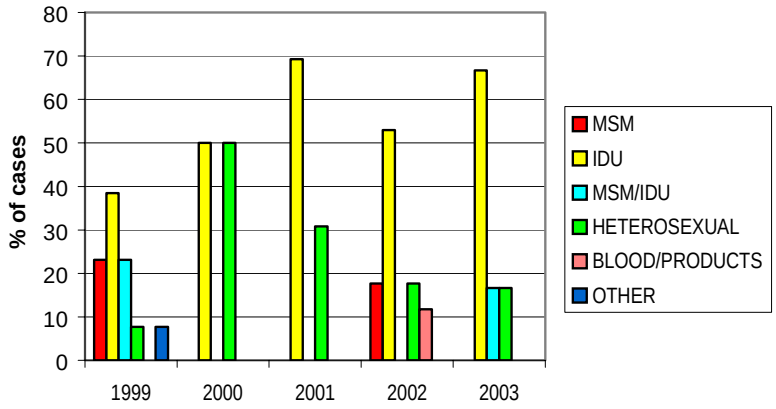
Females



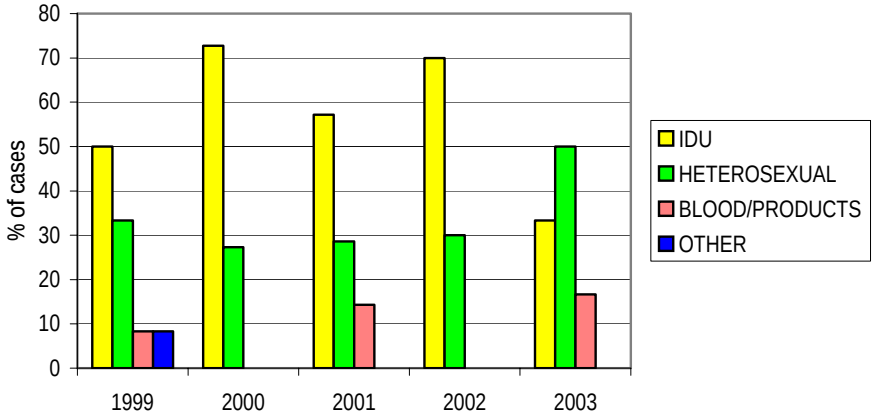
Among Aboriginal males testing positive for HIV (see Figure 3), injection drug use is the most significant risk factor, accounting for more than half of all cases in recent years. For Aboriginal females, injection drug use similarly accounts for the majority of cases; however, heterosexual contact with persons at risk of HIV is a significant contributing risk factor, accounting for almost one-third of all female cases.

Figure 4. Distribution of Self-Reported HIV Risk Factors* for Self-Reported Aboriginal Persons in Manitoba, January 1999 - June 2003

Males



Females



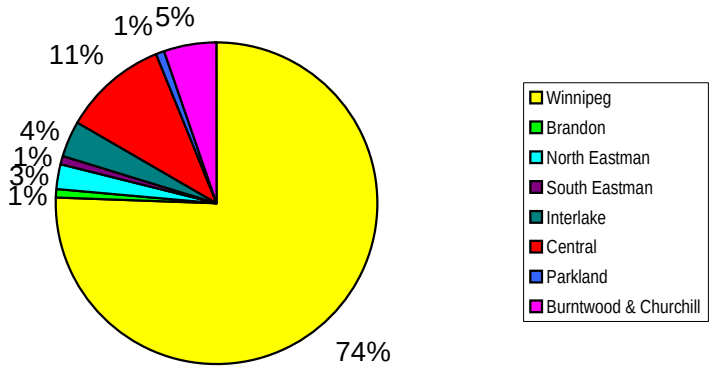
Risk Factors include:

- MSM - men who have sex with men
- IDU - injection drug use
- Blood/Blood Products - recipient of blood or blood products at any time, including prior to 1985 when Canadian Blood Services implemented screening for HIV

Figure 5 (page 15) shows the geographic distribution of newly diagnosed HIV cases for Aboriginal people, based on the first three digits of the tested individual's postal code as recorded on the Provincial Notification of HIV Infection form. The area under the jurisdiction of the Winnipeg Regional Health Authority (WRHA) accounts for almost two-thirds of all new cases identified over the past four-and-one-half years. The Central Regional Health Authority accounts for the next largest proportion, with 11 per cent of cases. While specific location of individuals is unknown, the cases attributed to the Central Regional Health Authority may reflect the location of three correctional facilities in the region (Agassiz Youth Centre, Headingley Provincial Correctional Institution and the Portage Correctional Centre for Women). The high rate is significant for this strategy because there is a large Aboriginal population in the Winnipeg and Central regions. It is important to remember that these data are based on self-reported information provided at the time of testing, and may reflect the location of the medical facility where the client seeks testing rather than the client's residence.

Due to the geographic size of the RHAs and the uncertainty as to whether individuals are reporting their home postal codes or the code of the centre where tested, a limited number of assumptions can be made based on self-reported geographic information.

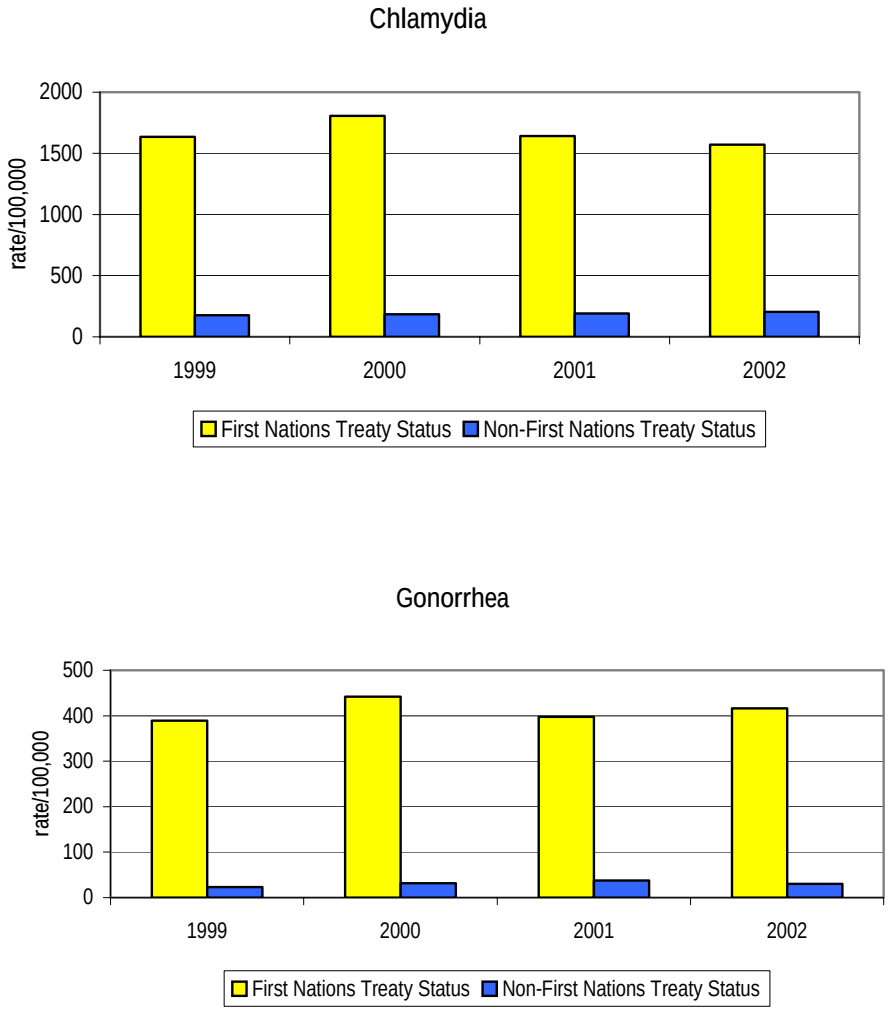
Figure 5. Geographic Distribution of Newly Diagnosed HIV Cases for Self-Reported Aboriginal Persons in Manitoba, January 1999 - June 2003



An important risk factor for HIV infection is the presence of sexually transmitted infections (STI), such as gonorrhea, chlamydia and syphilis. Untreated STIs can cause lesions and irritation in the genitourinary tract resulting in increased vulnerability to other bacterial and viral infections, including HIV. Detailed in Figure 6 (page 16), both chlamydia and gonorrhea rates are considerably and consistently higher for Manitobans with First Nations Status compared to the remainder of the population.

Prior to 2003, Manitoba had not seen a case of locally acquired syphilis since 1995. Between January and February of 2003, Manitoba Health recognized the re-emergence of locally acquired syphilis. By the end of 2003, Manitoba had 41 cases of locally acquired syphilis, all among Winnipeg residents. The mean age of infection is 39.6 years, although the majority of the females are in the 30-34 year age group, while most of the males are in the 40-44 year age group. Approximately one-quarter of the cases are among individuals who have self-identified as First Nations persons.

Figure 6. Chlamydia and Gonorrhea Rates per 100,000 Population According to First Nations Status, 1999-2002



Effective strategies for protecting at-risk populations from contracting HIV/AIDS and addressing social problems faced by people who have already contracted the disease must be culturally appropriate and community-based (Joint United Nations Programme on HIV/AIDS, 2001). In Manitoba, as in other jurisdictions, the local gay community has played a central role in the organizing, lobbying and educational efforts essential in reducing the infection rate for men who have sex with men. This community-based, grassroots response, undertaken in the face of discrimination and social stigma, also played an important role in improving care delivery for people with HIV/AIDS.

Community involvement and ownership are essential for reducing the rates of infection in the Aboriginal population.

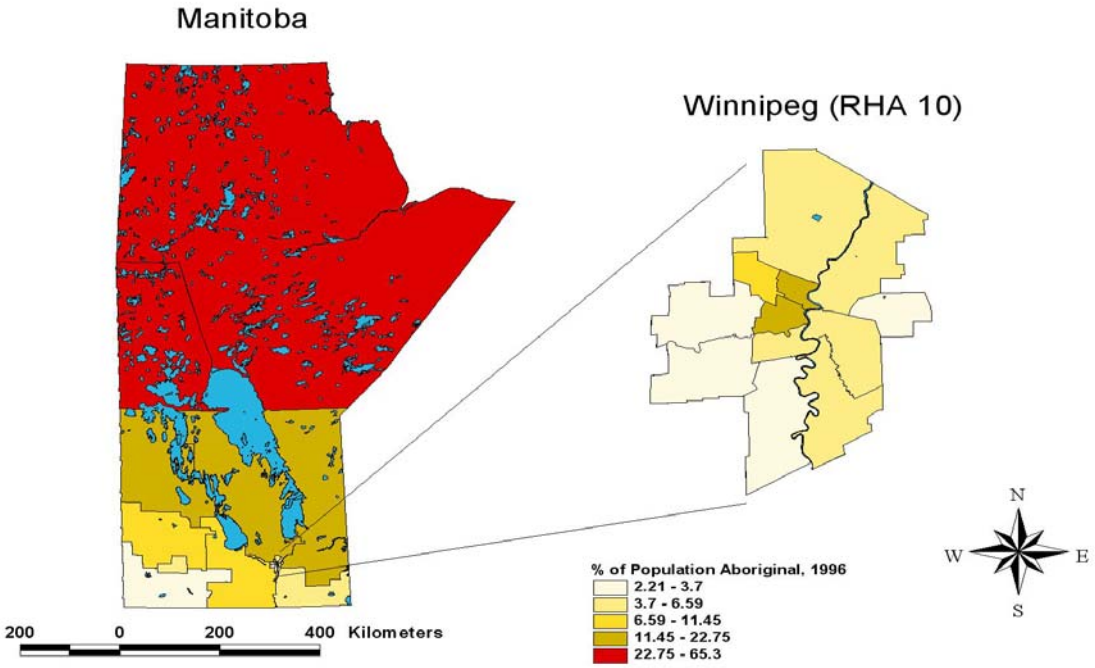
This point was also raised in the report of the Royal Commission on Aboriginal People. This report commented that "…proposals for action to support people with HIV/AIDS and for appropriate public education measures to prevent the spread of the infection among high-risk groups must come from within Aboriginal nations and their communities. If the ideas originate elsewhere, they will fail to take into account Aboriginal sensibilities and social realities." (The Royal Commission on Aboriginal People, 1996) For these reasons, it is appropriate to review the current situation of Aboriginal people in Manitoba and that community's response to HIV/AIDS.

Aboriginal People in Manitoba

According to the 2001 Canadian census, there were 150,045 Aboriginal people in Manitoba in 2001, an increase of 16.6 per cent since the 1996 Census. Aboriginal people accounted for 13.5 per cent of the Manitoba population, up from 11.7 per cent in 1996. The median age for the Aboriginal population was 22.8 years, while for the non-Aboriginal population it was 38.5 years (Statistics Canada). These figures should be viewed as a minimal estimate, as there is ongoing debate over the precise number of Aboriginal people in Manitoba. Many different levels of government, including several federal and provincial departments, collect data on the number of Aboriginal people in Manitoba, and these numbers often under represent the actual totals of Aboriginal people in the province.

While the individual numbers vary, trends in recent population data are apparent. As numerous reports have underlined, the Aboriginal population is a growing sector of the Manitoba population and, increasingly a young population. In coming years, Aboriginal people will account for one of every four people entering the labour force in Manitoba. The youth and potential of Manitoba's Aboriginal community represent a tremendous opportunity for all Manitobans. Unfortunately, that opportunity is currently undermined by the presence of many of the socio-economic conditions associated with poor health in general and HIV/AIDS in particular.

Figure 7. Percentage of Population Reporting Aboriginal Background, 1996 Census



As recognized in Manitoba's provincial AIDS strategy (Manitoba Health, 1996), Aboriginal people tend to be disproportionately affected by high unemployment rates, poverty, substance abuse, incarceration and reduced access to and utilization of health services. Manitoba's geographic size and the proportion of Aboriginal Manitobans living in geographically remote areas create barriers to the accessibility and availability of health promotion and education services. Aboriginal people also tend to be mobile, thus creating further challenges for planning and implementation of programs in education, social services, housing and health care. Map 1 (Appendix Four) indicates the major First Nations communities in Manitoba and their location in relation to both Tribal Councils and the regional health authorities.

The underlying causes of the social problems besetting Aboriginal communities have been the topic of a number of important national and provincial studies over the past two decades. Three of the most prominent studies were the *Manitoba Review Committee on Indian and Métis Adoptions and Placements* (1985), the *Report of the Aboriginal Justice Inquiry of Manitoba* (1991) and the *Royal Commission on Aboriginal People* (1996).

Each of these reports underlines the role that colonization, domination and attempts at assimilation have played in creating a self-reinforcing legacy of poverty, ill health and self-destruction. The studies emphasized that because these problems are inter-connected, solutions must be holistic and based on the development of self-governing, economically reliant and healthy communities. And while progress has been slow and uneven, over the past two decades Aboriginal people have begun to regain responsibility for many aspects of their lives and their communities. The emergence of health agencies, child welfare agencies, education authorities, policing agencies and development corporations under Aboriginal control are essential elements in the healing process by which Aboriginal people are seeking to bring their communities into balance. As *Long as the Waters Flow: An Aboriginal Strategy on HIV/AIDS* is conceived as a contribution to that process.

In addition to the issues outlined above, the number of jurisdictions involved in the provision of health care services for Aboriginal people presents numerous challenges. The results can be fragmented health care delivery and duplication of services. In particular, there are problems in tracking people as they move from federal to provincially-supported agencies and communities. Jurisdictional disagreements, particularly in the case of people who are moving either on- or off-reserve can create gaps, leaving people either without care or without appropriate care. This was corroborated by a recent review of the federal government role in the Canadian Strategy on HIV/AIDS, which concluded that the "…efforts and strategies of the federal and provincial/territorial governments are not well co-ordinated" (Health Canada, 2003c). Appendix Three of this strategy provides a brief overview of the main players involved in the delivery of health care to Aboriginal people in Manitoba.

Developing an Aboriginal Strategy

The Manitoba AIDS strategy committed the Government of Manitoba to:

- developing a complementary strategy to address HIV/AIDS issues affecting Aboriginal people;
- ensuring that the strategy is based on evidence, is proactive and is developed directly by Aboriginal people in consultation with all levels of government, key

departments and organizations and all other stakeholders – including people affected by and infected with HIV/AIDS;

- building on the programs and services that already exist and have demonstrated their efficiency and effectiveness; and
- supporting a strategy that, where appropriate, integrates the provincial and national HIV/AIDS strategies.

In 1999, an HIV/AIDS Implementation Committee was established to advise the Health Minister on the implementation process for the provincial AIDS strategy. At the same time, an Aboriginal sub-committee was established. In April 2000, the Aboriginal sub-committee recommended that the Public Health Branch and Aboriginal Health Branch of Manitoba Health co-ordinate and support the development of an Aboriginal strategy on HIV/AIDS in Manitoba. In November 2000, the Aboriginal Health Branch, with the support of the Public Health Branch, invited key stakeholders to participate in the Aboriginal Working Group on HIV/AIDS (AWGHA) to develop the provincial Aboriginal strategy on HIV/AIDS.

Under the direction of the AWGHA, four focus groups were convened in 2001. Participants in the groups included the Aboriginal community, service organizations, Aboriginal people living with HIV/AIDS and government representatives. The results of this work were recorded in *Developing an Aboriginal Strategy on HIV/AIDS in Manitoba: A Discussion Paper* (Manitoba Health, 2002). The discussion paper reported that Aboriginal people had identified several trends during the consultations, including:

- Aboriginal people with HIV/AIDS not making use of available treatment, due to a number of factors including concerns about the stigma attached to HIV/AIDS in their home communities and jurisdictional issues relating to on- and off-reserve residency;
- Aboriginal people with HIV/AIDS increasingly turning to traditional healing;
- increases in high-risk behaviour, including injection drug use (the presence of crack cocaine in many communities was identified), body piercing, sexual activity at a younger age and high rates of teen pregnancies and sexually transmitted diseases;

- a reluctance to be tested for HIV/AIDS due to concerns over lack of confidentiality. For similar reasons, some people hide the fact that a family member has been diagnosed with the disease;
- a lack of effective parenting skills, family violence, gambling and substance abuse by parents (seen as a legacy of residential schools) continues to leave young people prey to recruitment by street gangs; and
- a lack of basic health resources, migratory patterns, community attitudes towards people at risk and jurisdictional problems, especially in Northern Manitoba.

Many of the messages delivered during the consultation process underlined the community's view that an Aboriginal strategy on HIV/AIDS must demonstrate awareness of and begin to address the burdens of discrimination and socioeconomic disadvantages that leave young Aboriginal people despairing of their future. Participants said:

- "If people see that they have a viable, positive future they are better able to make positive choices for themselves."
- "Instill the value of self-respect, respect for your body, preventative health and lifestyle practices – this is a traditional value which unfortunately has been lost or altered."
- "Poverty, and all it includes, is the biggest risk factor for First Nations. It sets up other risk factors like addictions, abuse, early sexual activity, school concerns, job concerns, gang involvement, legal problems, access to medical care and health promotion barriers."
- "The next generation is taking our problems into their hands – a lot of the current generation is still into drugs, teen pregnancies – they are continuing the circle, they need to break the circle." (Cook Consulting, 2001)

Many participants spoke of the need to help Aboriginal young people develop healthier attitudes towards sexuality and individuals with different sexual orientations. Of particular concern were issues of control and power, particularly as they related to the use of condoms. It was noted that in Aboriginal communities, people tended to shy away from workshops and young people were reluctant to take direction from traditional authority figures. The need for community-based research to develop effective, culturally appropriate programs to begin to change attitudes towards sexuality was also identified.

Others spoke of how several Aboriginal communities once conceived of homosexuality in terms of “Two Spirit” individuals with certain spiritual and ceremonial roles, but that one of the legacies of colonialism was a homophobic attitude. The result has seen many homosexual men and women becoming estranged from their families and communities. Efforts have to be made to end this ostracism and find a place for Two Spirit people, allowing the community to benefit from their experiences.

While participants recognized the need for long-term social and economic change, they also spoke of immediate needs, particularly the need for harm reduction policies. These included improved and confidential availability of needles and condoms. This was particularly true in the case of Aboriginal people who had been incarcerated. People spoke of a need for needle exchanges in institutions, testing, policies that would assist family members when a person who had tested positive is released and follow-up policies through probation services.

Several people also spoke of the difficulties that Aboriginal people with HIV/AIDS experience. The working group was told, "There are very few, almost no resources for women who have HIV/AIDS and give birth to a child." Another person spoke of children being threatened by their peer groups upon learning that a family member had HIV/AIDS. There was, as one person described it, a "…fear of the grapevine." These attitudes also discourage people from seeking testing, thereby putting others at risk through their behaviors. In the opinion of some presenters, Aboriginal people with HIV/AIDS not only need improved services in the areas of income support, housing and health care, but need to be involved in both determining what kind of services are needed and how they are provided.

The consultations also highlighted concerns over the perceived fragmentation and lack of services. During the consultations, Aboriginal people spoke to varying levels of service depending on many factors such as geography, status and gender. There was also concern about potential and actual overlaps and gaps in health care services because the federal government, provincial government and regional health authorities each share some responsibility for the delivery of health care to Aboriginal people. This potential confusion in the delivery of health care to Aboriginal people is not restricted to HIV/AIDS (Cook Consulting, 2001).

Finally, it was stressed that the control and prevention of HIV/AIDS in the Aboriginal community will require increased services, supports, resources and facilities. There were calls for more prevention, more education, more health care, more nursing care and more mental health care. Participants stressed that these services need to be delivered in ways that are appropriate to the specific community and culture.

In addition to these focus groups, Manitoba Health and Health Canada also sponsored a northern consultation hosted by the Northern AIDS Initiative and the Manitoba AIDS Co-operative Special Session (2003). Three important additional principles for an Aboriginal strategy on HIV/AIDS were identified at these meetings:

Cultural Diversity – The Aboriginal strategy on HIV/AIDS acknowledges and respects the cultural diversity of Aboriginal communities in Manitoba. Aboriginal communities will be empowered by their participation in identifying, defining and designing appropriate programs for HIV/AIDS education, prevention, care, treatment and support of those infected and affected by HIV/AIDS.

Determinants of Health – Health cannot be addressed in isolation from social and economic environments. The determinants of health affect the resilience and ability of individuals, families and communities to make healthier choices. Aboriginal people, leadership and advocates called for all organizations and jurisdictions to provide policy and service programs reflective of the determinants of health. Therefore, the strategy advocates that programs, services and activities be planned, delivered and evaluated with a focus on the determinants of health, where appropriate and applicable.

Harm Reduction – Harm reduction strategies engage people who are at risk of contracting HIV or hepatitis C, focusing on where they are in their lives. It is a pragmatic approach that recognizes the limitations of abstinence-based approaches for populations with well-entrenched high-risk behaviour patterns. Harm reduction approaches focus on decreasing the negative consequences of high-risk behaviours to individuals, communities and society. Rather than necessarily attempting to have people cease engaging in behaviours that are associated with the spread of HIV (such as sharing injection drug equipment and unprotected sexual contact), it seeks to reduce the potential harm of such activities. These strategies may result in some people abstaining from risk behaviours; however, abstinence is not the primary objective of harm reduction. The focus is on assisting people to change their risk behaviours through education, peer support and opportunity building. Harm reduction strategies can include confidential

condom provision; needle distribution and exchange; safe disposal sites for used injection equipment; safe injection sites; a policing focus on drug dealers; and pharmacy, health centre, nursing station and community involvement in needle exchange and sales. They can also include media campaigns focusing on the continuing prevalence and risk of HIV, sexually transmitted disease and hepatitis C infection, prevention and harm reduction activities and the benefits of early testing and treatment in reducing transmission to others and improving quality of life for persons with HIV/AIDS. Harm reduction approaches must recognize and be sensitive to Aboriginal cultural diversity, the traumatic effects of attempted assimilation and the unique aspects of post-colonial cultural revitalization.

Aboriginal People at Risk

Based on our understanding of current science, epidemiology and population statistics, an Aboriginal strategy on HIV/AIDS should focus on the following at-risk populations.

Youth and Young Adults

In Canada, young people seem to be especially vulnerable to HIV infection. Factors contributing to this vulnerability include high-risk sexual behaviour (for example, the early onset of sexual activity, multiple partners and unprotected sex), injection drug use, alcohol and other drug use, and a perception of invulnerability to HIV (Health Canada, 2003b).

Research indicates that street-involved youth are at least twice as likely to self-report an STD as non-street-involved youth within the age category of 14-24 years (Macdonald, Fisher, Wells, Doherty and Bowie, 1994). Since 1999, Manitoba Health has been involved in a national enhanced surveillance study of street-involved youth. Results from the second phase of this study reveal that, among the 319 street-involved youth between the ages of 14 and 24 years that participated in Phase II (January-August 1999) of the study, the majority of the sample self-identified as Aboriginal (53 per cent) and 39.2 per cent identified as Caucasian. At the time of interview, more than half of the street-involved youth sample was not registered for school. Additionally, two-thirds of the sample admitted having been in trouble with the law to the extent that they spent at least one overnight stay in a detention facility. Approximately 11 per cent of the sample tested

positive for chlamydia and about two per cent tested positive for gonorrhea. Of the youth who consented to blood testing, four per cent tested positive for core hepatitis B antibodies indicating that they had contracted hepatitis B. Results further indicate that the Aboriginal youth were significantly more likely either to have a past or a current sexually transmitted disease (Beaudoin, 2004).

Greater mobility among Aboriginal youth may also increase their risk of HIV infection. It is not uncommon for young people to leave their home communities and move to larger cities where the risk of HIV is greater, and then return home – potentially spreading infection (Canadian Aboriginal AIDS Network, 2000).

Aboriginal youth face a myriad of social problems. According to *Aboriginal People in Manitoba*, a statistical overview of demographic trends published by the governments of Canada and Manitoba in 2002, these include:

- 22 per cent on-reserve and 10 per cent off-reserve Status youth aged 15-29 have not completed grade nine;
- 20 per cent of First Nations births are to single mothers under 20 years of age;
- over 70 per cent of Manitoba children in the care of child and family service agencies in 1997 were Aboriginal; and
- unemployment among Aboriginal youth was 35.5 per cent (Human Resources Development Canada, Manitoba Family Services and Housing, and Manitoba Aboriginal Affairs Secretariat, 2002).

Injection Drug Users

The majority of new HIV cases for Aboriginal Manitobans list injection drug use as their most likely exposure to HIV. This highlights the need for HIV/AIDS prevention programs specifically focused on injection drug use and the factors related to unsafe injection drug use. A 1998 Winnipeg study of 1,068 injection drug users discovered that 64.2 per cent of injection drug users self-identified as Aboriginal people. The fact that cocaine is the preferred drug of most injection drug users in Manitoba presents additional problems, since cocaine users often make numerous injections a day and are more likely to share needles (Elliott et al., 1999).

Women

Statistics demonstrate an increase in HIV infections among women. From 1985 to 1996, only 61 of the 574 Manitobans diagnosed with HIV were female. Between 1997 and 2002, 129 of the 412 similarly diagnosed Manitobans were female. The risk is highest for Aboriginal females. Between 1997 and 2002, the average rate of infection for Manitoba women self-reporting as Aboriginal was 53 per 100,000, while the rate for all other women was 3.5 per 100,000.

Two potential areas of concern are injection drug users and sex trade workers. While provincial data does not capture sex-trade work or safer sex practices in Manitoba (ex: condom usage), research data may fill in some of the gaps in knowledge. Data from the Winnipeg Injection Drug Epidemiology Study suggests that sex-trade work is common among injection drug users, with over 70 per cent of all female injection drug users and 30 per cent of all male injection drug users having been involved in sex-trade work at least once. Reported condom use in this study revealed overall low usage rates, particularly with regular partners. Nearly 70 per cent of the female injection drug users and 60 per cent of male injection drug users interviewed said they never used condoms with their regular partners. (The study defined sexual partnerships of over three months as “regular partners” and non-sex-trade partnerships of less than three months as “casual partners.”) While condom usage for females involved in sex-trade work was quite good, (only two per cent reported never using a condom with clients), usage for male sex-trade workers was much lower, with 13 per cent reporting they never used a condom with clients (Elliott et al., 1999).

The fact that the vast majority (and in some years, all) of the self-identified Aboriginal women testing positive for HIV in Manitoba are of childbearing age is a matter of particular concern. While HIV can be transmitted perinatally, with proper screening, testing and treatment it is often possible to prevent the transmission of the infection. This underlines the need for an effective testing policy (with informed consent) and education, counselling and follow-up for pregnant women diagnosed with HIV.

Incarcerated Individuals

As of April 2003, Manitoba Justice (Manitoba Justice, 2003) reported that 68 per cent of incarcerated adults were Aboriginal, and 74 per cent of incarcerated youth were

Aboriginal. Department of Justice Canada (Department of Justice Canada, 2003) further reported that in May 2000, 23 per cent of Aboriginal youth in custody across Canada were in custody in Manitoba. Incarcerated individuals face increased risk of HIV and other blood-borne pathogens, such as hepatitis B and C. This increase may be due to tattooing, body piercing, unprotected sexual activity and injection drug use occurring in correctional facilities. In addition, incarceration leads to further marginalization by disconnecting people from families.

Men Who Have Sex with Men

While the Manitoba data cited in this report (see Figure 4) suggests that there have been very few Aboriginal men infected with HIV/AIDS in Manitoba who have reported having sex with men, this group has been included as a risk group for the Manitoba Aboriginal strategy on HIV/AIDS. This decision has been made for a number of reasons. First, men having sex with men remains a risk group for the overall provincial HIV/AIDS strategy. While the primary source of infection in Manitoba is shifting from a situation where men having sex with men was the predominant source of infection, the number of new cases reporting men having sex with men has remained relatively constant over the last five years, with an average of 13-15 cases per year. Exceptions include the years 2001 and 2002, where there were only nine and 10 cases, respectively**.**

Secondly, ongoing concerns exist that many men who have sex with men who are infected may not be undergoing testing. Aboriginal men having sex with men may not be seeking testing due to concerns over privacy and community response identified elsewhere in this document. For similar reasons, they may choose not to identify men having sex with men as their risk factor if they do undergo testing.

Gay and Two Spirit Aboriginals – Although the term “men who have sex with men” (or MSM) is frequently used to define this population, it is an epidemiological term which does not capture the important cultural influences that may affect same-sex behaviours. Some Aboriginal men who have sex with men find support both within the gay and Two Spirit communities across Canada. It is necessary to involve these communities in program development when addressing the needs of Aboriginal men who have sex with men because they have experience in addressing homophobia, discrimination and HIV/AIDS, and they have established healthy living models.

An Aboriginal Strategy on HIV/AIDS

The Manitoba Aboriginal strategy on HIV/AIDS comprises a series of guides for action organized around four strategic goals. These goals were developed through the community consultation process and are directed towards the at-risk populations identified above (youth and young adults, injection drug users, women, incarcerated individuals and men who have sex with men). The guides for action are recommended to all stakeholders: government, health-care authorities, communities and Aboriginal organizations. Stakeholders are encouraged to examine them in terms of their organization's resources, mandate, strengths and goals. It should be noted that many communities, organizations and governments are currently taking action in many of these areas. The purpose of this strategy is to develop a broader framework for co-ordinated action.

Four strategic goals

Based on community consultations, the best available research and the provincial AIDS strategy, *As Long as the Waters Flow: An Aboriginal Strategy on HIV/AIDS* has adopted the following four strategic goals:

- prevention and education;
- care, treatment and support;
- co-ordination of services; and
- research and evaluation.

These goals can be most effectively reached through co-operative implementation of the following guides for action.

Prevention and Education Guides for Action

A Focus on Children – From the outset, Aboriginal people have responded to HIV by developing prevention initiatives, community-based service organizations and community development models. An example of one such model is the HIV/AIDS Medicine Wheel created by Aboriginal persons living with HIV/AIDS (APHA) in 1992. Based on traditional teachings, it explores the life stages of HIV infection as well as the physical, emotional, mental and spiritual stages that someone with HIV may experience. Its principle teaching is that life unfolds on a cycle (circle) from child, youth, adult and elder, and that all animate and inanimate entities, such as stones, trees and animals, are

part of this circle. Following this model, prevention should be focused on the infant or child stage of the Wheel.

Many Aboriginal HIV/AIDS awareness and prevention issues intersect with questions of sexual and reproductive health, youth rites of passage, child bearing and rearing, gender roles, community norms and values, and social and cultural change. Therefore, prevention initiatives should focus on the needs of vulnerable mothers and their infants, children, youth and women in general as they represent the well-being and future of the Aboriginal community. These initiatives must also integrate the Aboriginal languages of Manitoba, which will ensure there is cross-generation communication among elder, parent and child.

The process of consultations has recommended the following guides to action:

- Aboriginal communities ensure that HIV/AIDS awareness is a priority.
- Prevention is led by Aboriginal people, with the participation of elders, with respect for culture and spirituality, and with support for the use of traditional practices and medicine.
- Aboriginal people living with HIV/AIDS are involved in all aspects of prevention and treatment program development.
- Specific education and prevention programs are developed for and by Aboriginal women to reduce their risks of HIV infection and to remove barriers to self-empowerment.
- Programs are developed at the community level to reflect community values and norms and to develop healthy attitudes toward sexuality. This requires adequate human and fiscal resources and the provision of training.
- Programs are culturally, age and gender appropriate, particularly in the case of information intended for high-risk groups.
- Curricula and information are developed that focus on the awareness and prevention needs of children (ages seven to 12).
- School-based health programs are linked with community outreach services such as recreation centres.

- Sexual health promotional materials are made accessible to people who have concerns about their privacy, for example, communities that lack the resources to provide anonymous and appropriate access to sexual health information and resources.
- The availability of sexual health phone lines and websites is expanded and promoted.
- Education authorities ensure partnering occurs with communities to assess the existing curriculum on HIV/AIDS in primary and secondary facilities, as well as in university and college faculties (education, medicine, social work and nursing). They should work to determine the need for enhancement or refinements of culturally appropriate information related to HIV/AIDS in the Aboriginal population.
- Prevention work takes a multidisciplinary approach towards reaching young people, addressing the various social and media influences that confront young people.
- Harm reduction strategies are expanded, particularly in those settings where people are at the greatest risk of HIV/AIDS, sexually transmitted disease or hepatitis C infection.
- Prevention and harm reduction programs are available in federal and provincial correctional facilities in a manner that does not compromise security. Elements of such programs could include peer support, support on release and support and counselling for families.
- Health care professionals are made aware of risk activities and have the information to provide adequate, non-judgmental counselling and testing.
- Other sectors work toward a reduction in social and economic inequalities that contribute to behaviours that place individuals at an increased risk for HIV/AIDS.

Care, Treatment and Support Guides for Action

Aboriginal people living with HIV/AIDS, and those affected by HIV/AIDS, require appropriate services that reflect their identity, cultural diversity, family and community values, and an understanding of their life experience. Engaging Aboriginal service users in the design and delivery of their care is important to successful health management.

The process of consultations has recommended that:

- infected and affected people are consulted about the development and delivery of programs and services.
- an environmental scan on the availability of care and services for Aboriginal people in Manitoba is carried out to assess current care, treatment and support programs. In conjunction with a feasibility study of the capacity and strength within communities, this scan would provide a guide to the provision of care, treatment and support.
- professional and community supports are made available to assist infected individuals in understanding the full complement of treatment options available and to facilitate and support their treatment decisions.
- traditional Aboriginal health and healing practices are combined with conventional medical approaches. This would include the use of elders and traditional healers in a confidential manner that respects the needs of infected individuals and their family members.
- services are integrated, comprehensive and community-based and provide a continuum of care including palliative and hospice care, and support for the affected family after the death of a loved one from AIDS. APHAs need to have access to care network*s* that flow across a spectrum of jurisdictions (inter-provincial, urban, rural and First Nation communities).
- an increase in support services is made available to HIV positive women, women at risk and pregnant women infected with HIV/AIDS, sexually transmitted diseases or hepatitis C. Support is needed to assist with issues such as single parenthood, respite, foster care and adoption.
- the availability of culturally appropriate education, screening, HIV testing, surveillance and treatment for HIV/AIDS, sexually transmitted diseases and hepatitis C are made available in federal and provincial correctional institutions. Support services and prevention tools (for example, needle exchange and distribution) need to be available to APHAs and people at risk who are leaving institutions, as well as information packages and outreach for Aboriginal people who are in conflict with the law.
- policies and programs recognize and work to reduce the following barriers to treatment:

  - inadequate funding for public health initiatives (for example, absence of, or uneven delivery of prevention, care, treatment and support workshops);

- stigmatization and isolation of people with HIV/AIDS;
- the lack of resources and community health physicians outside of Winnipeg; and
- the lack of adequate funding for many support programs.

- mentoring and education of primary-care physicians and nurses on HIV/AIDS, sexually transmitted diseases and hepatitis C is improved.
- empowerment and rehabilitation for APHAs (for example, education, life skill, computer and employment training) are facilitated. Such support should include settlement services for individuals moving from rural to urban areas.
- services are developed that address the needs of diverse genders and sexual orientations, specifically, transgender individuals, transsexuals and Two Spirit people.
- the needs of Aboriginal people who are involved in the sex trade are addressed.
- the unique mobility and transportation needs of APHAs, their families and those at risk are recognized and addressed.

Co-ordination of Services Guides for Action

Historically, Aboriginal people travelled great distances to find sustainable resources and to trade. Today, Aboriginal people are still very mobile, travelling to and from urban, rural, Métis and First Nations' communities, for employment, shopping, education and medical services. For this reason, it is important that local, municipal, provincial, federal and Aboriginal authorities and governments increase awareness of their jurisdictional responsibilities as they pertain to health and HIV/AIDS related services for Aboriginal people. It is recommended that each sector re-prioritize their resources and collaborate to ensure that the needs of APHAs, vulnerable and affected people are addressed in an equitable and cross-jurisdictional manner.

The process of consultations has recommended:

- the implementation of all strategic actions be led by Aboriginal people, with fair representation of APHAs, First Nations, Metis and other affected stakeholders.
- ongoing development and maintenance of partnerships with community organizations, various levels of government, regional health authorities, the health care community and Aboriginal leadership take place in an effort to co-ordinate the delivery of sustainable prevention programs, treatment and support services, addressing the challenges of geographic location.

- a network of service delivery providers, including but not limited to regional, provincial, federal and Aboriginal governments, as well as community participation, specifically with inclusion of people living with HIV/AIDS and those affected.
- collaborative efforts address the need for:
  - co-ordination and sustainability of existing services and programs at a regional level;
  - policies relating to Aboriginal people infected with HIV/AIDS, sexually transmitted diseases and hepatitis C that are non-discriminatory, culturally sensitive and appropriate;
  - programs to strengthen and empower Aboriginal communities to adequately address HIV/AIDS (for example, mental health and housing); and
  - co-ordinated communication regarding the availability of services.

Research and Evaluation Guides for Action

Along with epidemiological and academic HIV/AIDS research, community-based research (CBR) and Aboriginal community-based research (ACBR) can assist us in responding more effectively to epidemics such as HIV/AIDS by using evidence to inform policy and programming. These two research streams assist and enable communities to ask their own questions, collaborate with researchers, design their research methods and share and implement their findings. The principles of Aboriginal ownership, control, access and possession (OCAP) promoted by non-governmental organizations like the Canadian Aboriginal AIDS Network and the Assembly of First Nations can also support and build on research methods.

The process of consultations has recommended:

- Aboriginal people infected and affected by HIV/AIDS are involved in the planning and implementation of research activities at the community level.
- community-based research is undertaken to:
  - identify environmental and personal barriers to change and develop strategies to address them; and
  - develop cultural, age and community appropriate programs.

- research is conducted on patterns of occurrence and trends of co-infections in Aboriginal people infected with HIV/AIDS, including but not limited to tuberculosis, sexually transmitted infections and hepatitis C, as well as on the relationship of these infections to individual behaviours and social environments.
- the understanding of other groups at risk and potential target populations is enhanced. This would indicate a need for further research in the areas of:
  - Aboriginal men who have sex with men;
  - infection rates among individuals with substance addictions; and
  - sex-trade workers.
- community-based research findings are shared with the participating community members so that they may be informed by, and see the benefits of the research.
- program-based evaluation must be based upon measurable indicators where possible, should meet the needs of target groups, and be culturally appropriate.

Summary

These guides for action cannot be reached without the full involvement of all community stakeholders, including First Nations, Metis and Inuit communities and political structures, elders, community organizations, child and family services, counselors, drop-in centres, clinics and Aboriginal people with and affected by HIV/AIDS. The medical system (including Manitoba Health, the federal government and the regional health authorities), the education system (including elementary schools, secondary schools and universities), the justice system, social and family services and a range of service providers including friendship centres, HIV/AIDS clinics, home care and community health services, are also necessary partners to successfully implement an effective Aboriginal strategy on HIV/AIDS.

Conclusion

As Long as the Waters Flow builds on provincial government policy, community consultation and contemporary research to develop an Aboriginal strategy on HIV/AIDS. The strategy identifies the following at-risk populations in the Aboriginal community as priorities for action:

- youth and young adults;
- injection drug users;
- women;
- incarcerated individuals; and
- men who have sex with men.

In addition to the nine main principles of the provincial AIDS strategy, the Aboriginal strategy on HIV/AIDS is based on the following three principles:

- cultural diversity;
- determinants of health; and
- harm reduction.

It has also set out the following guides for action to achieve those goals, including:

- prevention and education;
- care, treatment and support;
- co-ordination of services; and
- research and evaluation.

Finally, the success of the strategy requires:

- the willingness and commitment of all partners to identify their individual roles and work together in a co-ordinated approach;
- the acknowledgement that Aboriginal communities and organizations have a leadership role in program development and implementation;
- a well-developed implementation plan with the support of community and APHAs;

- the potential reallocation of existing resources, as many of the recommended actions will require a different ways of doing things within current resources; and
- an appropriate level of funding and resources.

The findings of the provincial Aboriginal strategy on HIV/AIDS show both the seriousness of HIV/AIDS in the Aboriginal population and the need for a co-ordinated response from all levels of government, Aboriginal leadership, service providers and those at the community level. This response will be most effective when the Aboriginal population participates in all aspects of planning and implementation. Any long-term solution to reducing the burden of illness from HIV/AIDS in Aboriginal populations will involve a concerted and co-operative effort to enhance the control that Aboriginal people have over the social and environmental determinants of their lives and their health. The quality of our social environments has implications for the stability of our society and the health and well-being of our population as a whole – not just those in poverty (Mustard, 1996).

As Aboriginal people work towards self-determination, it is an opportune time to draw on the strengths of existing partnerships and build new ones. The success in implementation of the Aboriginal strategy on HIV/AIDS requires innovative ways of thinking and performing. Now is the time for action.

Appendices

Appendix One

Principles

The provincial Aboriginal strategy on HIV/AIDS accepts and endorses the following nine principles identified in the provincial AIDS strategy (Manitoba Health, 1996):

- **Healthy Public Policy Philosophy** - The planning, delivery and evaluation of Manitoba's HIV/AIDS policies and strategies will be based on the well being and health of Manitobans.
- **Targeted Efforts** - All programs and activities will focus where the risk and needs are greatest.
- **Accessibility -** Manitobans will have access to information about HIV, its prevention and the services available. Persons living with HIV/AIDS will have access to information, care, treatment and support, regardless of culture, sex, income, sexual orientation or geographic location.
- **Continuum of Co-ordinated Services** - All medical, psychosocial, financial and spiritual support services will be provided in a coordinated and compassionate manner. Every effort will be made to promote partnerships and reduce service duplication.
- **Co-ordination and Integration** - Other departments have a role to play and should become actively involved and committed to achieving the goals of the provincial AIDS strategy.
- **Client-Centered Services and Confidentiality** - The determination and provision of HIV/AIDS related services will be client-focused. All matters relating to a client's care, treatment and support will be handled confidentially.
- **Human Rights** - All HIV/AIDS policies, standards and programs will reflect the principles of the Canadian Constitution and the Manitoba Human Rights Code.
- **Community Development and Health Promotion** - Manitoba will provide surveillance data/information that will enable communities to assess their local needs, and develop ways to meet those needs.
- **Reflecting the National AIDS Strategy** - Where appropriate, all HIV/AIDS programs will support the national AIDS strategy, its programs and initiatives.

Appendix Two

Determinants of Health

Health Canada (Health Canada, 2003a) acknowledges the following underlying determinants of health:

- income and social status;
- social support networks;
- education;
- health services;
- employment and working conditions;
- physical environments;
- biology and genetic endowment;
- personal health practices and coping skills;
- healthy child development;
- social environments;
- gender; and
- culture.

Appendix Three

Key Players in Aboriginal Health-Related Services in Manitoba

One of the issues that members of the Aboriginal community identified on a number of occasions during the preparation of this report is the need for improved co-ordination of services between federal and provincial agencies with responsibility for providing health-care services to Aboriginal people in Manitoba. The following listing, which is not intended to be comprehensive, is a brief overview of key federal and provincial agencies involved in the provision of health services to Aboriginal people in Manitoba, with a special emphasis on public health issues. The organizations are listed under provincial and federal headings in alphabetical order.

Government of Manitoba

Aboriginal Health Branch

The Aboriginal Health Branch is a resource for all areas of service, policy, programming and initiatives that involve First Nations, non-status, Metis and Inuit people. The branch works with other provincial jurisdictions, territories and other authorities. The development of relationships with the federal government and other Manitoba government departments is ongoing.

Addictions Foundation of Manitoba

The Addictions Foundation of Manitoba is a provincial crown agency responsible for providing intervention, rehabilitation (residential and community-based), prevention, public information and education services for Manitoba citizens relating to addictions. Adult and youth services are provided through a number of rehabilitation facilities and offices located in 26 communities across the province.

Communicable Disease Control Unit

The Manitoba Health Communicable Disease Control Unit's primary responsibility is the prevention and control of communicable diseases in Manitoba. Activities to meet this

responsibility are conducted in consultation with those involved in the identification, diagnosis, treatment and legal, ethical and social management of communicable diseases.

Manitoba Health Insured Benefits

Manitoba Health provides health coverage to Canadian citizens or landed immigrants and permanent residents who have a permanent residence in Manitoba and live in Manitoba for at least six months in a calendar year. Manitoba Health Insured Benefits include (with certain restrictions): physicians' services, surgery/anaesthesia, X-ray and laboratory services, eye examinations, chiropractic treatment and hospital care. These include diagnosis and treatment for HIV/AIDS.

Pharmacare

Pharmacare is a benefit program that applies to most, but not all, prescription drugs. It is available to Manitobans who are eligible for Manitoba Health Insured Benefits who do not have their drugs paid for through another provincial, federal or municipal program, and do not have prescriptions fully paid for under a private drug insurance program. There is an income-based deductible for the program, with a minimum $100 deductible.

Public Health Branch

The Public Health Branch is responsible for ensuring effective health promotion and disease-prevention and control activities with respect to provincial public health programs and initiatives. It is responsible for monitoring, identifying and addressing emerging public-health threats. The branch also interprets data and provides the Minister of Health with information forecasts and warnings of emerging or impending health threats and appropriate actions.

The Aboriginal Health Branch and the Public Health Branch have separate roles and mandates, but work together to reach the Aboriginal population with respect to public health programs and initiatives. This coordinated approach between branches ensures public health policy and programs are delivered in a culturally relevant manner and reach the appropriate Aboriginal population.

Regional Health Authorities

Regional health authorities (RHAs) are established under provincial authority and are responsible and have the authority to plan, manage, deliver, monitor and evaluate health services within their regions. These services are delivered through a variety of mechanisms including hospitals, public health offices, personal care homes and a variety of public programs. They provide input into the development of provincial policy and planning direction as well as into standards development, and are responsible for implementing and establishing a sustainable, integrated system of health services for their geographical area (Manitoba Health, 1999). While the RHAs are responsible for all populations within their geographic area, program delivery has been limited to outside the reserve boundaries.

Government of Canada

Aboriginal Health Authorities

The role of Aboriginal health authorities is to oversee the operation of community-based health programs, address health issues at the community level and liaise with other health authorities and governments to improve the health and well-being of Aboriginal people within their respective areas. Typically, these would be federally funded through transfer initiatives; however, these entities are either provincially or federally funded or a mixture of both.

Community Programs Directorate

The First Nations Inuit Health Branch Community Programs Directorate (CPD) includes the Children and Youth Division and the Mental Health and Addictions Division. The Community Programs Directorate works in partnership with First Nations and Inuit people to deliver a wide range of programs in key community health sectors. All CPD activities have as their goals to maintain and improve the health of First Nations and Inuit people, and to facilitate First Nations and Inuit control of health programs and resources. Child and Youth Division programs include the Canada Prenatal Nutrition Program (CPNP), the Aboriginal Head Start on Reserve program, a fetal alcohol syndrome and fetal alcohol effects (FAS/FAE) program and a maternal health program. The Mental

Health and Addictions Division includes a focus on alcohol, drug and solvent abuse, tobacco, the National Native Alcohol and Drug Addiction Program (NNADAP) and mental health.

First Nations and Inuit Health Branch (FNIHB)

The First Nations and Inuit Health Branch supports the delivery of public health and health promotion services on-reserve and in Inuit communities. It also provides drug, dental and ancillary health services to First Nations and Inuit people regardless of residence. The branch also provides primary care services on-reserve in remote and isolated areas, where there are no provincial services readily available. In First Nations communities, these services are often provided through nursing stations or community health centres. Transportation for medical care outside one's community is limited to on-reserve residents. FNIHB has also established a Reserve Community-Based HIV/AIDS program that funds on-reserve HIV/AIDS projects.

Population and Public Health Branch (PPHB)

The Population and Public Health Branch is primarily responsible for policies, programs and systems relating to prevention, health promotion, disease surveillance, community action and disease control. Its main areas of focus are:

- public knowledge about the determinants of health and actions to take to maintain and improve health; access to tools to improve health; and enhanced community capacity to deal with individual and collective health issues;
- collaborations that help Canadians maintain and improve their health;
- preventive initiatives and practices that have enabled a reduction of illness, disability, injury and/or death; and
- improved health surveillance, emergency preparedness and response strategies.

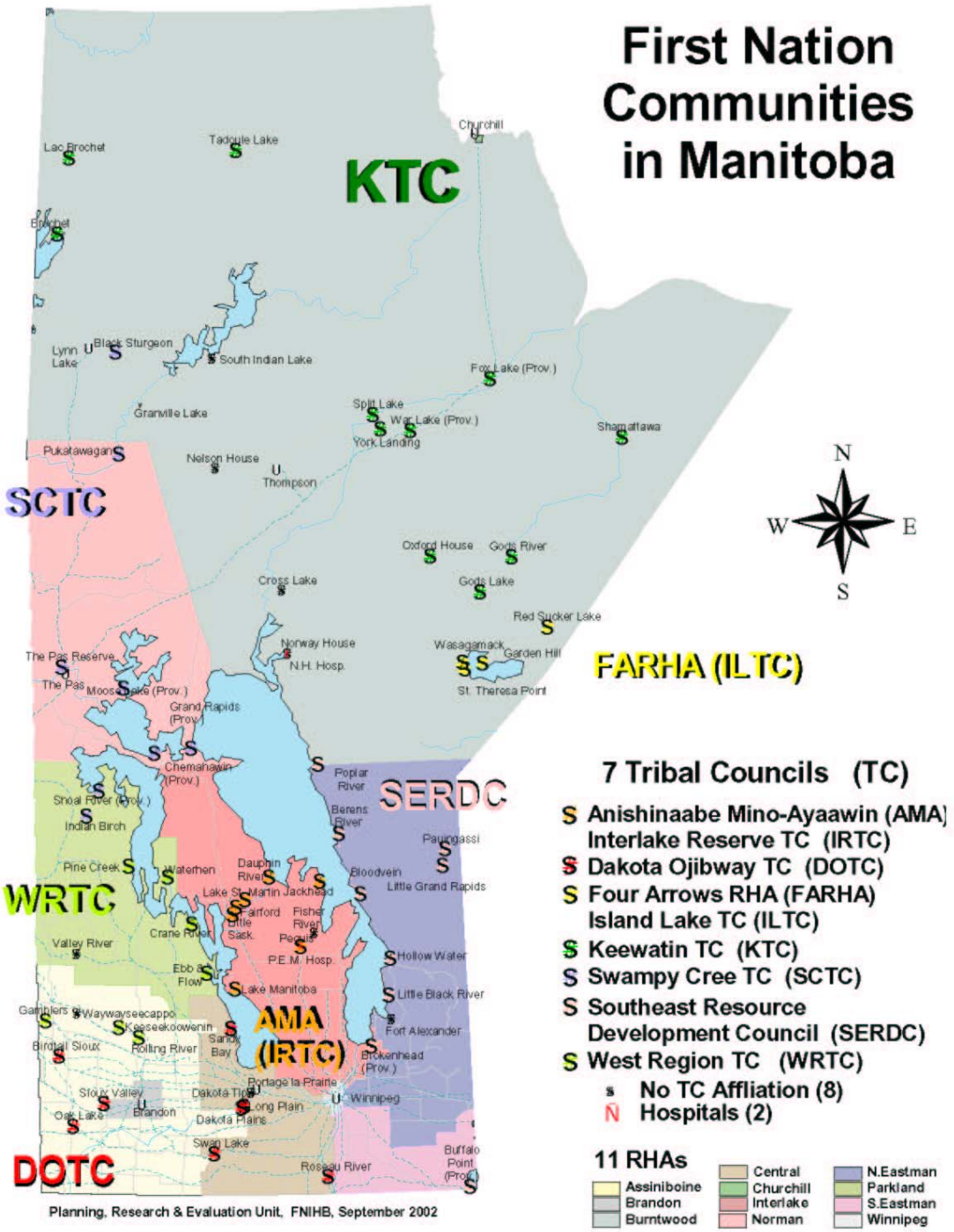
Primary Health Care and Public Health Directorate

The FNIHB Primary Health Care and Public Health Directorate (PHCPH) is responsible for primary health-care delivery in partnership with First Nations and Inuit health authorities. It includes a Primary Health Care Division, an Infectious Disease Control Division and a Dental and Pharmacy Programs Division.

The Primary Health Care Division's responsibilities include primary care services, home and community care, First Nations Health System reforms and alternative models and health human resources. The Infectious Disease Control Division's responsibilities include tuberculosis, HIV/AIDS, hepatitis C, sexually transmitted diseases and risk assessment and management of emerging diseases. The Dental and Pharmacy Programs Division's responsibilities include program and policy development, promotion and prevention programs and the National Dental Therapy Program. Drug coverage is provided based on a national formulary.

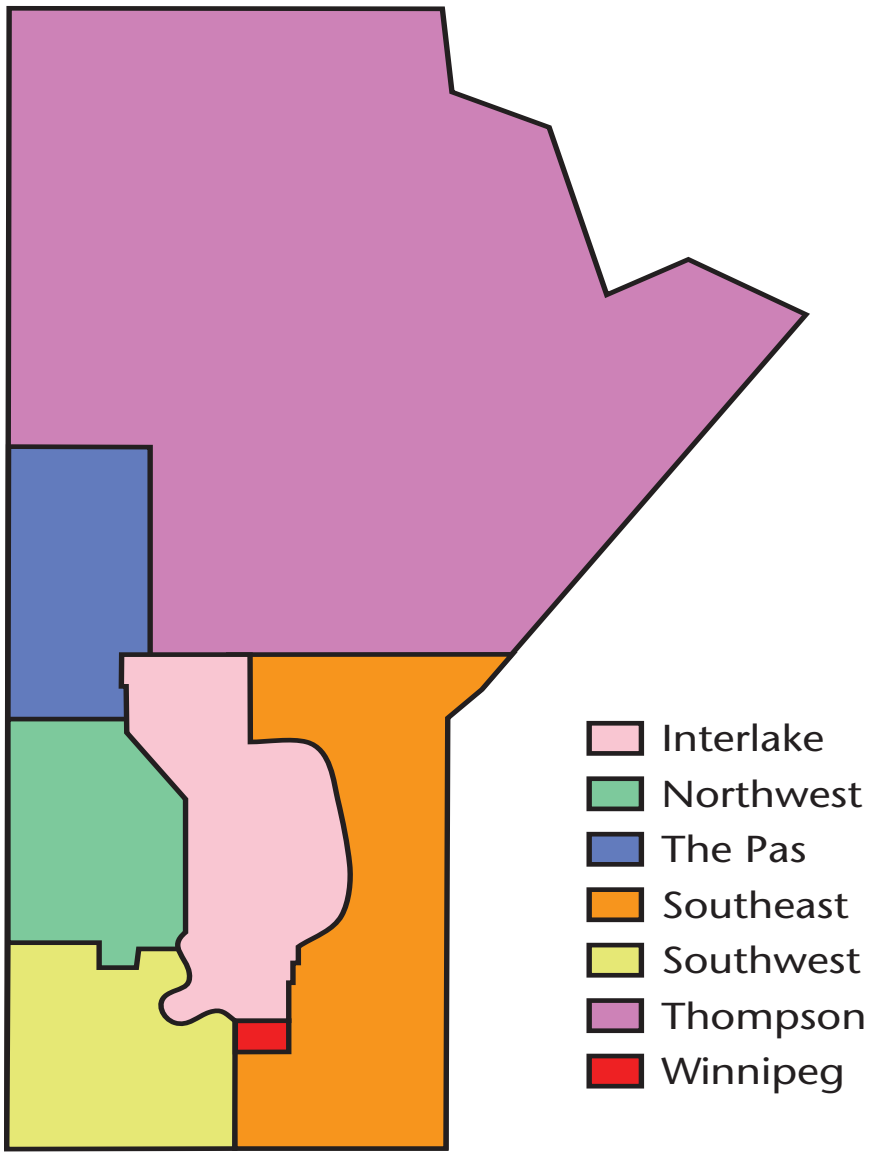
Appendix Four

First Nation Communities and Regional Health Authorities in Manitoba



Appendix Five

Manitoba Metis Federation Regional Map



Appendix Six

GLOSSARY

AIDS (acquired immunodeficiency syndrome) - a severe disease syndrome that represents the late clinical stage of infection with HIV.

APHA – Aboriginal person living with HIV/AIDS

HAART – Highly Active Anti-Retroviral Therapy

HIV (human immunodeficiency virus) - a viral infection that is transmissible via both unprotected sexual activity and blood, usually through the sharing of needles and other equipment for the purposes of injecting drugs or body piercing/tattooing.

OCAP – Ownership, control, access and possession is a political term that is being used by Aboriginal peoples to highlight the right to self-determination in the area of HIV/AIDS research. As Aboriginal communities and organizations increase their capacity to conduct their own research these principles will become increasingly visible.

OCAP is an important term in HIV/AIDS research in Aboriginal communities. It indicates that Aboriginal people have relinquished the notion of "being researched," and have taken up the call to become active participants in the research process. In HIV/AIDS research, these initiatives must be taken seriously as Aboriginal people are disproportionately affected by social, economic and behavioural factors which greatly increase the risk of HIV infection. For example, Health Canada reports that "…the proportion of AIDS cases attributed to Aboriginal persons has declined since 1999, yet the proportion of positive HIV test reports ...continue to increase" and that, "…injection drug use is the main exposure category among Aboriginal HIV/AIDS cases." Finally, "…a high proportion of HIV-infected pregnant women are Aboriginal." (HIV/AIDS Epi Update, April 2002), (CAAN 2002).

Two Spirit People – a term used to describe Aboriginal people who assume cross -, or multiple gender roles, attributes, dress and attitudes for personal, spiritual, cultural, ceremonial or social reasons. These roles are defined by each cultural group and can be fluid over a person's lifetime. Modern terms like gay, lesbian, bisexual, transgender, transsexual and intersexed (in combination with, or exclusive to, Two Spirit) may be adopted by some Aboriginal people to define who they are.

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Community Health Centres
First Nations & Inuit Health Branch, Health Canada
Focus Group Participants
Kali Shiva AIDS Services
Manitoba AIDS Cooperative
Manitoba AIDS Task Force
Manitoba First Nations AIDS Working Group (MFNAWG)
Manitoba Justice
Manitoba Metis Federation
Native Education Directorate
Nine Circles Community Health Centre
Northern AIDS Initiative
Population and Public Health Branch, Health Canada
Red Prairie AIDS Project, Brandon
Street Connections
Regional Health Authorities

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In conclusion, Manitoba Health wishes to honour the spirit of those Manitoba Aboriginal people living with HIV/AIDS, those who have died from the HIV/AIDS over the past two decades and their friends and families.

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