

# The Red Road:

PATHWAYS

TO WHOLENESS



AN ABORIGINAL STRATEGY FOR HIV AND AIDS IN BC

FOR THOSE WHO WENT BEFORE US

**Developed by the  
B.C. Aboriginal HIV/AIDS Task Force  
with the assistance of:**

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Healing Our Spirit - B.C. First Nations AIDS Society;  
High Risk Project Society;  
Kelowna Aboriginal AIDS Society;  
Tri-City Metis and AIDS Awareness Society;  
Tillicum Haus Friendship Centre (Nanaimo);  
United Native Nations;  
Vancouver Native Health Society;  
Vancouver Police & Native Liaison Society;  
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**in partnership with**

Correctional Service Canada;  
Ministry of Health and Ministry Responsible for Seniors  
Aboriginal Health Division & the Provincial AIDS Strategy Office  
Ministry of Attorney General;  
Health Promotion and Programs Branch - Health Canada;  
Indian and Northern Affairs Canada  
Medical Services Branch - Health Canada.

**Funding assistance for this project gratefully received from**

Medical Services Branch - Health Canada;  
Aboriginal Health Division - Ministry of Health & Ministry  
Responsible for Seniors  
Health Promotion and Programs Branch - Health Canada  
and  
BC Aboriginal AIDS Awareness Program,  
STD/AIDS Division, BC Centre for Disease Control.

Thank you to the member groups for their in-kind contributions  
and to all those who volunteered their time & expertise to the  
development of The Red Road; Pathways to Wholeness

**Special Thanks** to Dr. Andrew Jin for his research & writing assistance.



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# EXECUTIVE SUMMARY

**A**pproximately four to five percent (4.0% - 5.0%) of British Columbians are of Aboriginal origin (i.e., North American Indian, Inuit or Metis). With 32% of BC Aboriginal people under age 14 and another 32% between 25 and 44 years of age, Aboriginal HIV/AIDS programs and services must follow two main pathways. Fifty percent (50%) of newly diagnosed HIV infections between 1995 and 1997 were found in the 30 to 39 year range. Strong emphasis on prevention activities for children and youth is one pathway. The other is prevention and intervention activities for adults, particularly designed for those using injection drugs and for those at risk of using injection drugs.

Overall, 60% of newly diagnosed Aboriginal HIV infections in this time period identified Injection Drug Use ("IDU") as their primary risk factor. Aboriginal women also identified the sex trade as a frequent risk factor. Aboriginal specific HIV/AIDS prevention and intervention strategies should focus on these two risk factors (though not to the exclusion of others) and also address the conditions which lead young people into such dangerous and self-destructive behaviours. In a project funded by the National AIDS Strategy and Canada's Drug Strategy, an expert group developed a program for reducing HIV transmission from injection drug use, based on methods of harm reduction. This comprehensive report, HIV/AIDS and Injection Drug Use; A National Action Plan provides many valuable recommendations. Its implementation should not be further delayed.

Aboriginal women made up 40% of all new Aboriginal infections while non-Aboriginal women made up only 17% of total non-Aboriginal cases. Given the much higher birth rates (3-6 times) among Aboriginal women compared to the general population of BC, HIV/AIDS is increasingly becoming a family affair. Aboriginal HIV/AIDS programs and services will need additional emphasis on childbearing women and families with children, especially women injection drug users with children.

Compared to provincial averages, the Aboriginal population of BC experiences lower levels of education, lower average income (54% make less than \$10,000/year) and increased reliance on social assistance. These facts create challenges to providing services.

As well as needing to be culturally appropriate, Aboriginal health education programs will need to take into account lower levels of general education in the target audiences and also in the pool of community members who could be recruited as prevention and support workers. A wide range of materials at a variety of literacy and technical levels is needed. More and longer training



opportunities for those working in HIV/AIDS related health services will be required. Both material development and production and staff training expand the costs of providing services and reduce the hours being spent on direct service.

Ensuring community based HIV/AIDS educators and care providers are up-to-date in their information is a challenge when facing large geographic areas, few staff members and limited training funds. Standardized training programs that certify educators and care providers and that are accurate in their understanding of this complex disease will increase the quality of care to the client.

In recent years, among newly HIV-positive persons in BC, a disproportionately high number (16%) are Aboriginal. This suggests that in the future, a disproportionately large portion of the burden of AIDS illness, and all its associated health care and support service needs, will fall upon the Aboriginal population of BC. Emerging data is also indicating that, on average, Status Indian people living with AIDS die sooner than other people living with AIDS. Further research is needed to identify causes for this and ways to address it. The higher mortality rates from AIDS among Status Indian people in BC suggest that already the treatment, care and support needs of Aboriginal people living with AIDS are less well met than for non-Aboriginal people living with AIDS.

This may in part be due to the low average income of BC Aboriginal people. Low income has many consequences, including (but not limited to) crowded or inadequate housing, reduced availability of nutritious food, less access to health care and limited ability to cope with prolonged illness in oneself or in a family member. Care, treatment and support programs for Aboriginal persons with HIV or AIDS and their families will need to provide strong case management and referral programs in order to help link clients with appropriate services outside the direct responsibility of Aboriginal AIDS Service Organizations (“AASOs”). Adequate supplementary support through complementary health funds will be important to help offset the lacks in federal and provincial medical service programs.

The majority (70%) of Aboriginal persons in BC live off-reserve, with a sizable minority (27%) living in major urban centres. Off-reserve programs and services are necessary to reach the majority of Aboriginal British Columbians. Given the complexities of jurisdictional boundaries, which have increased with provincial health regionalization, participation of federal, provincial and regional health authorities in discussions with local Aboriginal communities, organizations (both off and on reserve) and leadership is essential. To date, Aboriginal participation in the regionalization process has been limited and appears to have limited effects. Review of the membership/participation process in the RHBs/CHCs is required.



Needed topics in regionalization discussions include identifying appropriate roles and responsibilities of service providers and funders, coordinating services to reduce overlaps and duplications while identifying those gaps and service priorities that have yet to be addressed. The main goal of these efforts must remain the desire to provide greater continuity of care for the client. This type of action, while often seeming time consuming and non-productive, is an essential first step to properly meeting the needs of Aboriginal people living with this disease and helping them to live longer, healthier lives.

The significantly higher level of indirect signs of risk for HIV infection seen in Aboriginal communities, such as rates of alcoholism, abuse, pregnancy and sexually transmitted diseases (STDs or VD), create concern that the emerging trend of HIV infection in Aboriginal people will be in those who live on reserves. Further investigation into this possibility is essential. Additionally, as HIV may be easier to catch or pass on in the presence of another STD, HIV prevention efforts must also work to lower the high rates of STDs found in Aboriginal communities.

Another path to follow takes us to Aboriginal prisoners. A high number of Aboriginal persons in BC are exposed to the hazards of life in prison, including the risk of exposure to HIV infection. Therefore, an HIV/AIDS prevention strategy must include programs and services for persons in prison. Policies of prohibition have not eradicated injection drug use, unprotected sex and other high-risk activities by inmates. Additional measures, using a strategy of harm-reduction, are needed to reduce the risk of HIV transmission among inmates.

The Expert Committee on AIDS and Prisons developed a strategy to advise on preventing the transmission of HIV infection in correctional facilities. While we have outlined some of their main points in this document, we recommend that their full report be read for those involved in correctional services. We support their recommendations, with one caveat. Parole and other early release programs for those Aboriginal prisoners experiencing AIDS requires extensive care planning and follow-up which is currently unavailable. Half-way houses have insufficient training, staffing and support to accept seriously ill patients. Maintaining access to medicine and health care services may be difficult for those released into community. Improved pre-release planning is necessary.

Aboriginal people experience many practical barriers to health care access, such as language barriers, lower levels of education, lack of knowledge about service providers, lack of respectful culturally sensitive or appropriate services, limited numbers of Aboriginal health care providers, inadequate levels of assertiveness required to get needs met by the medical system, residence in



rural or remote areas, transportation problems, conceptual and cultural differences and racial discrimination. As well, on-reserve, major challenges in providing health care services include frequent medical staff turnover which creates a barrier to appropriate continuity of care, the broad scope of duties and resulting heavy workload required by the limited number of nursing and CHR positions funded, and the limited and inconsistent level of health training required of, and provided for, CHRs.

Appropriate funding and training for mental health workers must become a priority for Aboriginal mental health services. Multiple trauma, unresolved grief, addiction and mental illness all increase risk for HIV infection. Mental health workers need to understand the interactions between these issues and ways of coping with them.

Complex funding processes, distances and limited numbers of clients in one community discourages professional service providers from setting-up home-based care programs on-reserve. At the same time, provincial funding programs for home-based care will not pay family members to provide such care. For those with certain opportunistic infections of HIV, such as CMV, or who have AIDS, the lack of trained and qualified home care nursing may make it impossible to remain in their home communities during their illness or final days. Because of this lack of home-based care services on reserves, public and community health nurses and CHR's are often called upon to provide home nursing care and home-maker support, in addition to their other duties. Changes to the funding, training and service structure are required to ensure that equitable access to qualified home based care is available for those with AIDS.

Greater physician training and support is needed to ensure physicians are providing appropriate care to patients, however physicians' must also be motivated to attend educational and training sessions being provided. Mentoring programs should be encouraged. Increased access to Centre of Excellence expertise and evaluation of the barriers to implementing training and care guidelines is required.

More research and program evaluation on a wide variety of Aboriginal HIV/AIDS issues by trained community based Aboriginal researchers is necessary. Research areas include Injection Drug Use among Aboriginal people, limited anti-retroviral use, alternative health maintenance practices, new and alternative models of addiction treatment, models of mental health services.

Given the current state of affairs with health care reform and the resulting confusion among community members and health care workers alike, it is the





recommendation of the Task Force that transfer of provincial Aboriginal HIV/AIDS funding to the Regional Health Authorities be delayed until the Aboriginal Health Division, Ministry of Health has had an opportunity

- to clarify its role in Aboriginal health,
- complete evaluations of existing services, and
- developed a comprehensive Aboriginal Health strategy.

This will allow for a more cohesive approach to dealing with a complex situation and for planning to proceed for the implementation of The Red Road; Pathways to Wholeness - an Aboriginal Strategy for HIV and AIDS in BC.

Nadine Caplette, Co-Chair

Alex Archie, Co-Chair





# B A C K G R O U N D

## TO THE B C A B O R I G I N A L H I V / A I D S T A S K F O R C E

**T**he B.C. Aboriginal HIV/AIDS Task Force originated from an earlier smaller group called the MSB Pacific Region HIV/AIDS Focus Group. Medical Services Branch ("MSB"), Pacific Region, of Health Canada began bringing together those working in the area of Aboriginal HIV/AIDS and/or on-reserve health meeting in the early 1990's. The purpose of the AIDS Focus Group was to share information and provide consultation and advice on HIV/AIDS issues to MSB.

Members of the Focus Group included MSB regional and zone officers; AIDS Community Action Program of Health Promotions and Programs Branch, Health Canada; B.C. Native AIDS Awareness Program<sup>A</sup>, B.C. First Nations Summit Health Committee, Healing Our Spirit BC First Nations AIDS Society and on-reserve community health workers, including a representative of those living with HIV/AIDS ("PHA"). The Focus Group met quarterly to provide advice to MSB and discuss issues related to HIV/AIDS on-reserve.

As the AIDS epidemic grew, difficulties between on and off reserve coordination of health care and prevention efforts became apparent. In order to address HIV/AIDS in a comprehensive way to reduce jurisdictional barriers and gaps in receiving services and to increase access to those services, it was decided that broader representation was needed on the Focus Group.

The BC Aboriginal HIV/AIDS Task Force resulted from the bringing together of on and off-reserve organizations and projects dealing with HIV/AIDS and other health issues, along with participation from a broader range of government representatives. Dr. David Martin, Regional Medical Health Officer at MSB, Pacific Region and Moffatt Clarke, then Director of the AIDS Strategy Office, BC Ministry of Health were instrumental in providing funding support to bring people together and to hire Art Zoccole as Task Force Coordinator in 1996.

Over the past year, the Task Force has worked to increase the network of those living with HIV/AIDS, those working in this field and those with an interest in addressing HIV/AIDS with their Aboriginal clients and communities. The Task Force has published an Aboriginal HIV/AIDS Resource Directory and has worked to identify the issues important in addressing HIV/AIDS in our communities. It has also resulted in the development of The Red Road; Pathways to Wholeness - an Aboriginal Strategy for HIV and AIDS in BC, which we are pleased to present for discussion and implementation.

A - now called the BC Aboriginal AIDS Awareness Program  
B - now called the First Nations' Chiefs Health Committee



## PHILOSOPHY OF THE TASK FORCE

It is the belief of the members of the B.C. Aboriginal HIV/AIDS Task Force that all people are affected by HIV/AIDS.

## TASK FORCE VISION STATEMENT FOR THE RED ROAD

The BC Aboriginal HIV/AIDS Strategy is a pathway to increase the quality of life of all Aboriginal people by respecting and integrating the traditional and cultural values and beliefs of individuals, families and communities and through helping to use those traditions in the treatment of HIV/AIDS in both our own and the broader community.

## PRINCIPLES OF THE TASK FORCE

1. Respect for Aboriginal individual, family and community autonomy and without prejudice to diversity, residency, gender, sexual orientation or HIV/AIDS status.
2. Design, develop and deliver through relevant participation by the Aboriginal community and which respects and promotes positive Aboriginal tradition, history and values.
3. Involve people who are living with and affected by HIV/AIDS.
4. Recognize, affirm and promote traditional healing and wholistic approaches that are consistent with the strategic policy framework.
5. Promote a wholistic system of care that is Aboriginal directed and provides a continuum of support, training and education throughout the life cycle for Aboriginal people living with and affected by HIV/AIDS that transcends religious, geographic, political and socio-economic restraints.
6. Promote networking, coordination and sharing of information and resources among Aboriginal individuals, families, care-givers, agencies, service providers, communities, leadership on and off reserve, spiritual and religious leaders and healers.
7. Link with and support other Aboriginal and supportive non-Aboriginal health and social service initiatives and strategies.
8. Utilize an Aboriginal community based evaluation process designed by the B.C. Aboriginal HIV/AIDS Task Force to assess the implementation and delivery of The Red Road.
9. Acknowledge and respect an Aboriginal person's choice of programs and services and respect a person's right to privacy.
10. Acknowledge and respect an Aboriginal person's freedom and responsibility to make decisions concerning their own lives, healing and care.
11. Promote the measures necessary to support the disease prevention.

## GOALS OF THE TASK FORCE

The goals of the B.C. Aboriginal HIV/AIDS Task Force, with the participation of the Aboriginal community at all levels, are to :

1. Develop a province-wide, integrated network of service providers dealing with HIV/AIDS issues.
2. Initiate and develop provincial policy across, between and among jurisdictions for the implementation of HIV prevention, education, care, treatment and support.
3. Identify and address program and service overlap, duplication and gaps to develop ways of better using all resources and to encourage the building of teams and partnerships.
4. Develop, implement and monitor program and service standards through process and outcome evaluation.
5. Encourage Aboriginal participation in Aboriginal research projects.
6. Ensure that technical and other information about HIV/AIDS is relevant and available to Aboriginal communities and organizations.

We have begun to fulfil these goals through increased membership in Task Force meetings, increased distribution of HIV related information, computerized service delivery mapping and development and consultation process of the draft B.C. Aboriginal HIV/AIDS Strategy.

Our next step is to develop and distribute an implementation guide for The Red Road and help to fulfil the goals outlined in the strategy.





# AN OVERVIEW

## OF THE CHARACTERISTICS OF THE ABORIGINAL POPULATION OF BC

### DEMOGRAPHICS

**T**o be an Aboriginal person in Canada is a complex thing. The Indian Act of Canada and subsequent legislation and interpretations of legislation have developed a system of “Indianness” that defines the type and level of responsibility the Federal Government of Canada is willing to admit to having for a particular type of Aboriginal person. This has been further complicated by poor enumeration of any type of Aboriginal person other than Status Indians. To help begin addressing this difficulty, the 1996 Census of Canada asked, “To which ethnic or cultural group(s) did this person’s ancestors belong? ...Specify as many groups as applicable.”<sup>2</sup> From the responses to this question, 5.0% or 184,445 British Columbians are of Aboriginal origin (i.e., North American Indian, Inuit or Metis), fully (76,430 persons) or in part (108,010).<sup>3</sup>

Other Census questions<sup>4</sup> asked, “Is this person an Aboriginal person, that is, North American Indian, Metis, or Inuit?”, “Is this person a member of an Indian Band/First Nation?” and, “Is this person a Treaty Indian or a Registered Indian as defined by the Indian Act of Canada?” The Census 96 Guide also reminded respondents of the Bill C-31 (1985) amendments to the Indian Act’s definition of Indian status. Metis people are recognized in the Constitution Act (1982) but they do not have Indian status as defined by the Indian Act. The responses to these three questions are summarized in Table I (see page 74). If one defines the Aboriginal population to be persons with a “Yes” response to any of these three questions, then according to the 1996 Census, the Aboriginal population of BC is 139,655 persons or approximately 3.8%.

Some people are concerned that significant numbers of Aboriginal persons might not have participated in the 1996 Census. At the community level, First Nations participation appears to have been very high in BC. Only seventeen of the 198 Indian reserves and settlements in BC were incompletely enumerated and are not included in the census counts. Based on the previous (1991) Census and 1993 band member counts maintained by Indian and Northern Affairs Canada,<sup>6</sup> the estimated on-reserve population of these 17 communities was only 2,275 persons.

At the individual level, Census participation by Aboriginal persons may have been lower. Persons with Indian status under the Indian Act of Canada are entitled to have their provincial health insurance premiums paid by Health



Canada. For this reason, the Medical Services Plan (“MSP”) of BC keeps a record of those with Indian status. In 1996, 118,659 out of 3,855,140 MSP registrants had Indian status recorded. This implies that 96% of total MSP registrants (3,689,755 out of 3,855,140) participated in the Census, however, among Status Indians, only 79% (93,835 out of 118,659) participated. So, it is possible that the Census may have underestimated the BC Status Indian population by as much as 21%. The total number of Metis in BC is uncertain therefore it is difficult to know how extensive their participation was.

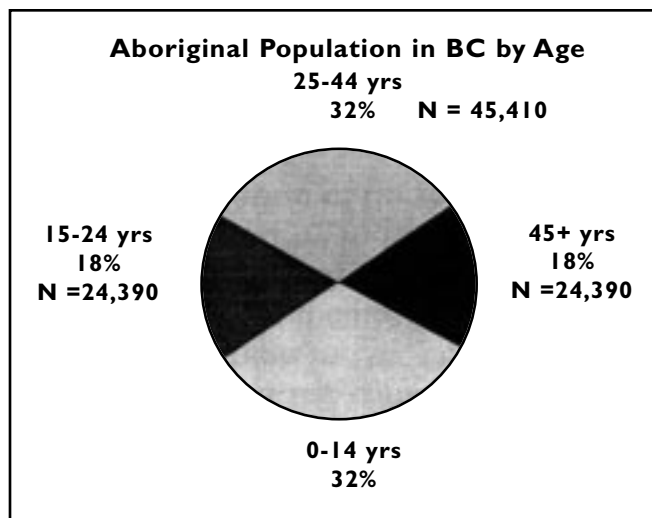
In Table 2 (see page 75) the total number of residents of Indian Reserves in BC is reported as 64,890. This population is much larger than the total number of Aboriginal persons in BC living on-reserve (42,455, see Table 1). The count of 64,890 includes the estimated populations of incompletely enumerated communities and reserve residents who did not have “Aboriginal identity” as defined by the 1996 Census. Some of these non-Aboriginal residents may be spouses, partners, children or other dependents or relatives of Indian Band members. The dependents could be part of the explanation for the difference between the numbers of Status Indians counted in the 1996 Census and those registered with the Medical Services Plan (see above). Some of the non-Aboriginal residents may be tenants who rent or lease Band-owned housing.

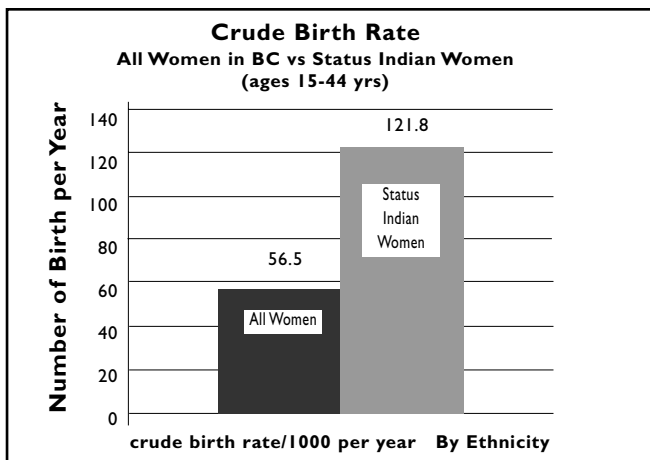
As shown in Table 1, only about 30% of the Aboriginal population live on reserves. About 27% of the Aboriginal population are urban dwellers, living in the Vancouver or Victoria Census Metropolitan Areas. The populations of other Regional Districts within BC are shown in Table 2.

About 80% of Aboriginal persons live in a “census family” (a husband-wife couple with or without children at home, or a lone parent with a child or children at home), 13% live with other people and 7% live alone.

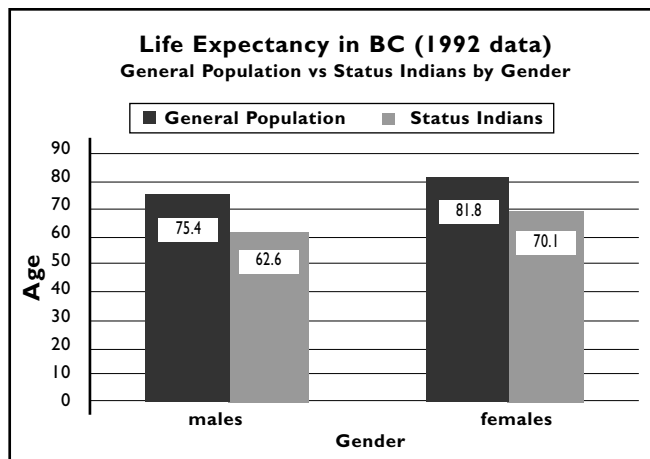
The outstanding feature of the Aboriginal population is its youth. About 32% of the Aboriginal population is 14 years old or younger (compared to 20% of the general population of BC).

Only 18% of the Aboriginal population is 45 years or older (compared to 34% of the general population).





The youthful character of the Aboriginal population is due to high birth and death rates, relative to the total population of BC. Fertility rates in BC for the period 1987-1994 are shown in Table 3 (see page 76). During this period, for all women aged 15-44 years in BC the crude birth rate was 56.5 live births per 1,000 women per year, but for Status Indian women the rate was 121.8 live births per 1,000 per year.



The Total Fertility Rate (the expected number of live births in a group of 1,000 women, followed for 30 years from ages 15 through 44) for all women in BC was 1,632 live births per 1,000 women, but for Status Indian women the rate was twice as high at 3,336 live births per 1,000.

For all persons in BC in 1992, the life expectancy at birth was 75.4 years for males and 81.8 years for females, but for Status Indian persons, life expectancy was about 12 years shorter (62.6 years for males and 70.1 years for females).<sup>9</sup> This is further shortened by HIV infection.

## SOCIOECONOMIC CHARACTERISTICS

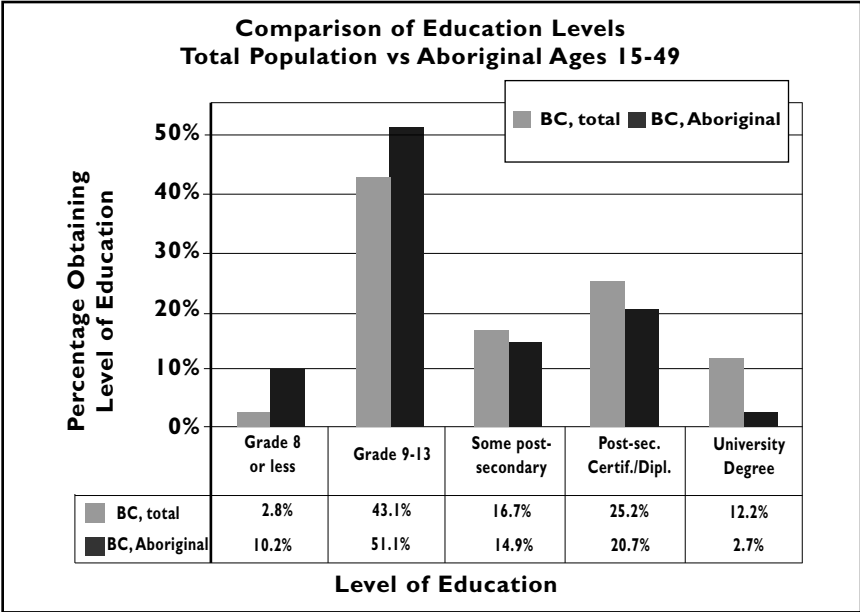
Based on statistics<sup>10</sup> of the highest level of education reached by individuals (Table 4 - see page 77), individual total annual income from all sources (Table 5 - see page 78), and unemployment and use of social assistance data (Table 6 - see page 79), BC's Aboriginal population is clearly suffering from socioeconomic disadvantage when compared with provincial averages.

Only 45% had employment (compared to the provincial figure of 61%.) A sizable minority (28%) of Aboriginal persons had received social assistance in the past year. Among persons aged 15 years and over, 54% of Aboriginal persons had less than \$10,000 income per year (compared to the provincial figure of 33%.) Only 6% had \$40,000 or more income per year (compared to the provincial figure of 17%.) This understandably results in a cycle of poverty, poor housing, poor nutrition, a poorer health status and reduced quality of life.

Education, a primary employment criteria in today's job market, becomes an even greater issue in breaking this cycle. Although some improvements have been made in Aboriginal education over the last several decades, significant further improvement is needed as quickly as possible. Particularly at the university level, as can be seen from current statistics on educational levels

achieved. Among Aboriginal adults aged 15 to 49 years, 10.2% had Grade 8 education or less (compared to the provincial figure of 2.8%) and only 2.7% university degree (compared to the provincial figure of 12.2%.) If we were able to break down the secondary school level (grades 9-13), it is likely that there would also be a significant difference between those who complete high school and those who do not graduate.

These socioeconomic conditions, low levels of employment, low wages when employed, and low levels of education at the higher levels, create a cycle of dependency on social assistance - which, although there has been some improvement, doesn't provide sufficient support for the longer term training necessary to move above minimum wage employment. This continues to result in reduced ability to move beyond dependency. If Aboriginal communities are to move from this place, more provision for educational support, longer life skills and job readiness programs and in many cases, therapeutic counselling to deal with the multiple traumas that many Aboriginal people experience is going to be required.



**Elders**

*The scarcity of our Elders make them all the more special for us. Elders are respected and cherished individuals who have amassed a great deal of knowledge, wisdom and experience over the period of many, many years. They are individuals who have also set examples, and have contributed something to the good of others. In the process, they usually sacrifice something of themselves, be it time, money or effort.*<sup>11</sup>

*Elders, Old Ones, Grandfathers and Grandmothers don't preserve the ancestral knowledge. They live it.*<sup>12</sup>

*Elders are generally, although not exclusively, older members of the community. They have lived long and seen the seasons change many times. In many Aboriginal cultures, old age is seen as conferring characteristics not present in earlier years, including insight, wisdom, and authority. Traditionally, those who reached old age were the counsellors, guides and resources for the ones still finding their way along life's path. Elders were the ones who had already walked a great distance on this path and were qualified to advise based on their knowledge of life, tradition and experience.*<sup>13</sup>

**AN ELDER'S THOUGHTS ON HIV/AIDS**

***"...there is a need for change, to promote healthy lifestyles, through the strengthening of our traditions and culture... We can not ignore a deadly killer such as AIDS that is now knocking at our door. As we approach the close of this century, it is time we take a major reassessment of our situation as First Nations people in our communities. This reassessment should respond to some perplexing questions. The list of questions is virtually endless for our people, among them, facing the challenge of AIDS.***

***We have survived attempts against our aboriginal souls of every description. These attempts have taken an enormous toll and we have learned...painfully and***





*with difficulty. But we should realize that AIDS is one of the greatest challenges we are going to face as First Nation peoples in our lifetime.*

*Many of our people believe that AIDS is not our disease. The truth is that hundreds of our people have already been exposed to the virus. What this means is that unless we take steps now to protect ourselves, our families and our communities, we may be facing an increase in AIDS related diseases in which our loved ones could lose their lives.*

*It is difficult to speak of AIDS in a public way, and still honour the traditional ways of our people regarding public discussion of issues related to sex. We have made every effort to speak in a respectful manner but our deepest respect is for life itself. It is because our people themselves are threatened by this disease that we have chosen to speak and give voice on the AIDS problem.*

*Our healers have taught us that every disease carries with it a set of lessons to be learned. One of the key lessons we will learn in listening to the voices you have heard is the importance of protection. Once a person has contracted AIDS, there is no cure.*

*The past few decades has brought so much change. It is almost as if we have not had a collective moment to reflect on where we came from, where we are and where we are going. This message is a call for reflection. It is a demand for change in our own attitude towards ourselves, in the attitude of others towards us and in our attitude towards others. It is a call for us to seize control over our own future in order to assure that the changes we experience in the future will not mirror our past...*

*I was born to the world in which my generation of aboriginals now live. We are the generation that grew up after World War II, that have lived through the movements for equality and whose members are struggling with our identities as Aboriginals...*

*There is nothing that this group can not accomplish in our time, unless we choose not to strive for it. This is not to say that we have not experienced difficulties regarding our culture, indeed it is because of our long history of victimization by others that many of our people hold back from assertively demanding equality. We worry about rocking the boat...a boat whose owner, we fear, may ask us to disembark.*

*I hope of course that my journey will continue for many more years - but the 60 years of life is an appropriate point for pausing and taking stock.*

*My Indian-ness is a very important part of my life, indeed, though I live and participate quite actively in the secular world, my Indian-ness is always with me, both consciously and unconsciously. Sometimes, particularly, during my younger years, my Indian-ness was most in evidence at the authority against which I rebelled. Occasionally, and even to this day, my Indian-ness and the history it rep-*



*resents, is the source of my anger... what some have called the permanent chip on my shoulder. Finally my Indian-ness is always with me as a reminder of who I am, where I came from and where I want to go... we share with all of you, an issue that will have a great impact in our future...*

*I want to share with you, a quote from some Indian wisdom. Being Indian is an attitude, a state of mind. It's a way of being in harmony with yourself, with others and with things. It is allowing the heart to be the distributor of this powerful energy we possess, allowing feelings and sensitivities to determine where this energy goes, bringing aliveness up from the earth, down from the sky, putting it in and giving out of the heart...*

**Ekosi**

**Andrew Yellowback, Elder**





# HIV / AIDS

## IN ABORIGINAL COMMUNITIES

### CANADA

*"I got it from injection drug use. And the problem that I'm having today is that most of society doesn't want to accept HIV and AIDS as a reality. And yet they expect me to accept it. And I'm supposed to stand up and be proud as a woman and let other people know so that they can be scared of me and call me names and call me down and treat me bad. I really agree with what you're saying before about that we're not dealing with just the epidemic of HIV and AIDS, we're dealing with feelings and things that happened in the past, residential schools and physical, mental and sexual abuse because I've been through all of them... I refused to deal with it before and that's why I turned to using cocaine... I didn't know who to talk to and I didn't know how to tell other people what happened to me, what somebody else did to me. And this disease has forced me into a corner, into standing up and fighting for my life. It's been really difficult and I've been hiding for a long time."*

*Janice, pg 72-3; BC Aboriginal HIV/AIDS Task Force Prince George Strategy Consultation, October 5, 1998*

**N**ationally HIV case reporting is inconsistent and ethnicity is not gathered in some cases therefore levels of HIV infection are under-reported and making comparisons across provinces is difficult. AIDS case reporting provides us with a somewhat more accurate look at the movement of HIV into the Canadian population, although ethnicity is still missing in many AIDS case reports.

From the beginning of the HIV epidemic, the majority of Aboriginal people living with HIV/AIDS have been found in urban centres like Vancouver, Toronto and Montreal. However, over time there has been a gradual increase in those testing for HIV away from major urban centres. At the national level, almost 60%<sup>4</sup> of the known Aboriginal AIDS cases are among homosexual/bisexual ("Two-spirit") men who have lived away from their communities for years. Often they are reluctant to approach their families or communities because they fear rejection and the stigma still, in many cases, associated with HIV/AIDS and with being "gay".

A major difference in Aboriginal AIDS case risk factors versus non-Aboriginal cases is the frequency with which Injection Drug Use ("IDU") is cited as a risk factor, particularly for Aboriginal women. Nationally 50% of Aboriginal women and 19% of Aboriginal men have IDU as their primary risk factor whereas for non-Aboriginal women it is only 17.4% and for non-Aboriginal men 3.2%. Injection drug use has not been a topic of discussion in most Aboriginal communities to date, although it was raised as a concern in the 1991 Aboriginal Peoples Survey. To begin to address injection drug use in Aboriginal communities it will take willingness, persistence and honesty to look at underlying causes for the use of injection drugs.

There has been little research into the role of alcohol abuse and HIV infection. It is not considered to be a primary factor in HIV transmission which is why it is not part of these statistics. It is well recognized, however, that alcohol plays a large part in social activities, sexual intimacy, sexual violence and other high risk behaviours. Alcohol is also a well known lead-in drug. Most people who have gone on to more "serious" drug using, started with smoking cigarettes and drinking alcohol. Aboriginal communities must continue in their strong focus to reduce the use and abuse of alcohol.



Generally heterosexual contact as a risk for spreading HIV is on the increase, accounting for “7.4% of HIV positive test reports in the 1985-1994 testing period, compared to 21.8% of HIV positive test reports in 1997”. For Aboriginal men, heterosexual contact is identified in 4.2% of AIDS Case Reports. For Aboriginal women, it is identified in 35.7% of AIDS Case Reports.

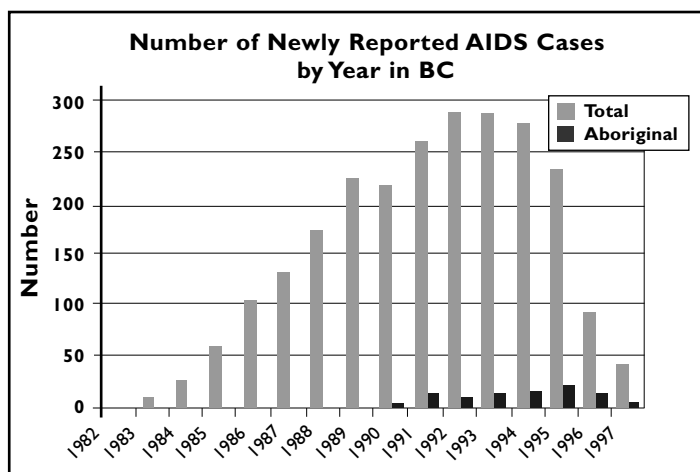
Overall, Aboriginal AIDS cases are younger than non-Aboriginal AIDS cases (29.8% vs 18.6% were diagnosed at less than 30 years of age) and more likely to be women compared to non-Aboriginal AIDS cases (15.9% vs 7%).

Similar to the non-Aboriginal community, in the absence of political and community leadership, Aboriginal people living with HIV/AIDS (“APHA”) have taken an active role in the AIDS movement. They have participated at every level of community development, speaking at workshops, conferences, meetings and consultations. They are an integral part of Aboriginal AIDS Service Organizations (“AASO”). They are staff, board members, volunteers and advisors. They put an Aboriginal face to HIV disease and help to personalize this issue for our community members. Unfortunately, many of our APHA leaders have died and their work remains unrecognized by their own communities.

## BRITISH COLUMBIA

In BC and all other provinces and territories of Canada, it is mandatory for health care personnel and agencies to report cases of AIDS to provincial public health authorities. The first Canadian case of AIDS was diagnosed in 1980. By June 1983, seven cases of AIDS had been diagnosed in BC. None were identified as Aboriginal. The first reported case of an AIDS diagnosis in an Aboriginal person in BC occurred between June 1989 and October 1989. This did not mean that this was the first Aboriginal person to develop AIDS in BC.

Before January 1988, ethnicity or race was not requested on the form that doctors filled out when reporting AIDS cases. This means that there were likely other cases of AIDS among BC Aboriginal people between 1983 and 1989 but that they were not recorded as Aboriginal people. For example, through historical records analysis and adjusting records for reporting delays the BC Centre for Disease Control has since identified one AIDS diagnosis in an Aboriginal person occurring in 1987.



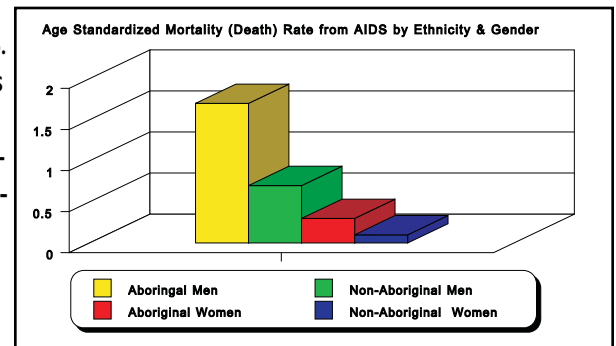
From this recorded beginning in 1989 we have seen a steady rise in the number of cases of AIDS among Aboriginal people in BC. The first diagnosis currently recorded to be made for a Metis person was in 1990 while for an Inuit person it was in 1991. The first diagnosed AIDS cases for Aboriginal women in



BC occurred in 1991. Overall, the number of AIDS cases in the province has risen each year until 1995 when the effects of new AIDS drug treatments began to be seen. As adjustments are made for delays in the reporting of AIDS cases, these numbers and dates will continue to be updated.

As of December 31, 1996, a total of 2,488 AIDS cases had ever been reported in BC of which 89 (3.6%) were known to have been in Aboriginal persons. This is about what one would expect based on the size of the Aboriginal population of BC. However, during the six year period 1991 to 1996, 73 Status Indian persons in BC (63 males and 10 females) died of AIDS. For Status Indian males, the age-standardized mortality (death) rate was 1.7 deaths per 10,000 persons per year. This was 1.5 times higher than the rate for all males in BC. For Status Indian females, the age-standardized mortality rate was 0.3 deaths per 10,000 persons per year. This was 3.0 times higher than the rate for all females in BC. These rates can be explained by the likelihood that the number of Aboriginal AIDS cases has been underestimated and also, according to emerging data from the BC Centre of Excellence in HIV/AIDS, that on average Status Indian people living with AIDS die sooner than other people living with AIDS.

Further research is needed to identify causes for this and ways to address it. Of course, the level of HIV infection among the Aboriginal participants in these studies cannot be taken as representative of the level of HIV in the general Aboriginal population of BC, the majority of whom do not belong to disproportionately high number of Aboriginal people in these disadvantaged groups, and that within these groups, Aboriginal persons areas likely to be HIV-infected as non-Aboriginal persons. For example, the Aboriginal Alcohol & Drug Treatment Centre study being carried out by MSB showed that as of November, 1997, 1561 Aboriginal participants had HIV and Hepatitis. There were six positive results for a rate of 3.8/1000 (95% CI) which compares with an expected rate of 4/1000 for a BC population not selected for specific risk factors.



Unfortunately, examining AIDS case data is a process of examining history. People living with or dying from AIDS are only a small fraction of all HIV-infected people, also, they are mostly people who were first infected with HIV many years ago. The symptoms of AIDS show up 7-10 years after infection with HIV. AIDS case reporting has not kept up with this rapidly expanding and changing epidemic. This has led to greater emphasis on HIV case reporting, which tells us more about the characteristics of those currently testing positive for HIV, rather than those already sick with AIDS.

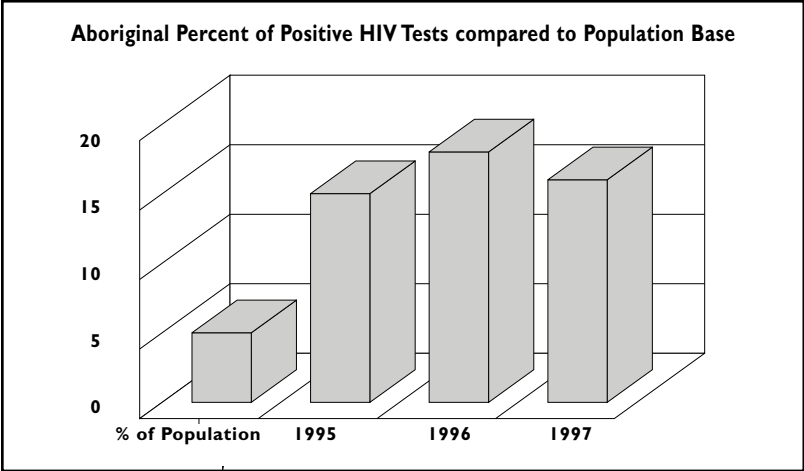
BC began testing for HIV in 1985. Anyone in BC wanting to know his or her HIV-status can get confidential testing by having a blood specimen sent to the Provincial Laboratory of the BC Centre for Disease Control. Regardless of which doctor or clinic takes the blood, the HIV-testing is done by the Provincial Laboratory. To protect privacy, people are allowed to use fake names or code numbers which only their doctors can identify. Over the years there have been changes in the way that HIV test reporting data has been collected, along with advances in computer systems. This has allowed better analysis of the data collected, however it was not until 1995 that we were able to examine HIV by ethnicity with accuracy. This information provided us with a more immediate picture of the Aboriginal epidemic of HIV in BC.

We have seen a huge increase in the number of tests being performed. This is a positive sign that the public is learning about the risks associated with HIV and the need for testing if risks are taken. Knowing that you are HIV positive early on in your infection is important to maintaining your health. It also provides an opportunity to help those with HIV learn ways to reduce the possibility of passing this virus on to others. We do not have very complete data about the characteristics of those who are testing HIV negative.

Although BC has among the best data in Canada on ethnicity in HIV tests there is still much that is unknown about Aboriginal people in BC and HIV. For example, the prevalence of HIV-infection (i.e., the percent who are now HIV-positive) is unknown. No broadly-based population surveys have ever been done. There have been some surveys of groups thought to be at higher risk of HIV infection in which data for Aboriginal participants are distinguishable:

- a 1988-92 study of clients of an outreach program for persons in the urban street-subculture,<sup>21</sup>
- a 1991-93 study of clients of needle-exchange programs for injecting drug users,<sup>21</sup> a 1992 study of inmates of provincial correctional facilities,<sup>22</sup>
- a study on-going since 1992 of clients of Aboriginal alcohol and drug treatment centres and<sup>21</sup>
- a 1994 study of young offenders in provincial youth custody centres.<sup>21</sup>

Of course, the level of HIV infection among the Aboriginal participants in these studies cannot be taken as representative of the level of HIV in the general Aboriginal population of BC, the majority of whom do not belong to any of these high-risk groups. But these studies generally show disproportionately high numbers of Aboriginal people in these disadvantaged groups, and that within these groups, Aboriginal persons are as likely to be HIV-infected as non-Aboriginal persons. For example, the Aboriginal Alcohol & Drug Treatment Centre study being carried out by MSB showed that as of November, 1997, 1561 Aboriginal participants had been tested for HIV and Hepatitis. There were six positive results for a rate of 3.8/1000 (95% CI) which compares with an expected rate of 4/1000 for a BC population not selected for specific risk factors.<sup>23</sup>



*“The longest known social institution in the world is community. Community is a core value for indigenous societies. It is through community structures and processes that the wholistic health of the people is fostered and maintained.*

*For more than one hundred years the self-managing features of indigenous community life have been damaged through interference from the outside. Among other things this has led to the lowering of standards of respectful behaviour towards self and others. This is due to the loss of mechanisms through which such standards were taught and enforced. The abilities of indigenous societies to transmit their respective cultures have declined. Their restoration is part of meeting the challenge of creating a brighter future.*

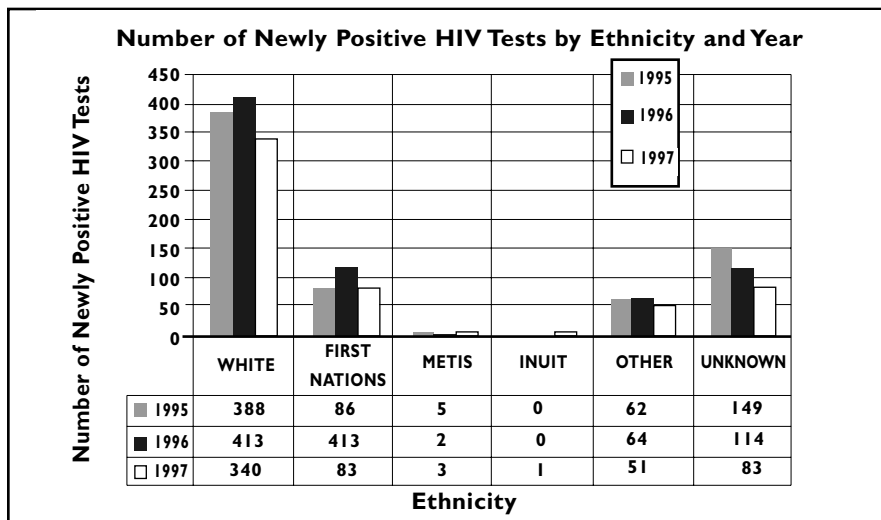
*The degeneration of standards was an inevitable outcome of the devaluation of indigenous cultures by colonial governments and their interference with lifeways through which cultures are taught. As cultural identity and healthy community life are rebuilt, high standards are rediscovered and reactivated. Thus, developing and maintaining high standards of honorable behaviour is both an outcome and a necessary part of the process of building a health community.*

*Building a health community calls for commitment and dedication. The people involved are consciously working towards a positive vision. They believe in the ability of human beings to change themselves and in their own capacity to help bring about desired change. They are willing and able to “commune”, to enter into mutually respectful communication with others through which the knowledge necessary for change can be created and applied.”*

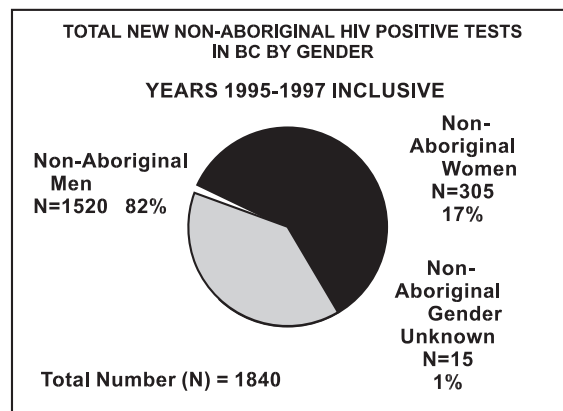
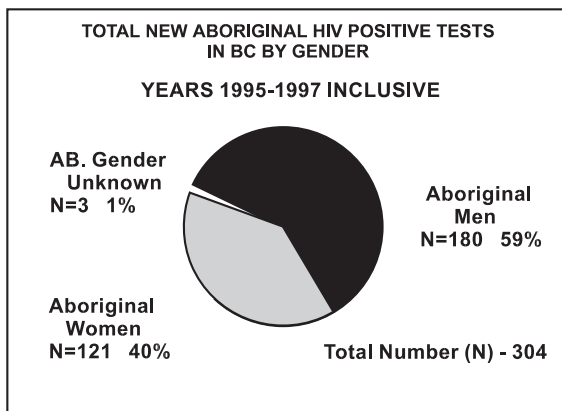
*Aboriginal Standards Committee: Family Violence & Sexual Abuse Workers. Highest Goals and Standards for Quality Programs and Services, A Framework for Community Building. 1994; pg ii. BC Ministry of Health and Ministry Responsible for Seniors*

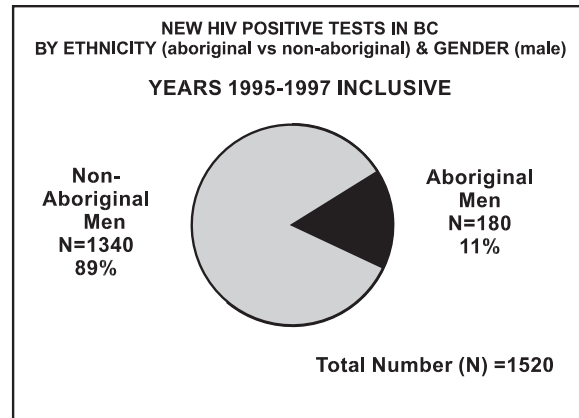
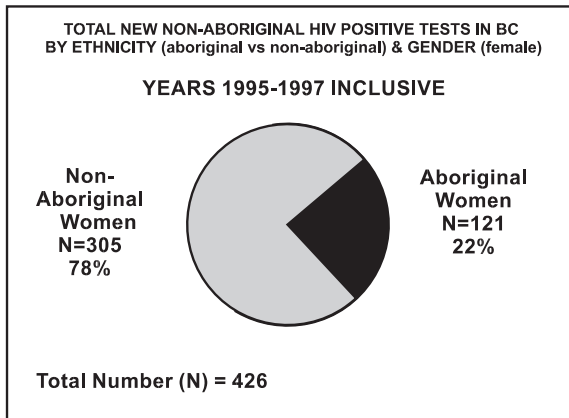
In BC, Aboriginal people made up 15% of 1995's newly diagnosed positive HIV tests, 18% of 1996's and 16% of 1997's, while making up only 5% of BC total population. This level of over-representation indicates the need for urgent attention to managing this crisis through prevention and appropriate care, treatment and support of those already infected.

While the majority of positive Aboriginal tests over the last three years (1995-1997) have been identified as being from First Nations people (290 or 96.4%), the number of Metis (10 or 3.3%) and Inuit (1 or 0.3%) are likely to be under-reported. This may be due to a number of reasons, including lack of self-disclosure of ethnic background, assumptions of those filling out test requisitions on ethnicity or feeling uncomfortable asking for ethnic background. Although improvements are being made in data collection, ethnicity is still missing in 17.6% of all HIV positive tests.

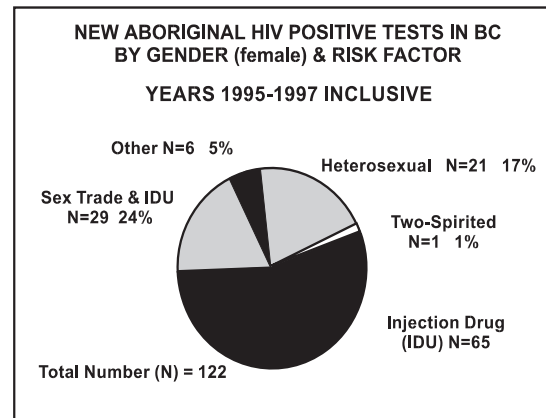
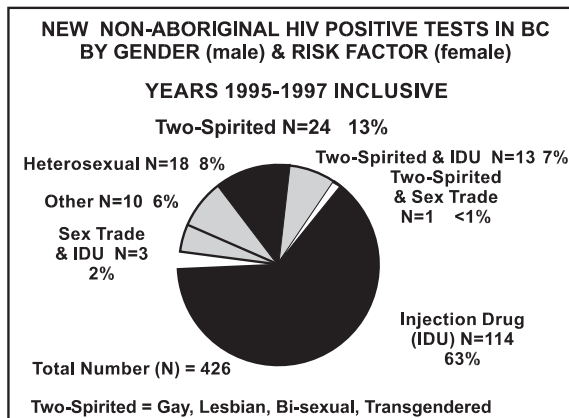


Examination of the BC Centre for Disease Control's enhanced HIV data from 1995 to 1997 has shown that BC's Aboriginal HIV epidemic does not follow the trends seen in many other parts of the country or in other populations within BC. One major difference is the proportion of women that make up Canada's HIV epidemic. Based on 1997 national estimates females made up 21.8%<sup>25</sup> reported HIV cases overall. In BC between 1995 and 1997 women made up 17% (305) of non-Aboriginal tests and 40% (121) of Aboriginal tests.<sup>24</sup>





When we break this data down by gender we also see a difference. Aboriginal men made up 12% of new male HIV positive tests while Aboriginal women made up 28% of all new female tests in BC.



Another difference is the risk factors - between 1995 and 1997 30.3% nationally (total population) versus 60% for Aboriginal people within BC who identified Injection Drug Use (“IDU”) as their primary risk factor. For BC Aboriginal men IDU was cited as a risk factor 63% of the time while for Aboriginal women it was cited 53% of the time. While both men and women identified IDU as the major risk factor, there were gender differences found in other risk factors.

Heterosexual contacts (17% for Aboriginal women, 8% for Aboriginal men) were more significant for women than men, however for Aboriginal men it is a more common risk factor than for non-Aboriginal men. Combined sex trade and IDU (24%) was a significant risk factor among Aboriginal women but only 2% for Aboriginal men. Men, on the other hand, identified being two-spirit people as a significant risk factor (13%). Identifying as being two-spirit people and also using injection drugs was identified in another 7% of HIV positive Aboriginal tests.

The difference in risk factors also explains another shift in HIV epidemic in BC’s Aboriginal community - age range. The majority of positive Aboriginal HIV tests between 1995 and 1997 have been older than is being seen provincially or



## Two - Spirit People

The term, "two-spirit people" has a number of meanings within several different contexts. For instance, in contemporary times, with the advent of lesbian and gay liberation, "two-spirit people" means Aboriginal people who identify themselves as gay or lesbian. The terms, "gay" and "lesbian", are European in origin. Therefore, "two-spirit people" is preferred because it is more culturally relevant to Aboriginal lesbians, bi-sexuals and gay men, and better reflects historical beliefs.

Many Aboriginal nations in America had specific names for two-spirit people ie. Anshinabek had the word "Ogokwe". Sioux had the word "Winkte", etc. Each Aboriginal nation had specific roles and influences that the two-spirit persons played within the community calling. Not every two-spirit person was a shaman, healer, teacher or wife, etc., but rather concentrated on their specific gift or talent to better enhance the community.

Aboriginal culture is recognized for its emphasis on balance and harmony in all of creation. No one element, force, or impulse dominates the others. The term "Two-spirit people" originates from the First Nations recognition of the traditions and sacredness of people who maintain a spiritual place in our world. We learned that before colonization that to be "two-spirit people" was a gift, which had promise and potential. Two-spirit people were respected and honoured, and were visionaries and healers in our communities. We have rediscovered that we continue to have a spiritual place in our world.

nationally, with both males and females largely being in the 30-39 age range. The second largest Aboriginal age group testing HIV positive is the 20-29 range, however positive tests are being seen across all age groups. This data makes it clear that although prevention with youth is essential, different approaches that appeal to those in the adult years is also needed in BC.

Having infected adults in their prime reproductive years increases the exposure risk to children born to HIV positive women. Oak Tree Clinic in Vancouver provides holistic care to families infected with HIV. Between 1989 and 1997, Oak Tree had seen 126 children of whom 35 (28%) were HIV positive. Overall, 45 or 36% of the children were Aboriginal. Of the total number of positive children 29% (10) were in foster care and 60% (6) of those were Aboriginal. Another 12 of the Aboriginal children who were not positive but had been born to <sup>26</sup> positive mothers were also in foster care. This indicates a need for ensuring that foster parents are educated HIV and AIDS and its impacts on families.

## RURAL AND URBAN ABORIGINAL POPULATION

Approximately 97% of Aboriginal HIV cases are being tested in Vancouver.<sup>24</sup> Due to limitations in the way that HIV testing information is gathered, it is not possible to know whether or not those who are testing in Vancouver actually live in Vancouver. Given that a high percentage of Aboriginal tests are from First Nations people, it is likely that some are taking advantage of being in Vancouver to test for HIV rather than testing in their home community or region. There is great concern that the emerging trend of HIV infection in Aboriginal people will be in those who live on reserves. Further investigation into this possibility is essential.

## HIGH-RISK BEHAVIOURS

Among Aboriginal people in BC, the prevalence of high-risk behaviour for HIV infection (e.g., injection drug use, needle-sharing, sex-trade work, unprotected sex, etc.) is unknown. No broadly-based surveys of the Aboriginal population have ever been done. Indirect signs of risk such as rates of alcoholism, abuse, pregnancy and sexually transmitted diseases (STDs or VD) create concern for the Aboriginal community as they tend to be significantly higher than in the non-Aboriginal population. This current state of affairs is understandable in the context of the experience of colonialism, systemic discrimination and institutionalized abuse in the Residential School System experienced by many Aboriginal people until recent years. To address HIV in Aboriginal people, the underlying issues that have led to the current level of risk for HIV infection must be acknowledged and incorporated during the development of services and programs.

As HIV may be easier to catch or pass on in the presence of another STD. HIV prevention efforts must also work to lower rates of STDs. Aboriginal communities need to encourage development and use of women's wellness clinics and other types of STD screening programs. Although in BC we have access to fairly detailed information on HIV in Aboriginal people, we should be cautious about jumping to conclusions. The total number of Aboriginal HIV cases remains relatively small. We still have much to learn. For comparison, the characteristics of all persons (Aboriginal and non-Aboriginal combined) in Canada with new HIV-positive tests in 1995<sup>27</sup> are shown in Table 7 (see page 80).



*I'm William Blackwater of the Gitxsan Nation. Date of birth, September 30, 1954. I'm a member of the Wolf clan from the house of Tszbux. My chief name is Agh Sii Haast from the village of Gisigaast. I was raised from an infant by my grandparents until 10 years of age. It was in the school year of September 1965 that Indian Affairs took me away from my home community of Kispiox BC and sent me to Alberni Indian Residential School ("AIRS"), which is located in Port Alberni BC, approximately 1000 miles away from my home. DIA sent me to this school for my own benefit, they claim, where I would get a better education. I am also the main plaintiff in a civil litigation against both the Federal Government and the United Church of Canada for the horrible atrocities inflicted on First Nations children during "our term" in AIRS.*

*I have been given the impression [through discussions during Healing Foundation consultations] that the HIV/AIDS history has a very "minimal connection" to the legacy of various Indian Residential Schools throughout Canada. Therefore I will give a brief history of my personal experiences while in AIRS. During my first week, I was sexually abused by my dormitory supervisor. He forced me to fondle him and to perform oral sex. Within a month it progressed. The abuses continued at a minimum of once a month for 3 long years. I tried to disclose about the sexual abuse on three separate occasions but no one believed me. I was beaten by the Principal and after the third disclosure, nearly beaten to death by the Dormitory Supervisor.*

*I finally realized the only way to continue living was to immediately implement a code of silence about the nightmares that were being inflicted on me. This is only one example of the many abuses inflicted on me during my sentence in the Residential School System. Other abuses that I've endured include being made to eat a bar of soap for speaking my Gitxsan language and being stripped of our clothing and being forced to run a gauntlet of students who were made to kick, hit and punch as hard as possible.*

*Now anyone who claims that Aboriginal people with HIV/AIDS has a very minimal connection to the legacy of Indian Residential Schools, obviously hasn't spent any time at all in the Residential School System. Visualize the obvious connection - the very fact of our Aboriginal continuous destructive behaviours should be evident enough. The prisons are full of First Nations people who have either gone through the Residential School System themselves or a member of their family has. The loss of connection, being striped of our dignity and self-respect should be evident enough. We have lost our identity. The skid-rows of every city across Canada is full of our First Nations people who have no other place to call home upon completion of their sentences in various Indian Residential Schools. These survivors are coping with their own traumatic memories by the only means that is easily accessible - alcohol and drugs. These very survivors share whatever is needed to ease their painful memories, including needles... Ultimately, after all the various abuses endured, it would be absurd that the term "safe sex" would carry a significant prevention meaning to them.*

*May the Creator continue to guide and watch over you  
Respectfully yours  
Willie Blackwater  
November 12, 1998*



# ABORIGINAL

## PRISONERS

**I**n Canada, provincial and territorial governments are responsible for offenders serving sentences of less than two years, offenders sentenced to probation and young offenders. The Correctional Service of Canada is responsible for the administration of sentences of two years or more.<sup>28</sup> As of March 31, 1997, the Correctional Service of Canada had a total of 1,962 persons in custody in its nine Pacific Region facilities. Among the 1,927 male inmates, about 358 (18.6%) were Aboriginal.<sup>28</sup> Among the 35 female inmates, 7 (20.0%) were Aboriginal. During the one-year period ending March 31, 1997, a total of 11,531 adults were sentenced and admitted to provincial correctional facilities in BC, of whom 2,076 (18%) were Aboriginal.<sup>29</sup>

Two studies have measured the prevalence of HIV infection among prison inmates in BC. A 1992 study<sup>24</sup> involved adults admitted to provincial correctional facilities. A total of 2,482 inmates participated (91.3% of eligible admissions during a 3 month period.) Of the 2,482 participants, 150 (6%) were female, 572 (23%) were Aboriginal and 744 (30%) had a history of injection drug use. Saliva tests for HIV antibody showed that 28 (1.1% of participating inmates) were HIV-positive, 18 of the 28 had a history of injection drug use. Of the 572 Aboriginal participants, 5 (0.9%) were HIV-positive.

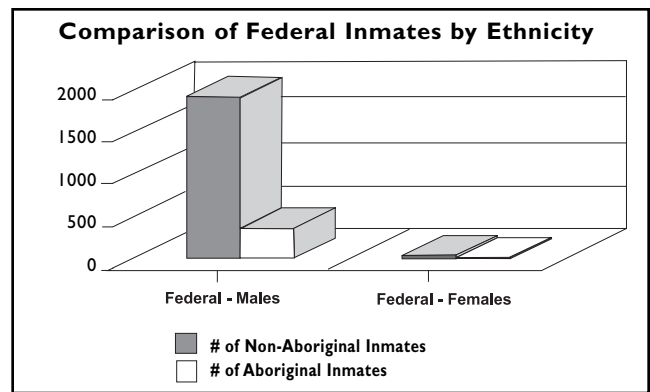
The same researchers (Rothon et al)<sup>21</sup> conducted a 1994 study of young offenders (aged 12 to 19 years) admitted to provincial youth custody centres in BC. A total of 788 persons participated (97.8% of eligible admissions during a 12 week period.) Of the 788 participants, 206 (26%) were Aboriginal (160 males and 46 females.) Saliva tests for HIV antibody showed that two (0.25% of all participants) were HIV-positive. None of the 206 Aboriginal participants were HIV-positive. This study may have underestimated the prevalence of HIV infection. The number of participants is small for an HIV-prevalence survey, so this study has a wide margin of error. For all young offenders, the 95% confidence interval for the prevalence of HIV infection is 0.04% to 1.02%. For Aboriginal young offenders, the 95% confidence interval for the prevalence of HIV infection is 0.00% to 1.45%.

In 1995, the Correctional Service of Canada sponsored a nation-wide survey of male federal inmates, which included questions about HIV/AIDS risk behaviours.<sup>30</sup> A total of 4,285 inmates completed questionnaires. The participation rate was 65%.



Fifteen percent of the participants were Aboriginal persons. Among the findings of the survey:

- 11% admitted injecting an illegal drug since coming to the current institution,
- 5% (of all inmates in the sample) had injected drugs without knowing if the injection equipment was safe,
- 6% had sex with another male inmate since coming to the current institution,
- 4% (of all inmates in the sample) had sex with another male inmate without using a condom,
- 3% had been sexually assaulted since coming to the current institution,
- 6% had been pressured for sex since coming to the current institution,
- 13% (of all inmates in the sample) had a tattoo done in prison and were unsure about the safety of the equipment,
- 5% (of all inmates in the sample) had skin pierced and were unsure about the safety of the equipment.



This in spite of the fact that federal correctional facilities are controlled environments where all of the above activities are prohibited. In addition, 64% of respondents reported that they had received HIV testing, and 46% believed that they were in greater danger of contracting HIV in prison than when they are in the community.

In 1992, the Solicitor General of Canada created the Expert Committee on AIDS and Prisons to advise on preventing the transmission of HIV infection in correctional facilities.<sup>3</sup> In 1992 and 1993 the Expert Committee visited facilities in BC, Ontario and Quebec, reviewed relevant national and international policies, reports and documentation, and solicited information from inmates, prison staff and other interested groups.

The Expert Committee produced numerous recommendations, including:

- make anonymous, voluntary HIV-antibody testing available to all inmates,
- protect the confidentiality of inmates' HIV status and other personal medical information,
- protect inmates living with HIV or AIDS from harm or discrimination (including the areas of housing, education, jobs and vocational training),
- take action to prevent sexual assault and abuse (reduce crowding, identify and segregate sexual predators, protect vulnerable inmates),
- mandatory education on HIV and AIDS for all inmates and all corrections staff
- include external and community-based organizations in HIV/AIDS education programs for inmates,
- provide HIV/AIDS education programs for inmates with special needs (women, Aboriginal people, other ethnic groups, those with low levels of literacy and inmates with disabilities),
- permit consenting sexual activity among inmates,
- make condoms, dental dams and waterbased lubricants available to inmates,
- strengthen efforts to prevent or reduce illicit drug use,
- make methadone maintenance treatment available to inmates who are addicted to injecting heroin or other opiate drugs,

- make bleach and instructions on disinfecting injection equipment available to inmates,
- in scientifically evaluated pilot projects, make sterile injection equipment available to inmates
- allow inmates access to professional tattooing and body piercing services, using approved equipment and supplies,
- develop protective procedures and provide protective equipment for corrections staff who may be exposed to HIV (e.g., cleaning up blood or other body fluids, body searches, handling of aggressive inmates)
- for inmates living with HIV or AIDS, provide medical care comparable to that which is available in the community,
- for inmates living with AIDS, consider compassionate early release whenever they do not pose a threat to the community.

The Correctional Service of Canada has accepted in principle almost all of the Expert Committee's recommendations. However, implementation by federal correctional facilities has been spotty and slow. In provincial facilities, since 1992, BC Corrections has initiated inmate education on HIV/AIDS and other infectious diseases, made bleach kits available to inmates and reviewed its policy regarding methadone maintenance programs.

## DEMOGRAPHIC IMPLICATIONS FOR HIV/AIDS PREVENTION POLICY

Due to significantly different age structure and birth rates compared to the general population of BC, programs and services for the Aboriginal population need additional emphasis on youth, childbearing women and families with children as target groups.

The majority (70%) of Aboriginal persons in BC live off-reserve, with a sizable minority (27%) living in major urban centres. Off-reserve programs and services are necessary to reach the majority of Aboriginal British Columbians. The Medical Services Branch of Health Canada and transferred First Nations health authorities provide public health services to reserve communities in BC, but off-reserve Aboriginal community-based organizations and the province's Regional Health Boards, Community Health Councils and local Community Health Service Societies will all have major roles in providing HIV/AIDS prevention services to Aboriginal persons living off-reserve and in urban centres. Greater communication, cooperation and coordination between jurisdictions will be necessary to reduce service gaps and overlaps and increase continuity of care. The authority, roles and responsibilities of Aboriginal community organizations must be clarified and supported in an integrated fashion.

Perhaps as many as one-third of the residents of Indian Reserves in BC do not meet the 1996 Census definition of a person with "Aboriginal identity." However, they may be family members or otherwise have daily social contact with Aboriginal persons, and they may depend on Aboriginal health programs and services. Planning of HIV/AIDS prevention services for on-reserve populations will need to take into account the significant number of

non-Aboriginal residents of reserves. On-reserve HIV/AIDS prevention programs can be expected to benefit both Aboriginal and non-Aboriginal people alike.

## SOCIOECONOMIC IMPLICATIONS FOR HIV/AIDS PREVENTION POLICY

- As well as needing to be culturally appropriate, health education programs for the Aboriginal population will need to take into account lower levels of general education in the target audiences and also in the pool of community members who could be recruited as prevention and support workers. This will require a range of material at a variety of literacy and technical levels, longer training times for workers and will typically result in higher program costs to adequately address these issues.
- For Aboriginal persons with HIV or AIDS and their families, care, treatment and support programs will need to take into account the low income of the average Aboriginal family and all of the resulting consequences, including (but not limited to) crowded or inadequate housing, reduced availability of nutritious food, less access to health care and limited ability to cope with prolonged illness in oneself or in a family member.

## EPIDEMIC TREND IMPLICATIONS FOR HIV/AIDS PREVENTION POLICY

- HIV infection, ranging from asymptomatic HIV-seropositivity to full-blown AIDS, exists in the Aboriginal population of BC. So far, Aboriginal AIDS cases in BC have been about as common as one would expect from the size of the population. However, in recent years, among newly HIV-positive persons in BC, a disproportionately high number are Aboriginal. This suggests that in the future, a disproportionately large portion of the burden of AIDS illness, and all its associated health care and support service needs, will fall upon the Aboriginal population of BC. The higher mortality rates from AIDS among Status Indian people in BC suggest that already the treatment, care and support needs of Aboriginal people living with AIDS are less well met than for non-Aboriginal people living with AIDS.
- The pattern of HIV infection for BC Aboriginal people differs from the pattern usually seen in Canada. It does not, however, resemble that seen in "Pattern II" countries (i.e., equal numbers of males and females infected, with heterosexual contact the predominant mode of transmission) as suggested by some. Among BC Aboriginal persons, the predominant risk factors appear to be injection drug use and the sex trade. HIV/AIDS prevention strategies for the Aboriginal population should focus on these two risk factors (though not to the exclusion of others) and also address the conditions which lead young people into such dangerous and self-destructive behaviours, conditions such as poverty, unemployment, racial discrimination, lack of education and physical and sexual abuse of children.

- Although BC has a highly developed HIV/AIDS surveillance system which is capable of monitoring the Aboriginal population, health program planners still need information on the prevalence of HIV infection among Aboriginal persons in BC, such as could be obtained from broadly-based anonymous unlinked HIV-seroprevalence surveys. Such studies have been done for the general population of BC, but never yet for the Aboriginal population. There is also a need for broadly-based surveys of the Aboriginal BC population's HIV/AIDS-related awareness, knowledge, attitudes, beliefs and behaviour.
- The HIV/AIDS surveillance system is not capable of monitoring HIV infection rates in the transgendered population of BC. Modification of the system's gender classification scheme is needed. This information would assist in planning HIV/AIDS prevention programs relevant to this segment of the population. Future seroprevalence and knowledge-attitude-behaviour studies would be improved if they included provision for recording if individual participants were transgendered.

## PRISON IMPLICATIONS FOR HIV/AIDS PREVENTION POLICY

- A disproportionately high number of Aboriginal persons in BC are exposed to the hazards of life in prison, including the risk of exposure to HIV infection. Therefore, an HIV/AIDS prevention strategy for the Aboriginal population of BC must include programs and services for persons in prison.
- Policies of prohibition have not eradicated injection drug use, unprotected sex and other high-risk activities by inmates. Additional measures, using a strategy of harm-reduction, are needed to reduce the risk of HIV transmission among inmates. The recommendations of the Solicitor General of Canada's Expert Committee on AIDS and Prisons regarding sex among inmates, injection drug use, tattooing and body piercing are examples of harm-reduction.
- Parole and other early release programs for those Aboriginal prisoners experiencing AIDS requires extensive care planning and follow-up which is currently unavailable. Half-way houses have insufficient training, staffing and support to accept seriously ill patients. Maintaining access to medicine and health care services may be difficult for those released into community.



# THE HEALTH CARE SYSTEM

## FOR THE ABORIGINAL POPULATION OF BC

### MEDICAL SERVICES PLAN OF BC



**A**ll residents of the province are eligible for health insurance from the Medical Services Plan of British Columbia. The Plan charges a monthly premium for all those registered. The amount of the premium is reduced for people with low income. Health Canada (through its Medical Services Branch) pays the premiums for Status Indians. This benefit is not available to Aboriginal persons without Indian status.

The Medical Services Plan pays for hospitalization, transportation by ambulance, diagnostic procedures, physicians' fees and fees for certain other health professionals (including optometrists, dietitians, physiotherapists and occupational therapists.) These services are provided by a wide variety of sources (non-profit or charitable institutions, the provincial government, commercial enterprises and independent professionals.) All of these services are subject to control by the provincial government, directly or indirectly by control of funding, by regulation or by decisions regarding Medical Services Plan coverage. Aboriginal people get these services from the same sources as other British Columbians.

In addition MSP coverage, certain First Nations communities have access to care by nine Nursing Stations operated by Health Canada (through its Medical Services Branch). These are small acute-care hospitals staffed by Nurse-Practitioners. In BC, they serve 10 remotely located First Nations and surrounding communities with a total on-reserve population of about 3,970<sup>33</sup> persons. Medical Services Branch also provides on-reserve health services through 19 Health Centres, which are staffed by Community Health Nurses who provide a wide range of programs including "maternal and child health, communicable disease control, school health, chronic disease and services to the elderly". In addition there are 37 Health Stations which are "usually staffed by a Community Health Representative (CHR), a Native para-professional serving the Band and providing health education and first aid to local residents"<sup>33</sup>. Major challenges in providing these services include frequent medical staff turnover which creates a barrier to appropriate continuity of care, the broad scope of duties and resulting heavy



workload required by the limited number of nursing and CHR positions funded, and the limited and inconsistent level of health training required of, and provided for, CHRs.

#### **Barriers To Access**

- *language barriers*
- *lower levels of education*
- *lack of knowledge about service providers*
- *confidentiality concerns*
- *lack of respectful culturally sensitive or appropriate services*
- *limited numbers of Aboriginal health care providers*
- *levels of assertiveness needed to get needs met by the medical system*
- *residence in rural or remote areas*
- *local transportation and transportation funding issues*
- *conceptual and cultural differences and racial discrimination*

In theory registration with the Medical Services Plan of BC gives all British Columbians the ability to pay for a broad range of health care services. But for Aboriginal people there are still other practical barriers to access, such as language barriers, lower levels of education, lack of knowledge about service providers, confidentiality concerns, lack of respectful culturally sensitive or appropriate services, limited numbers of Aboriginal health care providers, levels of assertiveness needed to get needs met by the medical system, residence in rural or remote areas, local transportation and transportation funding problems, conceptual and cultural differences and racial discrimination (usually subtle, but sometimes overt.) Due to these and other issues, the Health Canada Act requirements of comprehensive and universal access to care are often difficult to maintain.

### PROVINCE OF BC PHARMACARE PROGRAM

In BC, the provincial government's Pharmacare program pays for prescription drugs for senior citizens and people who are on social assistance. Some benefits are also available to low-income persons. Aboriginal people are eligible for Pharmacare coverage on the same terms as other BC residents. In addition, Status Indians are eligible for certain other drug coverage through Health Canada's Non-Insured Health Benefits ("NIHB"). This can result in community members being unclear about the extent of coverage under each plan and frustration in trying to access payments for non-Pharmacare covered products and certain over-the counter products covered by NIHB. A single comprehensive information package that addresses both provincial and federal coverage and where to access each would begin to reduce confusion and would help in evaluating the full extent of coverage.

### HEALTH CANADA'S NON-INSURED HEALTH BENEFITS ("NIHB") PROGRAM

While Status Indian persons are eligible for the NIHB program, this program is not available to Aboriginal persons without Indian status. There is no premium. This program covers prescription drugs, some over-the-counter drugs when taken under a physician's direction, medical supplies and devices, transportation for medical care outside one's community of residence, eyeglasses, dental care and psychotherapy. With federal devolution of health care to First Nations community control, many of these services are being capped or reduced. Federal Health Transfer Agreements with BC First

Nations may effect the Federal role in on-reserve and Status Indian health provision, requiring increased participation of the provincial government to maintain similar levels of service and/or funding.

For some of the insured goods and services, beneficiaries may have to pay first, then apply for reimbursement. This is sometimes a problem for people who don't have ready cash. Inability to pay for transportation to specialized medical care is perhaps the most common example of this problem. Some First Nations have funds to loan to members, but this is not consistent across communities nor throughout the year. For dental care, the NIHB program has a system for direct payment of dentists (through an arrangement with the Medical Services Association of the Blue Cross network). Usually, Status Indian persons get NIHB-covered goods and services from commercial enterprises and independent practitioners (the same sources as for other British Columbians). This can provide challenges for First Nations people at times when service providers are unfamiliar with the NIHB program and its procedures and are concerned about receiving payment for their services. Clearer procedures and better liaison between NIHB and independent service providers may begin to minimize payment questions.

The NIHB program does not guarantee that appropriate services will be locally available. For example, Aboriginal people in rural areas still often have problems accessing dentistry and psychotherapy. Health Canada's Medical Services Branch directly provides some dental care to needy or remotely located Indian reserves. In BC, the Medical Services Branch employs 3 dentists and 10 dental hygienists for this purpose. Health Canada's Medical Services Branch directly provides residents of Indian reserves with the services of psychologists, family therapists and social workers, for mental health crisis intervention. In BC, the equivalent of two (2) full-time mental health professionals are employed. Independent practitioners can also, with appropriate prior negotiations, bill NIHB for mental health services. Throughout the devolution of the NIHB and other MSB programs to First Nations control, issues of equitable access by off-reserve Status Indians must be addressed. The long-term and overall effect of Federal Health Transfer on Aboriginal Health Services must be monitored to ensure equitable and appropriate health care is provided.

## ALCOHOL & DRUG TREATMENT PROGRAMS

The provincial government provides substance abuse diagnosis and treatment to residents of the province, either directly (through the Ministry of Children and Families, Alcohol and Drug Services Branch) or under contract with non-profit community-based organizations. In principle, Aboriginal people may access these provincial services on the same basis as other persons. For Status Indian persons, Health Canada's Medical Services Branch funds the National Native Alcohol and Drug Abuse Program ("NNADAP"). In BC, Indian bands employ about 163 NNADAP substance abuse workers on-reserve. In BC, NNADAP operates 10 residential treatment centres with a total of 112 beds.

Provincial alcohol and drug treatment programs typically have a short treatment time limitation of 1-6 months. Often they are unable to address the multiple traumas, such as physical and sexual abuse, experienced by many Aboriginal people. Many alcohol and drug counsellors, both those provincially employed and those working through the NNADAP program, have had limited training on HIV/AIDS issues. Addiction issues related to drugs other than alcohol, particularly injection drugs, may be poorly understood by some counsellors whose primary experience has been with alcohol abuse. Cocaine addiction in particular and its treatment is poorly understood overall. Further research is needed in Injection Drug Use among Aboriginal people. New and alternative models of treatment, such as Community Mobile Treatment program<sup>34</sup> which takes counselling expertise into First Nations communities for 21-28 day periods, need further evaluation and funding support.

## MENTAL HEALTH SERVICES

Mental health care is the primary responsibility of the provincial Ministry of Health. This responsibility is carried out through the provision of regional Provincial Mental Health Teams. Services for children and youth have been transferred to the Ministry of Children and Families. Throughout the province there are limited services (both in staffing levels and geographic catchment area) to deal with those who have a major mental illness such as schizophrenia or other serious emotional difficulties, such as depression and suicidal ideation. Psychiatric services are concentrated in urban areas and waiting lists often lengthy. For those with other mental health issues, such as Post-Traumatic Stress Disorder and the various Character Disorders, services are almost non-existent. Where they exist, often they will not accept patients with a dual diagnosis of addiction and a mental health disorder. Rather they will refer them to alcohol and drug treatment services, who may not be well suited to address the underlying mental health diagnosis.

In the lower mainland area, the main provider of mental health services, Greater Vancouver Mental Health Services (“GVMHS”) currently does not have a high percentage of Aboriginal people on its caseload. In April 1998, GVMHS, initiated a two year pilot position for a First Nations Mental Health Liaison in an effort to increase Aboriginal access to its mental health services. The priority focus of this position is on consulting with other mental health staff of GVMHS and on providing services to those Aboriginal people who have major mental illnesses. To address depression and suicide, GVMHS also provides free counselling and provincial consultation services through the Suicide Attempt Follow-up Education and Research (“SAFER”) program. Other mental health services are extremely limited, although GVMHS’s Community Mental Health Teams are also able, to some degree, to assist with AIDS dementia.

Other models of mental health services, such as those provided at The Circle of Harmony Healing Society (Terrace, BC), need to be examined in order to design appropriate mental health services for the complete range of mental health issues facing Aboriginal people. These complex mental health issues, reflected by multiple diagnoses, must be confronted. Appropriate funding and training for mental health workers must become a priority for Aboriginal mental health services.

## HOME-BASED CARE SERVICES

Home-based care for people living with illness in BC includes case management (assessments and coordination), home nursing care, nutrition counselling, rehabilitation therapy, adult day care, home-maker services, meal delivery and various forms of institutional residential care (temporary respite care, palliative care hospices and long-term care facilities.) The provincial government provides some case management and home nursing care, otherwise mostly non-profit community groups and institutions, and some commercial enterprises provide home-based care services.

The selection of available services varies greatly, depending on where one lives. Residents of rural and remote areas, low-income areas and First Nations reserves have fewer choices. Some First Nations reserves don’t even get the basic services that the provincial government provides. Some of these services charge user fees, usually scaled according to the user’s income, or severity of the medical condition. These services are paid for by a variety of provincial government programs, including the BC Ministry of Health’s Continuing Care and Long-Term Care programs, family support programs of the BC Ministry of Children and Families, and health-related income assistance programs of the BC Ministry of

Human Resources. For Status Indian persons, additional federal funding comes from Health Canada's Non-Insured Health Benefits program, and Indian and Northern Affairs Canada's social assistance and housing programs.

Health Canada's Medical Services Branch also provides some funds to registered Indian Bands to purchase home nursing care for band members living on-reserve. This amounts to about \$830,000 per year for all of BC, allocated to bands on a formula basis. Since most bands in BC are quite small, typical allocations are \$2,000 to \$3,000 per year, which is grossly inadequate considering that home nursing care for one seriously ill person can cost \$50,000 to \$100,000 per year. The funds usually go to hiring additional community health nursing staff, who provide public health nursing, and home nursing care as needed. Indian and Northern Affairs Canada provides modest funding to registered Indian Bands to purchase home-maker support services for band members living on-reserve. These services are not at the same level as the provincially funded services. Provincially funded home-makers are trained to provide low-level home nursing care, while federally funded home-makers are not required to have such training. The complexity of funding discourages professional service providers from setting-up programs for Status Indian populations. At the same time, provincial funding programs for home-based care will not pay family members to provide such care. For those with certain opportunistic infections of HIV, such as CMV, or who have AIDS, the lack of trained and qualified home care nursing may make it impossible to remain in their home communities during their illness or final days. Changes to the funding, training and service structure are required to ensure that equitable access to qualified home based care is available for those with AIDS.

The system of home-based care is typically beyond the understanding of the average person. People who have not previously had need to access home-based care often don't know what services are available to them, how much they would have to pay, or where they can get help. Hospital discharge planners and home care coordinators are often unaware of what services would be available (or unavailable) to a resident of a distant rural area or an First Nations reserve. The regional nature of the Continuing Care program also creates difficulties for family members residing in jurisdictions other than where the client lives from initiating and coordinating services for the client. Off-reserve the lack of single point access to the system, effective case management and complex referral requirements create barriers to accessing these services.

Public health services are preventive and are aimed at populations, rather than individuals. These services include health education and vaccinations delivered through prenatal clinics, well-baby clinics and school health programs, communicable disease control (contact tracing and notification, investigation and containment of disease outbreaks) and environmental health inspections of water and sewage systems, waste disposal facilities, food handling premises and public recreation facilities. In BC, these services are provided by provincially mandated Regional Health Boards, Community Health Councils or in rural areas, by Community Health Service Societies.

In BC, 55 registered Indian Bands (on 76 reserves, estimated on-reserve population : 10,418) receive public health services from a Regional Health Board, Community Health Council or Community Health Service Society. The Medical Services Branch of Health Canada provides public health services directly to 103 registered Indian bands (on 128 reserves, estimated on-reserve population: 27,302). Thirty-nine bands (on 66 reserves, estimated on-reserve population: 12,400) get public health services from local Aboriginal governments, funded by Health Canada under the terms of First Nations Health Transfer Agreements. The Medical Services Branch of Health Canada also funds about 133 Community Health Representatives, employed on-reserve by reserve communities to provide health education and to supplement the work of public health nurses. Because of the lack of home-based care services on Indian reserves, public and community health nurses and CHR's are often called upon to provide home nursing care and home-maker support, in addition to their other duties. Recognition of the high degree of need experienced by those with AIDS, through increased funding for health care training and staffing support is required.

## REGIONALIZATION AND HEALTH TRANSFER AGREEMENTS

### Regionalization

"Regionalization" or "Better Teamwork, Better Care - Putting Services for People First" refers to a current effort to reorganize some of the health care services previously delivered by the BC and municipal governments. Initial steps in this redevelopment were the creation of 11 Regional Health Boards ("RHB") in areas of sufficient population (typically centred around urban areas) with full responsibility for design and delivery of health services in their area

*E - Status Indian persons living on the bands' reserves, from Indian and Northern Affairs Canada, based on 1993 band membership lists.*

including regional health planning and policy development, along with the creation of 34 Community Health Councils (“CHC”) (typically found in less densely populated areas) which have limited powers and are primarily responsible for hospitals and residential care institutions. The most recent step (1997) was the creation of Community Health Service Societies in rural areas to deliver public health, mental health and home-based care services (previously delivered by BC Ministry of Health staff in the Public Health, Adult Mental Health, Community Home Care Nursing, Community Rehabilitation, Case Management and Health Services for Community Living programs.)

Despite the Ministry of Health policy to appoint a minimum of one Aboriginal representative to each RHB/CHC, with more seats available in areas of greater Aboriginal population, the majority (36 of 45) of RHBs/CHCs currently do not have Aboriginal population health advisory committees and 12 of 45 do not have Aboriginal contacts representing Aboriginal health issues. Many of those listing Aboriginal contacts referred to on-reserve representatives as contacts.<sup>36</sup> This may create conflicts of interests and difficulty in addressing off-reserve and Metis health issues and priorities in those regions. To date, Aboriginal participation in the regionalization process has been limited and appears to have limited effects. In addition, the ability of a minority vote on these bodies to create change and supportive policy and funding programs for Aboriginal related health services is questionable. Review of the membership/participation process in the RHBs/CHCs is required.

Coordination of regionalization and federal Health Transfer has not taken place in many cases. The full effect of this reorganization on health care in general and Aboriginal health care in specific is currently unknown. One hopes that it will lead to more appropriate services for Aboriginal people, particularly in those regions of the province where the Aboriginal population is most concentrated (see Table 2). Greater participation of broad range of Aboriginal community members is required to be successful in the goal of improving health utilization and health status through structural reorganization.

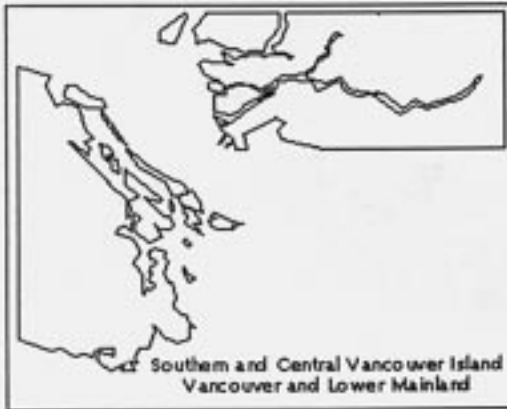
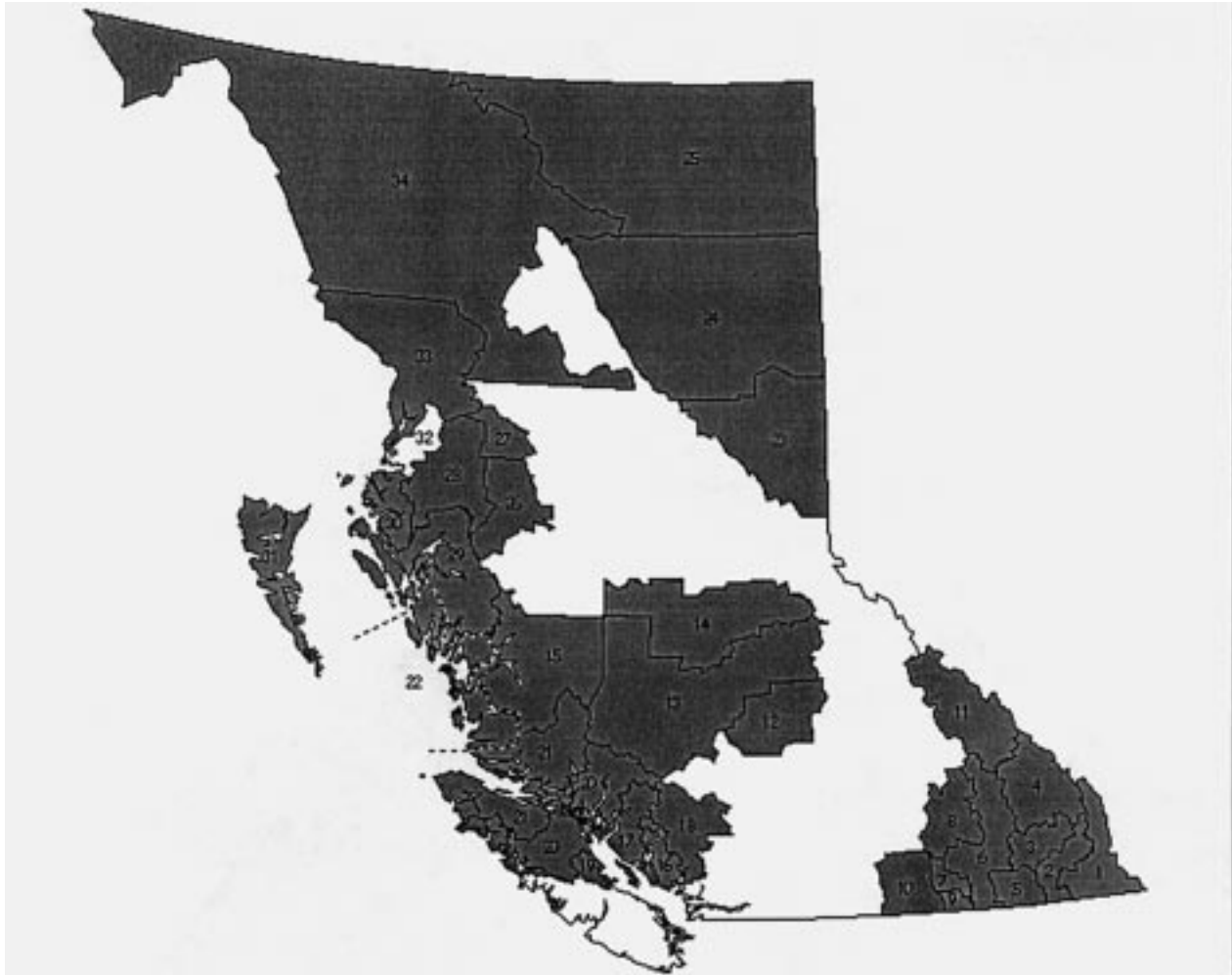
### **Health Transfer Agreements**

Federal “Health Transfer” and “First Nations Health Transfer Agreements” refers to having local Aboriginal governments (registered Indian Bands and Tribal Councils) deliver the health care services currently delivered to Status Indian people by Health Canada’s Medical Services Branch. Exactly which services are

transferred depends on the particular Health Transfer Agreement. In theory, except for the Non-Insured Health Benefits plan, any of Medical Services Branch's services could be included in a transfer agreement. After transfer, Health Canada continues to provide funding, but as block funding in a single "envelope". Aboriginal health authorities set priorities and may redistribute funds among health services according to local needs. In BC, the transfer process is difficult because of the large number of registered Indian bands (197) and the small size of most bands. So far, only a small fraction of BC's Status Indian population get any health services under a Health Transfer Agreement. With the involvement of the Provincial Ministry of Health in health service provision and health transfer, coordination of all sectors providing health care services within a region must be a priority in order to reduce overlaps and duplications while identifying those gaps and service priorities that have yet to be addressed.



**Better Teamwork, Better Care - Putting Services for People First  
Community Health Councils**

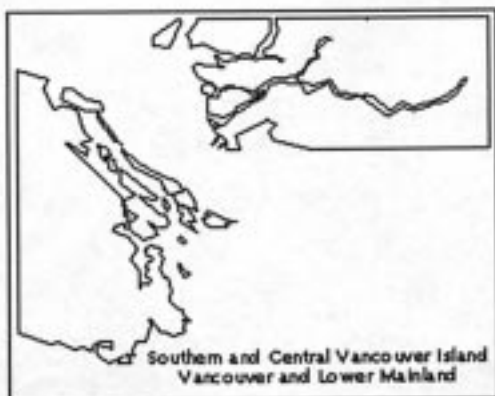
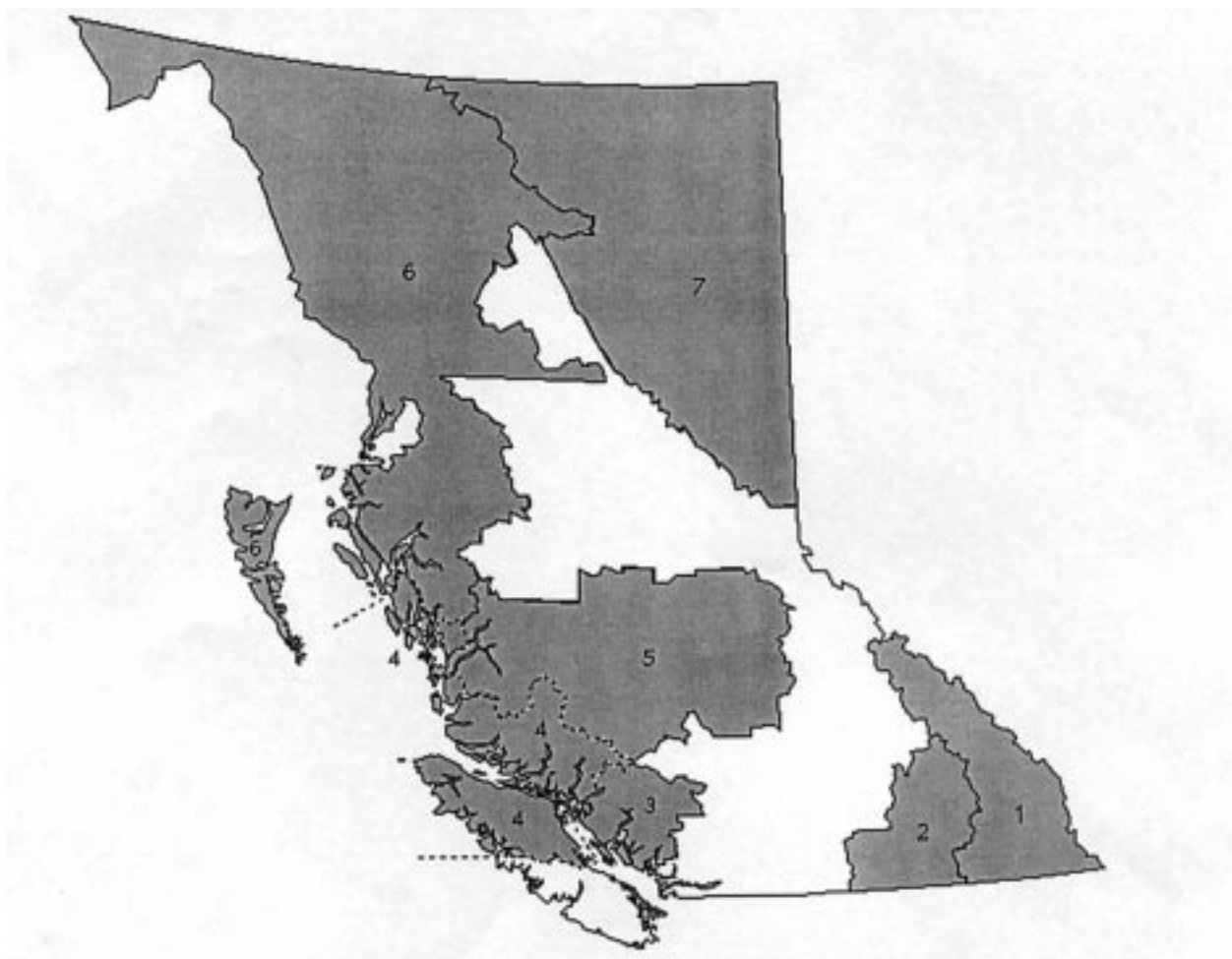


- |  |   |
|--|---|
| 1. Elk Valley and South Country            | 18. Sea to Sky                          |
| 2. Cranbrook                               | 19. Comox Valley                        |
| 3. Kimberley                               | 20. Campbell River/Nootka               |
| 4. Columbia Valley                         | 21. Mount Waddington                    |
| 5. Creston and District                    | 22. Central Coast Transitional*         |
| 6. Nelson and Area                         | 23. South Peace                         |
| 7. Castlegar and District                  | 24. North Peace                         |
| 8. Arrow Lakes/Upper Slokan Valley         | 25. Fort Nelson-Liard                   |
| 9. Greater Trail                           | 26. Bulldey Valley                      |
| 10. Boundary                               | 27. Upper Skeena                        |
| 11. Golden                                 | 28. Terrace and Area                    |
| 12. South Cariboo                          | 29. Kitimat and Area                    |
| 13. Central Cariboo Chilcotin              | 30. North Coast                         |
| 14. Quesnel and District                   | 31. Queen Charlotte Islands/Haida Gwaii |
| 15. Bella Coola and District Transitional* | 32. Snow Country                        |
| 16. Sunshine Coast                         | 34. Stikine                             |
| 17. Powell River                           |   |

32. Nisga'a (not designated under the Health Authorities Act)

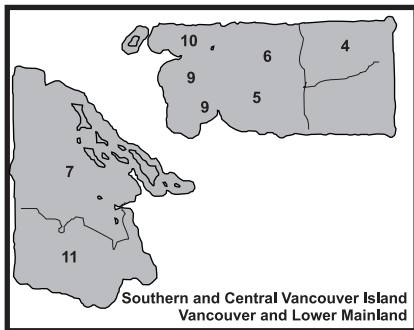
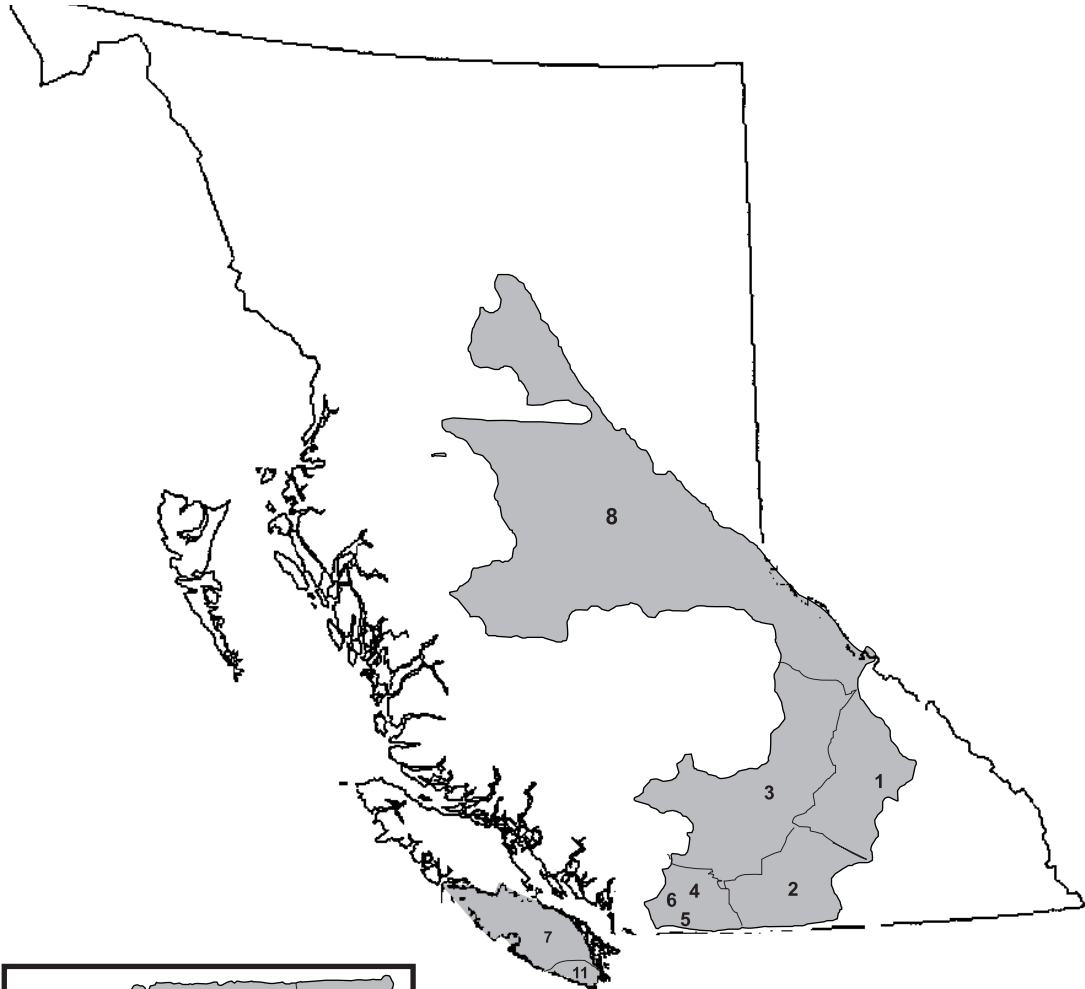
\* Name changed from Bella Coola Valley and District on Mar. 19/1998

**Better Teamwork, Better Care - Putting Services for People First**  
**Community Health Services Societies**



- 1. East Kootenay
- 2. Kootenay Boundary
- 3. Coast Garibaldi
- 4. Upper Island/Central Coast
- 5. Cariboo
- 6. North West (excludes Nisga'a)
- 7. Peace Liard

**Better Teamwork, Better Care - Putting Services for People First  
Regional Health Boards**



- 1. North Okanagan
- 2. Okanagan Similkameen
- 3. Thompson
- 4. Fraser Valley
- 5. South Fraser
- 6. Simon Fraser
- 7. Central Vancouver Island
- 8. Northern Interior
- 9. Vancouver/Richmond
- 10. North Shore
- 11. Capital



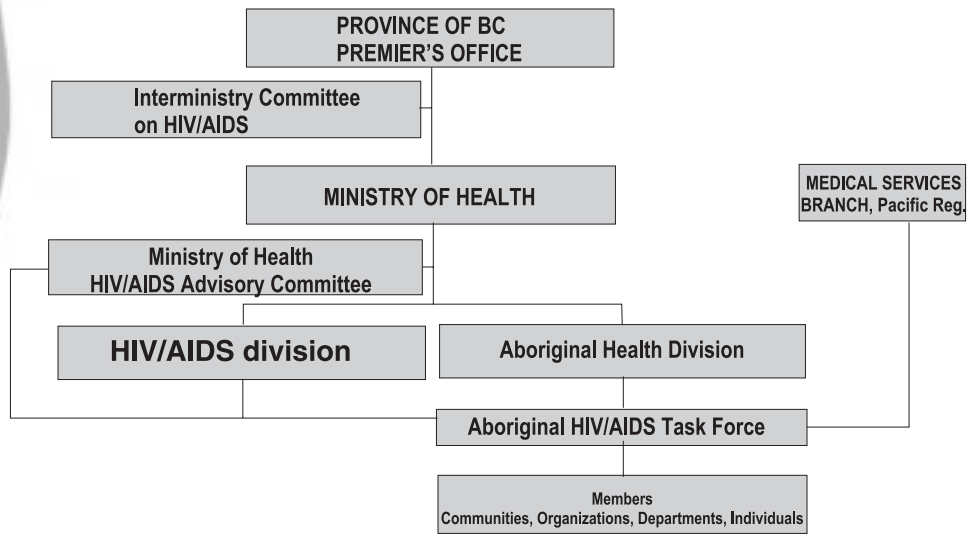




# CURRENT COMMITTEES

## INVOLVED WITH HIV/AIDS IN BC

### Connections Between Committees





# HIV/AIDS SERVICES

## ***BC Centre for Excellence in HIV and AIDS***

The BC Centre for Excellence in HIV and AIDS, based out of St. Paul's Hospital in Vancouver, is a provincial agency that does research, educates and trains health professionals, provides an HIV/AIDS Hotline for physicians (other health care providers have not been encouraged to use this line) and pays for anti-retroviral drug therapy for people living with HIV or AIDS. Aboriginal people in BC are eligible for the drug payment program, although current utilization of the program by Aboriginal people appears to be limited. Research is necessary to identify reasons for this limited use of anti-retrovirals and other AIDS medications and ways to increase use and identify alternative health maintenance practices. Increased access to Centre expertise through the Hotline would benefit rural health care providers.

## ***BC Centre for Disease Control Society***

The BC Centre for Disease Control Society ("BCCDCS"), STD/AIDS Division, provides HIV testing and counselling, research and surveillance, along with some Vancouver based clinical care and nursing outreach. Another service provided includes contact tracing and notification of test results. BCCDC is a major source for communicable disease policy for the Ministry of Health and regional health authorities. While the majority of MSB nurses have received appropriate training, only a few have continued on to actually provide many of these services in the community. The BCCDCS provides federal MSB nurses with their training in STD and HIV/AIDS testing and treatment. Evaluation of the barriers to implementing MSB nursing training is required.

The BC Aboriginal AIDS Awareness is an Aboriginal specific STD and HIV education and prevention program of the BC Centre for Disease Control Society. The program provides community and policy development services, professional development training, as well as consultation and research services on Aboriginal HIV/AIDS and other STD issues across the province to Aboriginal communities, organizations and individuals and those working in Aboriginal communities.

## **Local Physicians**

According to a recent study of physician utilization by Aboriginal people,<sup>37</sup> it was found that Aboriginal people were much less likely to use physician services, even though they rank their health similarly to the total Canadian population. Location of physician services is an important aspect of both physician use and health status, with Aboriginals residing on-reserve generally having lower levels of self-assessed health and being less likely to have seen a physician. While Aboriginals with the poorest health status were more likely to have seen a physician, other factors, including communication problems and disrespectful attitudes on the part of health care staff, are also barriers to use of health care.

Many stories have been told by Aboriginal people, especially Aboriginal women,

- of not being provided sufficient information about HIV by their doctors to ensure informed consent,
- of not even being told that they were being tested for HIV until they found out it came back positive,
- of not being encouraged to test if married or without other “obvious” risk factors
- of finding out about positive tests results in the mail, on their answering machines or in public areas of a clinic, and
- of receiving no pre- or post-test counselling or referral.

While the Ministry of Health has distributed Provincial Guidelines to all General Practitioners in BC, it does not appear to have been sufficient to ensure HIV testing and counselling are done appropriately. Greater effort on the part of the physicians, stricter enforcement of these “guidelines”, and greater involvement of the BC Medical Association to assist in these efforts is needed urgently.

Many physicians, through not having high numbers of patients with HIV/AIDS, have not gained the extensive experience needed to appropriately treat the many, diverse and sometimes infrequent conditions experienced by those with HIV/AIDS. Greater physician training and support is needed to ensure physicians are providing appropriate care to patients, however physicians’ must also be motivated to attend educational and training sessions being provided.

*“A few years ago I had lost a brother to HIV in downtown Vancouver and I was fortunate enough to spend his last eight months with him...One of the things he mentioned about having HIV is, he was often neglected by the professional ...the health people...There seems to be a neglect out there yet from the society.”*  
Helen H.

pg 52

BC Aboriginal HIV/AIDS Task Force Kelowna  
Strategy Consultation, October 15, 1998



## **Community-based Organizations**

The provincial government provides about \$8 million per year to community-based organizations for HIV/AIDS services. These include both prevention services (e.g., education, needle exchanges) and care services (e.g., home-based care and support). Very few of these services are designed to meet the needs of Aboriginal people. Aboriginal organizations may apply for funding, but rarely get funded. Currently the major Aboriginal AIDS Service Organization ("AASO") is Healing Our Spirit BC First Nations AIDS Society. Healing Our Spirit provides prevention education across the province, and rental subsidies, advocacy, peer counselling and life skills services through their outreach office in Vancouver. Other Aboriginal HIV/AIDS programs are typically run on a "one-person project" basis through community friendship centres and Aboriginal health centres. Ensuring community based HIV/AIDS educators and care providers are up-to-date in their information is a challenge when facing large geographic areas, few staff members and limited training funds. Standardized training programs that certify educators and care providers are accurate in their understanding of this complex disease will increase the quality of care to the client.

*Given the current state of affairs with health care reform and the resulting confusion among community members and health care workers alike, it is the recommendation of the Task Force that transfer of provincial Aboriginal HIV/AIDS funding is delayed until the Aboriginal Health Division, Ministry of Health has had an opportunity*

- *to clarify its role in Aboriginal health,*
- *complete evaluations of existing services, and*
- *developed a comprehensive Aboriginal Health strategy.*

*This will allow for a more cohesive approach to dealing with a complex situation.*

It is expected that by 1999, Regional Health Boards and Community Health Councils will distribute most types of health funding. Provincial AIDS funding had been an exception to this until April of 1998, when non-Aboriginal AIDS funding was moved from the jurisdiction of the Ministry of Health to the RHBs and CHCs. Funding for all provincially funded Aboriginal health programs has been transferred to the Aboriginal Health Division of the provincial Ministry of Health. Changes to funding administration are being delayed until the Aboriginal Health Division receives the recommendations of this document.



# HEALTH CANADA

## MEDICAL SERVICES BRANCH PACIFIC REGION

**H**ealth Canada's Medical Services Branch has an On-reserve Community-based HIV/AIDS Program. To date, HIV/AIDS prevention funds have not been included in the funding envelope provided under Federal Health Transfer Agreements. This program distributes funds to on-reserve community-based organizations and local Aboriginal governments for HIV/AIDS prevention projects aimed at Status Indian people living on reserves. Non-transferred bands must submit proposals each year to receive this funding while Transferred bands receive a yearly block grant that was negotiated at the time of transfer. This process means that those transferred communities which had not realized the scope of the HIV epidemic and its potential for spread in their community have not negotiated significant amounts of funds to deal with HIV. Often funds are identified for prevention efforts and not for care, treatment and support issues. As well, some Band members and other Aboriginal community-based organizations have concerns that band councils sometimes use the funds for purposes other than health, which places greater stress on already underfunded programs to try and meet the growing demands for HIV/AIDS services. Local coordination of on-reserve programs would benefit communities through increasing dollars available for care, treatment and support services.

### HIV/AIDS PREVENTION AND COMMUNITY ACTION PROGRAMS

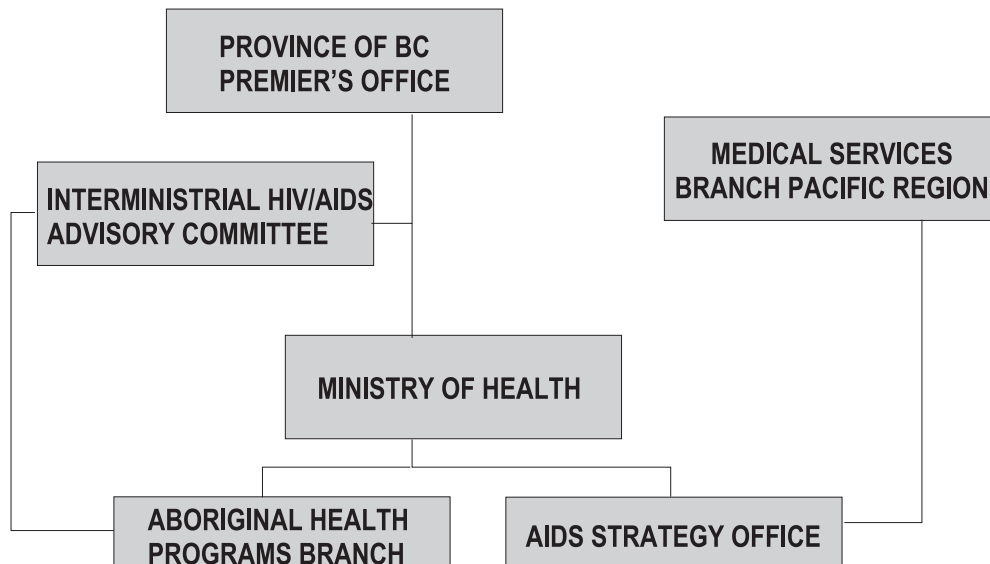
Health Canada's HIV/AIDS Prevention and Community Action Programs (part of the National AIDS Strategy, phase II) funds research and policy development projects, and community-based organizations involved in HIV/AIDS prevention. To avoid overlap with the On-Reserve Community-based HIV/AIDS program, the Prevention and Community Action Programs do not fund projects aimed at on-reserve Status Indian people. Organizations providing services for Aboriginal people without Indian Status or living off-reserve are eligible to apply, but they must compete with non-Aboriginal organizations for limited funding. Additionally, operational funding (60% of dollars available) is available only to those organizations whose primary mandate is HIV/AIDS. Organizations who have a general health mandate, such as health centres, or a mixed mandate, such as friendship centres, are eligible only for project funding (30-40% of dollars available). This presents a significant challenge to BC community

groups, as currently only Healing Our Spirit qualifies for operational funding under these guidelines. Other services must apply for the more limited project funding.

## HIV/AIDS CARE, TREATMENT AND SUPPORT PROGRAM

HIV/AIDS Care, Treatment and Support Program  
Health Canada's HIV/AIDS Care, Treatment and Support Program (part of the National AIDS Strategy, phase II) funds research, dissemination of scientific and technical knowledge, and training of both professional and family care-givers. Organizations providing services for Aboriginal people are eligible to apply, but they must compete with non-Aboriginal organizations for funding. To date it is believed that BC Aboriginal programs have not accessed this program. Greater promotion and awareness of, and access to, this program is needed.

### ABORIGINAL /GOVERNMENT AIDS RELATIONSHIPS IN BC





# HEALTH CARE

## SYSTEM IMPLICATIONS FOR HIV/AIDS POLICY

**A** boriginal people in BC must cope with a complex health care system. The system tries, but can't fully compensate for socioeconomic disadvantage. For these reasons, Aboriginal people living with AIDS (or any other chronic illness) will, as a group, have more trouble obtaining appropriate health care than will non-Aboriginal people with the same illness. The most obvious problems appear to be access to specialized medical care, ability to comply with complicated anti-retroviral treatments, availability of home-based care and payment for home-based care. Research is needed on the care, treatment and support needs of Aboriginal people living with HIV or AIDS.

- Health Canada's Non-Insured Health Benefits program is sometimes accused of causing prescription drug misuse among Status Indian people, much in the same way as BC Pharmacare is sometimes blamed for over-medicating senior citizens. In reality, the causes of these problems are complex, and the solutions involve educating both physicians and patients about the health hazards of excessive, unnecessary or inappropriate use of prescription drugs. De-insuring prescription drugs or otherwise cutting benefits would be like throwing the baby out with the bath water. Given the typically lower than average income and lack of employment-related supplemental health insurance, decreasing support for medically necessary prescription medicines and recommended nutritional supports, such as multi-vitamins and Ensure, counters the Ministry of Health's official goal of improving the health status of Aboriginal people in the province and the Federal government's emphasis on addressing Aboriginal HIV/AIDS issues under the current Canadian Strategy on HIV/AIDS.
- "Jurisdictional dispute" is only one of the causes of whatever ails the health care system for Aboriginal people in BC. In situations where health care services are inadequate or mal-distributed, one aspect of this problem may be the division of responsibility for services between levels of government. Clarity is needed, particularly within a regionalized system, about the ability and responsibility of off-reserve health care workers (especially those employed in the Community Health Service Societies) to provide care on-reserve. Developing linkages between, and coordinating



the roles of federally and band employed nurses and medical staff with provincially provided health services is essential to minimize the difficulties experienced in trying to access the full range of health care required by those with HIV/AIDS.

There is also a significant link between health status and the socioeconomic standing (“SES”) of Aboriginal people. In one recent northern study, “SES was strongly correlated with health centre visits... Communities with worse SES were more likely to have a higher rate of health centre visits.” Improvements in health status will require improvements in the poor socioeconomic conditions experienced by Aboriginal people in Canada.

While it has been recognized that health status and socioeconomic standing will not improve without the joint efforts of a variety of federal government departments (Indian & Northern Affairs, Health Canada, Correctional Services Canada, etc) and provincial government ministries (Health, Children and Families, Human Resources, the Attorney General, etc), policy and practice changes that creatively and effectively address these issues have been slow in coming. Stronger direction from the Prime Minister of Canada and the Premier of BC to their respective Ministers is necessary to ensure that plans for greater interministry and interjurisdictional coordination on HIV/AIDS issues become a priority for ministries other than Health and to ensure that they are committed to those plans being carried out over the long term.

Aboriginal governments, leaders, communities and individuals must be willing to inform and work with federal, provincial and regional health services to ensure that equitable access to care becomes a reality. At times, within all levels of non-Aboriginal and Aboriginal government, pointing the finger of blame at another level of government has been an excuse for inaction. Working together across jurisdictions may reduce this difficulty.

HIV and AIDS exposes the weaknesses of the current health care needs of those with HIV/AIDS, improving health care for Aboriginal people living with AIDS is an opportunity to improve the health care system for all Aboriginal people in BC.

- Reorganizations of the health care system (like “Regionalization” and “Transfer”) provide opportunities to create new programs and services, but they also pose challenges to preserve existing services and to maintain program standards. Aboriginal leaders and representatives of Aboriginal HIV/AIDS service organizations must participate meaningfully in the new regional health structures to address long-standing inequities. For those regions without Aboriginal participation, joint discussions on appropriate recruitment strategies are required. This will require a commitment to provide supportive funding for those involved in

the process. Aboriginal communities and individuals typically can not afford to “volunteer” their services and expertises. They are too busy trying to survive. For Health Transfer, negotiations and agreements must include specific provision for HIV/AIDS services and long range planning for future outbreak management. During the process of reorganization up-to-date information on changes to service delivery and access points is essential to reduce the stress on health care workers and to facilitate appropriate referral.

The federal government’s Aboriginal HIV/AIDS funding concentrates on programs for Status Indian people living on reserves. The large number of reserves with small population bases means that limited and insufficient dollars are provided to each reserve for HIV/AIDS services. National funding formulas do not recognize the differing geographic and community structure found in British Columbia. Different mechanisms for federal funding and delivery health services more closely linked with Aboriginal jurisdictional boundaries need to be considered to achieve economies of scale while addressing local Aboriginal realities. This also requires discussions between the Metis and First Nations communities to realign their differing jurisdictional boundaries.

Previous provincial funding for Aboriginal HIV/AIDS issues has focused almost exclusively on education and prevention. Even with current levels of funding there is a noticeable deficiency in HIV/AIDS-related services, particularly in care, treatment and support areas, by community-based organizations for off-reserve and non-Status Indian Aboriginal people. While current organizations provide valuable services, they are seriously understaffed and underfunded to address the full scope of needs that HIV/AIDS encompasses across the province. Further analysis and coordination of province wide requirements for a broad spectrum of HIV/AIDS services needs to be supported.

Other sources of funding require that Aboriginal organizations compete with non-Aboriginal organizations. In such competitions, Aboriginal organizations are at a disadvantage due to a relative lack of technical expertise, under-staffing and high workloads. National criteria for funding encourage the development of new organizational structures to route funding through, do not recognize the unique nature of the Aboriginal HIV epidemic in BC or recognize the diverse nature of BC’s Aboriginal health service providers. Regional variation of national funding priorities must be allowed to ensure local issues are addressed. HIV/AIDS, improving health care for Aboriginal people living with AIDS is an opportunity to improve the health care system for all Aboriginal people in BC.



# RECOMMENDATIONS

## TO ADDRESS ABORIGINAL HIV/AIDS IN BC

**T**he following recommendations flow from Task Force discussions and analysis of apparent limitations and gaps identified through compiling the information presented in this document. They are not a complete list of what needs to be done to address HIV/AIDS among BC's Aboriginal population nor do they focus strictly on HIV/AIDS... and while the recommendations below are numbered, the numbers do not represent their order of priority. The road being taken is a long one, with gentle slopes and steep mountains to climb before we reach its end. The health of the community and the individual is linked by many pathways. Following any one of the paths recommended below will begin a journey that leads to what we are all searching for - a healthy family and a healthy community. It's up to each of us - and up to all of us - to walk together on this journey, taking our own best pathway until we reach our journey's end.

### BUILDING HEALTHY COMMUNITIES

1. continue and increase prevention activities targeted to the underlying causes of high risk behaviour for HIV such as poor parenting skills, alcohol & drug use, emotional, physical and sexual abuse, historical abuse through the residential school system, etc.
2. increase STD prevention and treatment services available to rural, remote and reserve communities
3. develop mechanisms to increase on-reserve health care staffing levels
4. develop appropriate and realistic job descriptions for on-reserve health staff, especially CHR's
5. improve the level and standards of training on-reserve health staff receive, especially CHR's
6. develop joint MSB/MOH comprehensive health plan information package explaining coverage under each plan (MSP & NIHB) and access procedures for Status Indians on and off reserve
7. develop mechanisms to ensure equitable access to federal on-reserve health services for off-reserve Status Indians
8. redevelop mental health services for Aboriginal people to address the full scope of mental health issues experienced, including depression, post-traumatic stress disorder and dual/multiple diagnosis services

### RAISING AWARENESS OF HIV AND AIDS

9. continue HIV specific prevention efforts for youth
10. increase focus of HIV specific prevention and intervention efforts on adults 30-50 years of age

11. increase coordination between HIV, Sexually Transmitted Diseases (STD) and Tuberculosis (TB) health services with increased community education regarding their linkages
12. increase community education about harm reduction to ensure currently controversial services can be understood in the context of the HIV epidemic

## PREVENTING HIV TRANSMISSION

13. ensure harm reduction programs educate their clients about the risks of the chosen behaviour and the limitations of the harm reduction method
14. ensure harm reduction programs include non-judgmental skills building programming to encourage and support safer behaviour change
15. increase access to methadone maintenance in Vancouver and in rural areas of BC
16. increase number of methadone licensed physicians
17. reduce Crack Cocaine availability in BC
18. increase education about safe needle disposal in community settings
19. increase needle exchange services within reserve and rural communities
20. act on the the recommendations of the HIV, AIDS and Injection Drug Use National Action Plan

## DIAGNOSING HIV INFECTION AND STARTING TREATMENT EARLY

21. increase access to HIV testing in rural and remote communities
22. increase available alternatives, such as dried blood spot and saliva testing, to current HIV testing methods
23. increase awareness and promotion of treatment options and the potential benefits of starting anti-retroviral treatment early

## MAINTAINING THE HEALTH OF ABORIGINAL PEOPLE LIVING WITH HIV

24. improve referral networks within and across RHA's and ministries to improve continuity of care
25. improve MOH, RHA, MCF & MSB communications programs to ensure up-to-date information on service delivery changes and access points is available to health care workers

## CARING FOR ABORIGINAL PEOPLE LIVING WITH AIDS

26. increase levels of access to home based care in rural, remote and reserve communities through changes to the funding, training and service structure of home based care services
27. increase numbers and hours of health care staff available to reserve communities from regional RHA's, especially home makers and home care nurses, in recognition of high degree of need experienced



## PROVIDING LEADERSHIP

28. increase concrete interministerial and interjurisdictional coordination on HIV/AIDS issues through stronger direction from the Prime Minister of Canada and the Premier of BC to their respective Ministers stressing their support
29. increase equitable access to care through increased Aboriginal government, leadership, community and individual willingness to actively inform and work with federal, provincial and regional health services planning structures

## SECURING FUNDING FOR ABORIGINAL HIV/AIDS SERVICES

30. develop clearer procedures and better liaison between NIHB and independent service providers to reduce payment concerns
31. increase development of, and funding support for, Aboriginal alcohol & drug treatment programs, especially those targeted to women and youth
32. increase funding for training and hiring Aboriginal mental health workers, both within facilities and in the community
33. clarify Aboriginal Health Division's role within the Ministry of Health and with community based Aboriginal Health service structures
34. recommend that Aboriginal Health Division, Ministry of Health complete evaluations of existing services and develop a comprehensive Aboriginal Health strategy prior to regionalization of Aboriginal HIV/AIDS services
35. recommend and support Regional Health Authority development of mechanisms to involve a full and representative range of Aboriginal stakeholders in regional Aboriginal health planning and service development
36. increase cost effectiveness of funding for care, treatment and support services through joint community/MSB regional coordination and planning of federal on-reserve health services
37. increase flexibility in national and other funding guidelines and requirements to match BC based community and organizational needs and structures
38. increase promotion of available funding sources for HIV/AIDS services and provide proposal development support

## TRAINING THE NECESSARY PERSONNEL

39. develop Aboriginal specific standardized training programs to certify Aboriginal educators and care providers to increase accuracy, consistency and quality of trained personnel
40. increase access to the BC Centre for Excellence in HIV and AIDS Physician Hotline expertise by nurses providing care
41. provide, ensure and enforce adequate training of physicians in HIV pre & post test counselling protocols

research is needed in the following areas:

42. identification of reasons for level of, and barriers to, use of anti-retroviral and prophylaxis medicine by Aboriginal people
43. identification of alternative and traditional health maintenance practices
44. continued surveillance tracking spread of HIV infection with increased focus on-reserve
45. identification of initiating factors and challenges to reducing use of injection drugs among Aboriginal people in BC
46. evaluation of BC Centre for Disease Control MSB HIV/STD nursing training program to assess barriers to in-community implementation of training
47. evaluation of alternative models of alcohol and drug treatment, especially cocaine addiction and successful treatment models
48. evaluation of alternative models of mental health treatment, including family and community based therapies
49. analysis, mapping and coordination of funding policy and service development for the full spectrum of Aboriginal HIV/AIDS services across the province
50. evaluation of harm reduction programs impact on HIV transmission and the underlying behaviour in the Aboriginal population



# HARM REDUCTION

## AS HEALTH CARE

*With harm reduction I don't think it needs to be any more complicated than for our people to continue to ask for more treatment options. We see many people who have asked for treatment be turned away because they have already been twice in the ear. Those are people that have put themselves at risk of transmitting HIV because they wanted to get high."*

Michelle R.

Page 43; BC Aboriginal HIV/AIDS Task Force Vancouver Strategy Consultation, September 16, 1998

*I am an intravenous drug user, and I have spent a lot of time in the back lanes downtown, and I agree with the person that spoke earlier, that people are getting younger and younger, and I, myself, was educated and made a conscious decision to become HIV positive. The person {who gave him HIV} told me that one thing they had. We only had one {syringe} between us... Regardless of whether I knew what I was doing, which I did, I still made that decision. And I have been trying to get clean for a while now, and can't find a place where I am really comfortable to go to where I can speak about the fact that I am HIV positive. Bottom line is my drug addiction will kill me before my HIV will. But, I think there needs to be a place for people to go and feel safe, because a lot of people don't, specially the native community. They go into these houses and they don't feel safe, and I think there has to be something for people who are HIV positive and want treatment."*

Douglas C.

Page 47; BC Aboriginal HIV/AIDS Task Force Vancouver Strategy Consultation, September 16, 1998

**H**arm reduction" means different things to different people, but in this document, it means taking action to reduce the harmful effects of a behaviour, without requiring people to abstain from (stop doing) the behaviour. Examples of harm reduction include making condoms available to sexually active people and licensing and regulating tattoo and body piercing services in order to prevent transmission of HIV and other infections.

Harm reduction does not necessarily mean that you approve of people's behaviour, but it does mean that you want to prevent people from getting AIDS or spreading it to others. One of the main arguments against harm reduction is that practicing lower risk activities might give people a false sense of security and encourage them to continue or even to increase their risk-taking behaviour, resulting in the person becoming HIV positive. As no risk-reduction method is 100% effective for preventing the spread of HIV, lower risk activities are simply that - Lower Risk - however if abstinence is not possible, being as safe as possible under the circumstances is the next best alternative. For example, using a condom greatly reduces the chance of HIV being transmitted during sexual intercourse, but it doesn't eliminate the possibility completely. Therefore, harm reduction programs must educate their clients about the risks of the behaviour, and the limitations of the harm reduction measure. Also, harm reduction programs must include skill building to encourage and support positive behaviour change as well as evaluation of the programs' impact on both HIV transmission and the underlying behaviour in the target population.

For the problem of injection drug use, harm reduction means taking action to reduce the harmful effects (including HIV transmission) of taking drugs, without requiring the user to abstain from drugs. Harm reduction measures are aimed at those injecting drug users who cannot, will not or are not yet ready to quit using. Examples include providing injection drug users with clean needles and syringes, bleach kits and instructions for disinfecting needles, education about HIV/AIDS and other diseases transmitted by needles, condoms, non-judgmental medical care including safe injection practices, methadone maintenance, counselling and referral services, and decriminalization of drug possession. Community education about Harm Reduction as a way to improve the health of the typically most disadvantaged members in our communities is necessary to ensure currently controversial services such as prescription heroin can be understood in the context of the HIV epidemic. Both pros and cons must be fully understood before decisions affecting many generations can be made.



## METHADONE MAINTENANCE

Methadone Maintenance is a form of treatment for people addicted to heroin or other opiate drugs. Methadone itself is an opiate drug, but it is taken orally, it is made and distributed by legitimate pharmaceutical companies and it can lawfully be prescribed and administered by approved physicians (authorized by the federal Minister of Health).

Taking methadone prevents the withdrawal symptoms that would otherwise occur when an opiate-addicted person stops using. It also dulls the high feeling a person gets from heroin, removing much of the incentive to continue injecting. Methadone itself doesn't produce much of a high feeling. About 3,600 people in Canada are currently on methadone maintenance.<sup>39</sup> Methadone maintenance can not be used for people who are addicted to injecting cocaine, amphetamines or other non-opiate drugs. More access to the option of methadone is required both in Vancouver and in rural areas. This will require the Federal Minister of Health to authorize more physicians. It will also require greater education of physicians on the health care needs of injection drug users and a willingness to work with a sometimes challenging patient population.

## NEEDLE EXCHANGE PROGRAMS

Needle Exchange Programs provide injection drug users with clean needles and syringes, usually in exchange for used equipment. Often they provide other harm reduction services as well. Needle exchanges are responsible for safe disposal of the needles that they collect. Some needle exchanges collect and dispose of more needles than they give out as some users will bring in needles from friends and associates who are not willing or able to bring them in. Needle exchange programs have operated lawfully in Canada since 1989.

In BC, the provincial government provides funding and supplies for 15 needle exchange programs in 14 cities, operated by community-based organizations. Needle exchange also occurs at some provincial and municipal public health facilities, and some on-reserve health facilities operated by the Medical Services Branch of Health Canada. While federal regional policy is that federal nurses can provide needle exchange services, on-reserve needle exchange programs are at the discretion of the community and the nursing staff. Appropriate (safe) needle disposal is a frequent concern of communities. Education about safe disposal of needles in the community is important, particularly given the high number of Aboriginal diabetics using needles for insulin. There is concern improperly disposed of diabetic needles are being reused for injection drugs. Nursing staff and community leaders need to increase public awareness of needle exchanges in communities to reduce this type of unsafe behaviour.

In this document, decriminalization means changing laws and law enforcement policies in ways that reduce the criminal penalties faced by injection drug users. The rationale for this form of harm reduction is that criminal penalties increase the harmfulness of injection drug use by

- forcing addicts to turn to crime to obtain their drugs,
- by increasing the likelihood that they will use unsanitary methods to inject themselves, and
- by stopping addicts from obtaining medical care and social services.

Emerging research supports the belief that this increased harmfulness could outweigh any benefit that criminal penalties might have in stopping drug use.

Health Canada has formed a National Task Force on HIV, AIDS and Injection Drug Use.

In a project funded by the National AIDS Strategy and Canada's Drug Strategy, this expert group developed a program for reducing HIV transmission from injection drug use, based on methods of harm reduction.

Some of the many practical recommendations in the "HIV, AIDS and Injection Drug Use: A National Action Plan"<sup>39</sup> can be summarized as follows:

- *decriminalize the possession of small amounts of drugs for personal use,*
- *divert people who commit minor drug-related offenses away from prison and into substance abuse treatment, counselling and community service programs,*
- *heavily penalize people who traffic drugs to minors,*
- *national consistency in application and enforcement of the law by judges, prosecutors and the police,*
- *broaden the range of drugs that physicians may lawfully prescribe to addicts in methadone-style maintenance programs,*
- *for correctional inmates, increase the availability of methadone maintenance treatment,*
- *pilot projects of needle exchange programs in prisons,*
- *increased availability of substance abuse treatment services,*
- *reduce discrimination against injection drug users who attempt to access health care and social services*
- *broaden the range of available treatment options, especially those types of treatment that don't require abstinence*
- *increase the availability of needle exchange services,*
- *increase the number of health care facilities (e.g., hospital emergency rooms, public health clinics, community medical clinics, pharmacies) that offer needle exchange,*
- *the availability of other harm reduction services at needle exchange sites,*
- *increase the availability of and improve access to safe needle disposal sites,*
- *increase the availability of methadone maintenance treatment,*
- *make it easier for physicians to get authorization to prescribe methadone,*
- *increase the number of physicians trained to provide methadone maintenance treatment,*
- *research and pilot projects on the use of other drugs (both opiate and non-opiate) in methadone-style maintenance programs.*

The National Action Plan had specific recommendations relevant to Aboriginal people, including the following:

- meetings of Aboriginal Elders and spiritual leaders to discuss the harm reduction approach and how it relates (or doesn't relate) to Aboriginal culture and traditions,
- use existing cultural practices to mobilize communities to address this issue,
- increase training to existing service providers to heighten awareness of, and sensitivity to historic conditions and over-lapping risk factors experienced by Aboriginal people,
- promote Aboriginal-specific HIV/AIDS and injection drug use programs,
- increase provincial government support of programs aimed at Aboriginal people living off-reserve,
- increased research on injection drug use, treatment and HIV transmission in Aboriginal populations,
- more training and involvement of Aboriginal personnel and communities in this research,
- acknowledge the unique needs of Aboriginal women and develop services that recognize their role as caretakers of culture and family,
- provide women with appropriate information and skill building relating to the relationship between HIV and other STDs, alcoholism, family violence, etc.
- help for women IDU's in advocacy and the care of their children
- develop support groups and services for street-involved women
- encourage national coordination through the Canadian Aboriginal AIDS Network (CAAN)
- link Aboriginal HIV/AIDS and IDU programs with provincial programs .

Aboriginal communities have been dealing with alcoholism primarily through abstinence based programs. Alcohol and Drug Counsellors require opportunities to learn about, discuss and weigh the pros and cons of Harm Reduction as it might exist in their community. Many feel it is an either/or situation. While there is no consensus on some aspects of Harm Reduction, there is a true concern for the health of our people. Communities leaders and health care workers should talk the injection drug users in their communities in order to assess which harm reduction approaches will work for them.

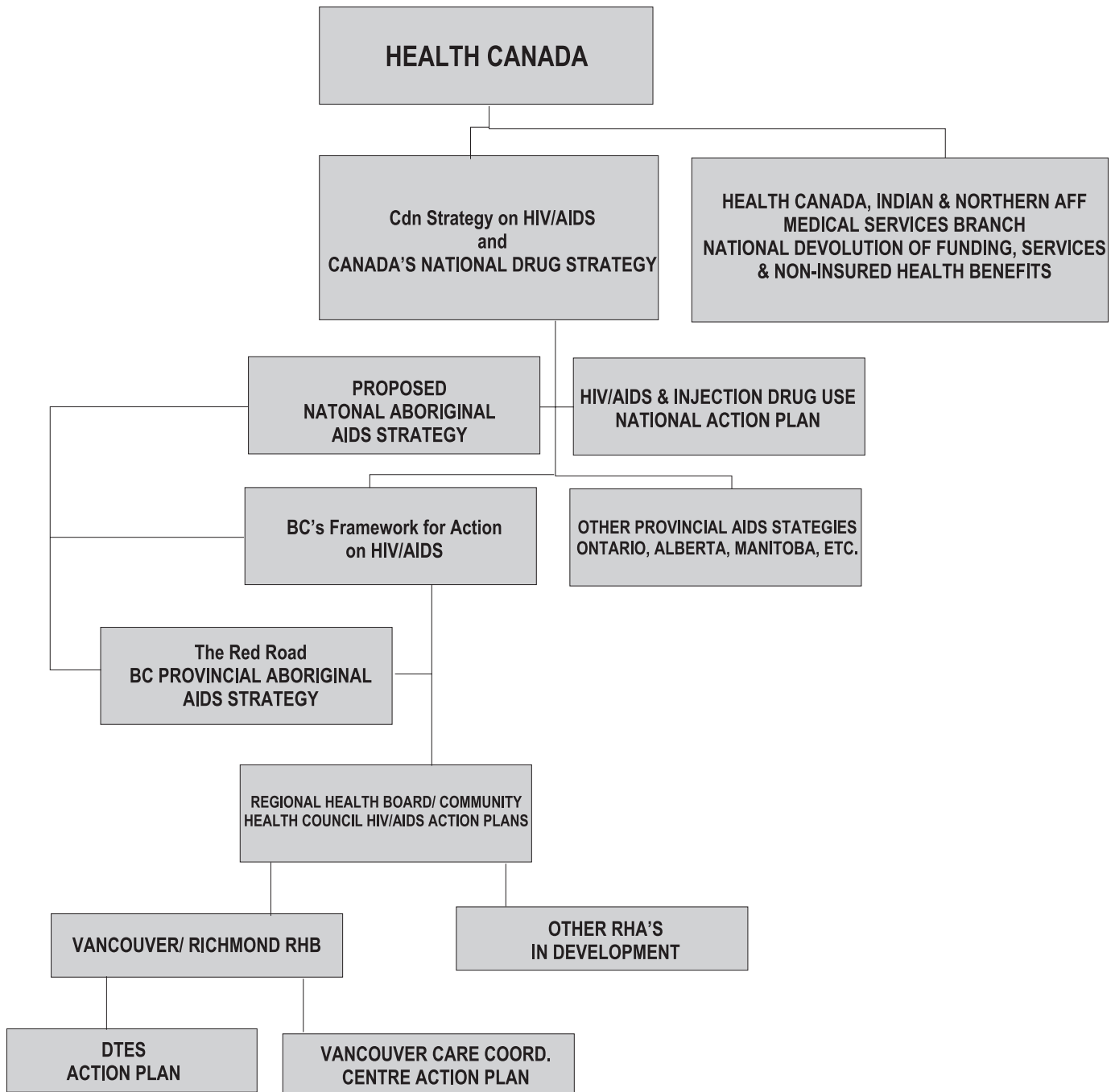
*"It's up to the individual to make it work."  
(Mary Louie, Elder)*

## STRATEGIC CONNECTIONS

BC is not the only province working on strategy development and provincial strategies are not the only planning process occurring. The following chart outlines some of the other current efforts to stem the increasing HIV epidemic. While we have focused on selected jurisdictions and activities to discuss, the connections between The Red Road: Pathways to Wholeness BC Aboriginal HIV/AIDS Strategy and those we've discussed are not the only factors effecting planning and service delivery. Further work is needed to ensure that all of the action plans for HIV/AIDS service delivery are integrated and work together to achieve common goals.



# CONNECTIONS BETWEEN STRATEGIES





# STRATEGIC GOALS

## OF THE RED ROAD PATHWAYS TO WHOLENESS

AN ABORIGINAL STRATEGY FOR HIV AND AIDS IN BC

**S**trategic Goals are long term. They can not be achieved over night. They require commitment, discipline and the willingness to work together to overcome obstacles to their achievement. While communities and organizations can put together services and programs, "It's up to the individual to make it work." (Mary Louie, Elder). We need to take this document and act on it, each in our individual way, where ever we are, in whatever capacity we work in.

And that's the way we're going to make change and reach the person on the street. Each of us is a stepping stone on the pathway to wholeness. As we walk together along the red road of the cycle of life - towards death and rebirth - together, through love, respect and caring, we can find, in the wholeness of time, the strength to complete the circle.

*"These are our human flesh and blood and now the people are scared of them. They have hearts, they have emotions, they're real human people, they're not aliens from another planet. We gave birth to these children. How can our own people do this? And it's fear. There are a lot of people who have education. My nephew went to Rupert and my sister was threatened. Her life was threatened. They said 'if you keep that person in your apartment we'll burn your building'."*

Melody J.

pg 19; BC Aboriginal HIV/AIDS Task Force Terrace Strategy Consultation, October 1, 1998

### STRATEGIC GOALS

The format for the following section will be to use the goal as the heading and to list objectives to reach that goal below. Each community, program or individual should look at what is currently being done, how current activities could be improved, and where gaps are that can be filled. The Task Force hopes that the following overview will provide a place to start this process. Identify an activity that is achievable for you currently and build from there. While there is much to be done, no one person, organization or community will be able to fully address all of these goals and objectives. Remember that help is available from Task Force Members. As well, an Implementation Guide is being developed to provide examples and samples of how these goals can be implemented. Good luck and keep trying!



# BUILDING HEALTHY COMMUNITIES

- to promote respect for traditional Aboriginal customs and teachings
- the development and use of culturally appropriate messages and materials for human body and sexuality health education
- awareness of the characteristics of healthy relationships
- awareness of and tolerance towards alternative lifestyles
- compassionate and constructive approaches towards persons with substance abuse issues, including those who have been in trouble with the law
- compassionate and caring attitudes towards people living with HIV/AIDS
- respect for the human rights of people living with HIV/AIDS
- to increase/improve  
self-esteem,  
critical thinking and decision making skills  
anger management skills  
general life skills  
parenting skills  
assertiveness and communication skills
- human body (anatomy & physiology) education
- sexuality and reproductive health education
- a broad range of mental health services
- substance abuse treatment services
- traditional healing centres and their acceptance of HIV/AIDS
- fostering options for HIV Positive children in care
- crisis intervention programs
- health care professionals ability to deal with suicidal ideation
- housing options
- to prevent/reduce sexual abuse, substance abuse and individual and community sense of hopelessness/ helplessness

*“There’s the lack of housing and shelter for homeless women...In the winter the homeless women slept under the bridge and they had to have somebody stay awake all the time in order to watch and protect their women. During the day they would go to the mission to catch up on their sleep.”*

*Debbie C. pg 87*

*BC Aboriginal HIV/AIDS*

*Task Force Kelowna Strategy*

*Consultation,*

*October 15, 1998*

# RAISING AWARENESS OF HIV AND AIDS

*I've been doing all that I can to try and educate our youth... it's been very difficult to try to get this information to our youth in such a way that I don't have to weed out any information that parents or teachers or principals or whoever don't want me to give out."*

*Alan B. pg 51.*

*BC Aboriginal HIV/AIDS Task Force*

*Kelowna Strategy Consultation,*

*October 15, 1998*

- to promote the development and use of culturally appropriate messages and materials for HIV/AIDS education
- awareness of HIV/AIDS among Aboriginal community leaders (Elders, spiritual leaders and healers, chiefs, councils, Metis leaders, friendship centres, political organizations, etc.)
- networking of Aboriginal community groups for purposes of planning HIV/AIDS education events
- awareness of the effects of Residential School Syndrome and its relationship to HIV
- awareness of the relationship between HIV and Fetal Alcohol Syndrome/Effects ("FAS/E")
- awareness of the relationship between HIV and Tuberculosis ("TB")
- development and acceptance of consistent and accurate HIV/AIDS, sexuality and relationship education within public and band elementary and secondary school systems
- to educate non-Aboriginal people about the need for Aboriginal-specific HIV/AIDS programs and services
- to increase the number of Aboriginal persons, especially parents, who could have attended an HIV/AIDS education event in their community
- awareness of HIV/AIDS care issues for foster parents and home makers
- content of HIV/STD and general sex information in parenting programs eg. Nobody's Perfect
- to inform funders of the needs and priorities of BC's Aboriginal communities around HIV services and programs
- to give the Aboriginal public accurate, factual information about HIV/AIDS in the Aboriginal community (cause, how it is transmitted, how one can protect oneself, how many people are infected, course of illness, effective treatments, coping mechanisms, life expectancy)

# PREVENTING HIV TRANSMISSION

- to prevent/reduce
  - alcohol and other drug addictions
  - injection drug use
  - the sharing of injection drug needles
  - the sharing of tattoo and body piercing needles, equipment and inks
  - sharing of cutting tools and blood during traditional ceremonies
- to promote
  - the need for, and acceptability of, condoms and sterile needles
  - public awareness of the harm reduction approach towards injection drug use (purposes, rationale, legality and known effects of harm reduction programs)
  - awareness and use of universal precautions among community health care workers, volunteer firefighters, and other Aboriginal community workers
  - awareness and use of preventative antiretroviral treatment in cases of needle stick injury and invasive sexual assault
  - communication and assertiveness skills around discussing use of precautions
- to increase
  - the availability and range of condoms and sterile needles
  - outreach activities aimed at difficult-to-reach groups (including street youth, injection drug users, sex-trade workers and their customers)
  - educational activities aimed at groups who need special information (including prison inmates, pregnant women, two-spirit people, those with FAS/FAE, the deaf)
  - the availability /accessibility of appropriate alcohol & other drug treatment programs, especially those designed for women and youth and within prisons-- the availability/accessibility of harm reduction programs (e.g., needle exchange, methadone maintenance, condom distribution, abstinence promotion) to Aboriginal people who are injection drug users
  - knowledge safer-sex education and of all of the options for reducing the risk of sexual transmission of HIV (including abstinence, use of condoms, non-insertive sexual options)
- to support the efforts of Aboriginal people who use injection drugs to access treatment services or to abstain



# DIAGNOSING HIV INFECTION AND STARTING TREATMENT EARLY

- to increase knowledge of the:
  - risk factors and myths for HIV/AIDS
  - benefits of early diagnosis of HIV infection
  - issues when testing HIV negative or HIV positive
  - potential benefits and risks to people living with HIV of starting treatment early
  - potential benefits and risks of anti-retroviral drug therapy for HIV-infected pregnant women
- to improve local knowledge of HIV knowledgeable referral sources
- to improve access to voluntary and confidential HIV-antibody testing under conditions of competent, culturally sensitive pre- and post-test counselling, including developing family based models
- to increase the availability of valid alternative methods of HIV testing (for instance, collecting and testing dried blood spots), under conditions of competent, culturally sensitive pre- and post-test counselling for residents of rural and remote communities
- to ensure that the full range of effective treatments for HIV infection and its complications is covered by the public programs available to Aboriginal people in BC (Medical Services Plan of BC, BC Pharmacare, BC Centre for Excellence in HIV/AIDS, Health Canada's Non-Insured Health Benefits Plan)
- to increase access to traditional medicines and practices among Aboriginal people living with HIV,
- to increase knowledge and use of:
  - opportunistic infections and current treatment options
  - monitoring tests such as CD4 and viral load
- the proportion who know that anti-retroviral drug therapy is available without cost to the user, through the BC Centre for Excellence in HIV/AIDS and how to access them
- practical coping skills for living with HIV and AIDS
- adequate and safe housing options
- appropriate diet and nutrition

## MAINTAINING THE HEALTH OF ABORIGINAL PEOPLE LIVING WITH HIV

- to increase awareness of health care providers of HIV progression, opportunistic infections, diseases and gender differences in HIV, treatment and home care issues
- to improve availability of and access to:
  - specialized medical care, including specific diagnostic procedures and treatments
  - Aboriginal HIV/AIDS care specialists
- primary health care for those living in remote areas (general practice physicians, nurse-practitioners, community health nurses, community health representatives)
- home support services and home-based treatments (including supportive medical equipment)
- emergency care
- counselling by a nutritionist/dietitian knowledgeable about HIV/AIDS
- legal services for people living with HIV (regarding discrimination, wills, living wills, powers of attorney, etc.)
- support in prison
- to improve coordination between community care providers, HIV/AIDS care specialists and primary health care providers through development of family based care planning models
- among Aboriginal people living with HIV, to increase the knowledge of HIV/AIDS (course of illness, opportunistic infections and other complications, effective treatments, adherence to treatment, coping mechanisms, life expectancy)
- to increase knowledge of TB and its relationship to HIV/AIDS, the appropriate uses of traditional Aboriginal medicines and cultural practices, the appropriate uses of prescription and over-the-counter medications (including vitamins and minerals)
- to improve understanding of and need for appropriate food sanitation techniques (sanitary methods of meal preparation, food handling, storage and preservation) and prevent food-borne illness among people living with HIV
- to improve nutrition of people living with HIV
- to promote harm reduction measures for people living with HIV who are still injection drug users (for example, clean needles, condoms, methadone)

- to ensure adequate housing for people living with HIV (“adequate” includes heating, electricity, clean drinking water, bathing and toilet facilities, cooking facilities, refrigeration, secure storage of medications, emergency telephone access, not crowded, affordable, near to health care and support services)
- to provide a range of housing options (emergency, short & long stay, etc) to serve specialized needs: the homeless, the mentally ill, persons with substance abuse issues who are still using, abused women, women with children, independently-living youth)
- to promote harm reduction measures for people living with HIV who are still injection drug users (for example, clean needles, condoms, methadone)
- to increase/improve mental health and crisis intervention services for people living with HIV/AIDS and those at risk for HIV
- to increase:
  - the number of trained Aboriginal peer support workers and advocates
  - access to trained peer-support workers and advocates
- to ensure that people living with HIV can access the above services confidentially

## CARING FOR PEOPLE LIVING WITH AIDS

- to improve access to: specialized medical care
  - recognized training in AIDS care
  - Aboriginal AIDS care specialists
  - counselling by a nutritionist/dietitian knowledgeable about AIDS
  - hostel accommodation (people living with AIDS and their companions), when travelling to a regional centre for specialized care
  - regional palliative care facilities
  - hospice facilities
- to ensure that the full range of nutritional supplements (vitamins, minerals, feeding formulas) relevant to people living with AIDS is covered by the public programs available to Aboriginal people in BC (BC Pharmacare and Health Canada’s Non-Insured Health Benefits Plan)
- to increase/improve:
  - home care services, including palliative care
  - training and support for family care-givers, including how to build care teams
  - support for the bereaved and the care teams
- to improve coordination between all persons and agencies involved in care of a person living with AIDS (family care-givers, band health workers, community health units, hospitals, physicians, etc.)
- to promote and facilitate the relearning of traditional Aboriginal roles, in conjunction with current roles of community support workers (Elders, spiritual leaders, traditional healers, mentors, etc.)

- develop care planning models for families with more than one member infected
- to promote respect for traditional Aboriginal customs regarding death and dying (preparation for death, dying at home, last rites, treatment of the deceased body, funeral ceremonies, final disposition of the body, mourning)
- increase knowledge and discussion of the issue of euthanasia
- to improve coordination of transporting bodies across provincial/national boundaries for final disposition

### PROVIDING LEADERSHIP

- **to increase the proportion of Aboriginal leaders who:**
  - regularly receive up-to-date information about HIV/AIDS
  - have heard a presentation about HIV/AIDS at a meeting within the past year
  - have talked about HIV/AIDS with a member of the Task Force within the past year
  - have ever endorsed or supported a research project on HIV/AIDS
  - have ever made a speech or presentation at an HIV/AIDS educational event
  - made a public statement about HIV/AIDS during their most recent election campaign
- promote awareness of the role of policy in dealing with HIV/AIDS (when policy is needed, appropriate uses, how to develop a policy, accountability, enforcement)
- **to increase the proportion of Aboriginal councils that have a written policy on:**
  - how to prevent HIV transmission in their community
  - fair treatment for people living with HIV or AIDS
  - providing care and support for people living with HIV or AIDS and their families
  - the use of harm reduction techniques in the community
- **to increase participation by Aboriginal leaders in public debate**
  - about:** - promotion of early school and community based education around HIV, anatomy, sexuality and communication skills
  - criminal justice and corrections policy towards injection drug users
  - publicly-funded drug benefit programs (such as BC Pharmacare and Health Canada's Non-Insured Health Benefits Plan)
- **to increase:**
  - participation in, and understanding of, HIV issues among Aboriginal Elders
  - opportunities for elders to share their stories and wisdom
  - number of Elders Councils on HIV/AIDS related issues
  - opportunities for Two-spirit people to regain traditional roles, such as advisors and mediators within communities

- to maintain or increase the amount of federal government Aboriginal health care funding that is dedicated to HIV/AIDS services
- to maintain or increase the amount of provincial government Aboriginal health care funding that is dedicated to HIV/AIDS services
- to maintain centralized funding of Aboriginal HIV/AIDS service contracts through Aboriginal Health Division until finalization of comprehensive Provincial Aboriginal Health Services Strategy
- **to increase:**
  - the proportion of First Nations Health Transfer agreements that include specific provision for HIV prevention and AIDS care services
  - Aboriginal representation in the province's new regional health structures (i.e., Regional Health Boards, Community Health Service Societies and Community Health Councils)
  - provincial government funding of Aboriginal community-based organizations providing HIV/AIDS services to off-reserve, non-Status Indian, Metis or Inuit people
  - funding for Aboriginal HIV/AIDS care, treatment and support services
- to promote equitable access by Aboriginal people to health care services delivered through the new regional health structures (especially services like Continuing Care, Long-Term Care and Mental Health where there is no materially significant federal government presence)
- to improve the competitiveness of Aboriginal community-based organizations in obtaining service and research funding

### TRAINING THE NECESSARY PERSONNEL

- **for Aboriginal community health representatives, health educators, correctional service liaison workers and HIV/AIDS community workers:**
- to standardize their training to ensure accuracy and consistency of information that they give out about HIV/AIDS
- to learn and teach:
  - culturally appropriate information presentation skills
  - traditions and protocols for working with Aboriginal leaders and Elders
  - methods of research and how to apply them
  - proposal writing skills for funding of research and pilot service-delivery projects
- to provide continuing education about HIV/AIDS (ex. Internet, newsletter, conferences)
- to increase number of youth peer workers
- to increase HIV educational programming within schools



- **for Aboriginal substance abuse program workers, to increase their training on:** HIV/AIDS
  - sexuality
  - harm reduction philosophies and models
  - grief management and coping skills
  - to promote compassionate and constructive policies towards people living with HIV or AIDS who have still have substance abuse issues
  
- **for Aboriginal Elders, spiritual leaders and traditional healers,**
  - to increase their knowledge of HIV/AIDS and the support needs of people living with HIV or AIDS
  - to promote compassionate and caring attitudes towards two-spirit people and those living with HIV or AIDS
  - to encourage their attention towards identifying traditional Aboriginal medicines that may have an effect on HIV/AIDS or their opportunistic infections
  
- **for physicians, nurses and other patient-care personnel:**
  - to increase the number of Aboriginal people trained and employed as health care professionals
  - to promote the development and training of Aboriginal HIV/AIDS care specialists among existing workers;
  - to increase their training on HIV/AIDS
  - to provide them with Aboriginal cultural sensitivity training
  - to increase their awareness of the family and community relationships issues faced by Aboriginal people living with HIV/AIDS
  - to increase their awareness of traditional Aboriginal medicines among primary care physicians, nurse-practitioners and community health nurses and community health representatives serving Aboriginal communities:
  - to increase the number who have received training in pre- and post-test counselling (i.e., the counselling associated with HIV-antibody testing)
  - to promote acceptance of holistic health beliefs
  - to improve communication skills with Aboriginal clients
  
- **for health and social sciences researchers:**
  - to increase the number of Aboriginal people trained and employed as health and social science researchers
  - to promote cooperative training in order to increase Aboriginal participation partnerships

*“I would like to see the people that are infected with HIV work with people that have HIV... train these people”*

*Helen H. pg 44. BC Aboriginal HIV/AIDS Task Force Kelowna Strategy Consultation, October 15, 1998*

## RESEARCH TO SUPPORT EFFECTIVE AND RELEVANT PROGRAM PLANNING

- to promote the participation of Aboriginal people, especially those living with HIV or AIDS, in the planning and conduct of all research on HIV/AIDS in the Aboriginal population
- **to encourage:**
  - researchers to recognize transgendered people as a distinct gender
  - the BC Centre for Disease Control Society to include “transgendered” as a separate gender category in its HIV/AIDS surveillance system
  - discussion around surveillance reporting in local areas of low numbers
  - discussion on meanings attached to confidentiality within Aboriginal communities and its appropriateness within an Aboriginal context
- to improve public access to the research literature on HIV, substance abuse and other related subjects among Aboriginal people through the creation of a “BC Aboriginal HIV/AIDS information clearinghouse” to disseminate research findings and to maintain a “BC Aboriginal HIV/AIDS prevention project inventory/database” to monitor the delivery of services
- to promote research around HIV and BC’s Aboriginal people in the following areas:
  - the relationship between alcohol, other non-injecting substances and HIV/AIDS
  - the epidemiology of HIV/AIDS (numbers of people infected, distribution of cases, risk factors, migration trends)
  - knowledge, attitudes and behaviours regarding HIV and AIDS treatment access barriers
  - the effects of the interaction between federal health transfer to bands, provincial regionalization and continued federal health services provision on First Nations health and access to health services
- evaluating the effectiveness for Aboriginal persons of various methods and models for:
  - changing behaviours that put people at higher risk for getting HIV
    - preventing the spread of HIV
    - on the nutritional, housing, health care and social service needs of Aboriginal people living with HIV or AIDS
    - harm reduction measures for substance abuse
- to promote research on traditional Aboriginal medicines (pharmacologic properties and effects, potential interactions with anti-retroviral drugs), while ensuring Aboriginal communities receive benefits for allowing access to traditional medicines through researching and applying available legal and contractual methods to ensure benefits are received



# IMPLEMENTING THE STRATEGIC GOALS

**I**n this document the Task Force has not specified methods for achieving the strategic goals and objectives. The Task Force and its members are a resource for helping people discover the best approaches at local levels. Those living with HIV/AIDS in your communities are your best resources for identifying what needs to be done about HIV or AIDS in your own communities. There is almost always more than one valid way to achieve a goal.

Take the information in this document and use it to develop ideas and approaches. Tear the ideas apart and identify what doesn't work as well. But don't give up trying. If something doesn't work the first time, try again or try something else. Talk to people, get them involved with helping to build your ideas and turn them into reality. HIV has taught us a lot. One of its teachings is that we can not achieve everything we need alone - we need each other to support and guide, be coaches, listeners and activists, for encouragement, pushing, and pulling, as needed.

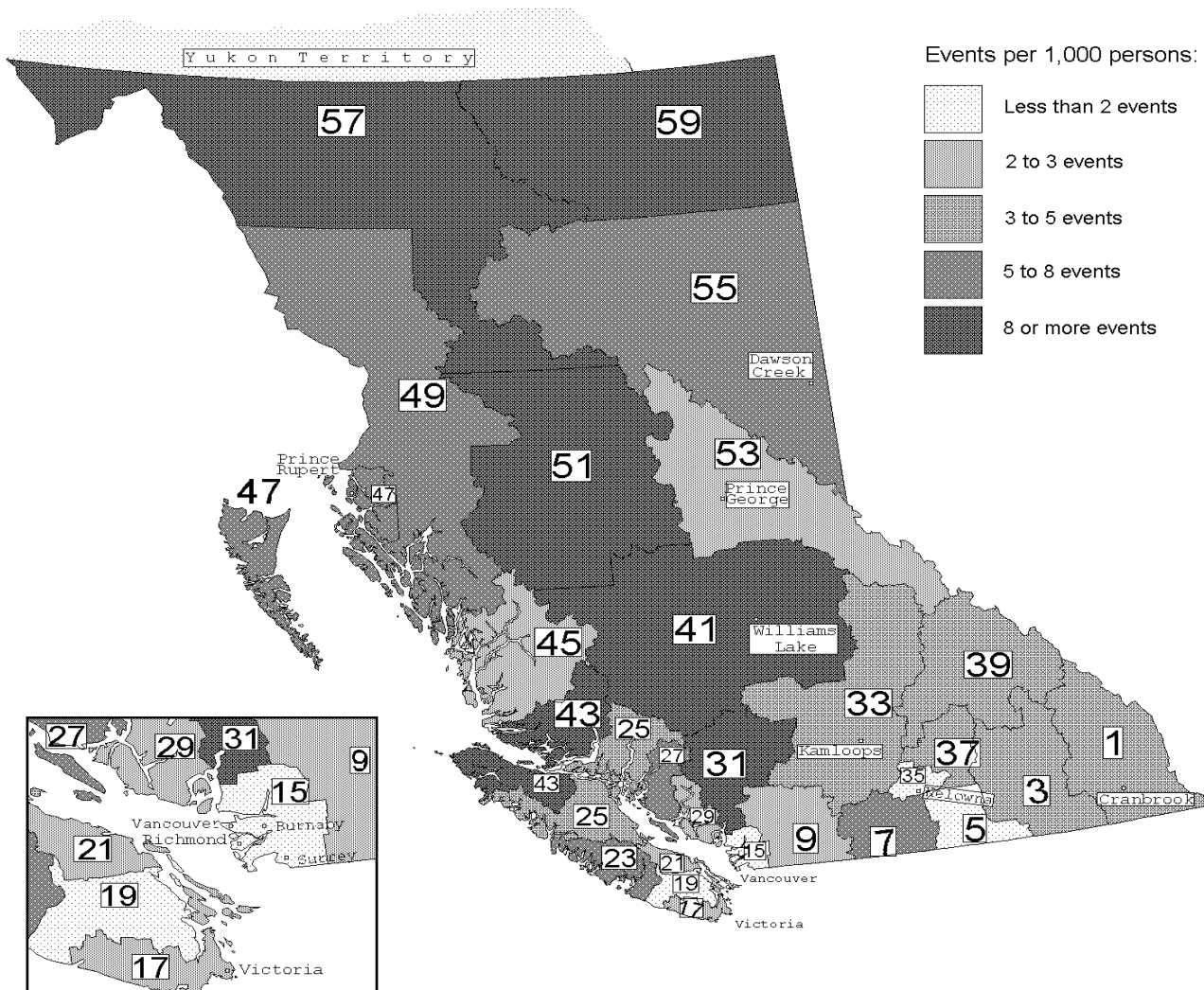
The Aboriginal HIV/AIDS Resource Guide outlines community programs that are able to help in your region. Get a copy and feel free to call the program most appropriate for you.

At a later date, the Task Force will produce an 'Implementation Guide', aimed at Aboriginal communities and community-based organizations, with concrete suggestions and examples on what individuals and groups can do to help make progress towards the strategic goals.

The Task Force has begun the process of identifying where services have been, in an effort to identify where we need to go. One part of that process has been to map out where in the Medical Services Branch funding and the BC Aboriginal AIDS Awareness Program services have been. Some of the projects that Medical Service Branch has funded include activities provided by Healing Our Spirit BC First Nations AIDS Society.



# HIV PREVENTION PROJECTS IN BC AND YUKON 1990-1997



**Regional Districts:**

- |                        |                      |                           |
|------------------------|----------------------|---------------------------|
| 1 East Kootenay        | 23 Alberni-Clayoquot | 41 Cariboo                |
| 3 Central Kootenay     | 25 Comox-Strathcona  | 43 Mount Waddington       |
| 5 Kootenay Boundary    | 27 Powell River      | 45 Central Coast          |
| 7 Okanagan-Similkameen | 29 Sunshine Coast    | 47 Skeena-Queen Charlotte |
| 9 Fraser Valley        | 31 Squamish-Lillooet | 49 Kitimat-Stikine        |
| 15 Greater Vancouver   | 33 Thompson-Nicola   | 51 Bulkley-Nechako        |
| 17 Capital             | 35 Central Okanagan  | 53 Fraser-Ft George       |
| 19 Cowichan Valley     | 37 North Okanagan    | 55 Peace River            |
| 21 Nanaimo             | 39 Columbia-Shuswap  | 57 Stikine (region)       |
|                        |                      | 59 Fort Nelson-Liard      |



# EVALUATING PROGRESS

**A** boriginal people in BC must decide for themselves whether or not progress is being made towards the strategic goals, based on accurate, factual information.

The Task Force will assist communities, organizations and individuals in the task of evaluating The Red Road. The Task Force believes that such information could be provided to the Aboriginal public in the following four ways.

## 1. CREATING AN INVENTORY OF B.C. ABORIGINAL HIV/AIDS PREVENTION PROJECTS

This is a current project of the BC Aboriginal HIV/AIDS Task Force. The inventory will list and describe HIV/AIDS prevention projects for the Aboriginal population of BC, from about 1989 to the present, and continuing into the future. "Prevention" includes all of primary prevention (e.g., awareness, education, condom distribution, needle exchange), secondary prevention (e.g., diagnostic testing for HIV, pre- and post-test counselling) and tertiary prevention (e.g., care and support for people living with AIDS.)

The inventory will be updated regularly. The inventory will be stored in an electronic database. The system will include computer programs to extract and to summarize statistics from the database (numbers of projects, types of activity, target groups, time of occurrence, geographic location, etc.) Annual reports will be available to the Aboriginal public.

Some of the strategic goals are to provide specific services, for example, to increase/improve sexual health education. The inventory will help people to see whether or not the amount of this type of activity is increasing, and also, for example, whether or not its geographic distribution is improving.

## 2. CAPACITIES AND NEEDS ASSESSMENT SURVEYS

There is an urgent need for surveys of Aboriginal people living with HIV/AIDS, in order to find out their nutritional, housing, health care and social support needs and the current individual, family and community capacities available to meet those needs. The BC Aboriginal HIV/AIDS Task Force wants to promote and to facilitate this kind of research.

Some of the strategic goals are to fulfil specific needs of Aboriginal people living with HIV or AIDS, for example, to improve access to specialized medical care. Surveys of the Aboriginal population, repeated periodically, will help people to see whether or not unfulfilled needs are decreasing.

### 3. KNOWLEDGE, ATTITUDE AND BEHAVIOUR SURVEYS

There is also a need for broadly-based surveys of awareness, knowledge, attitudes, beliefs and behaviour in the general Aboriginal population of BC, those living with HIV/AIDS and among IDUs regarding HIV and AIDS. The BC Aboriginal HIV/AIDS Task Force wants to promote and to facilitate this kind of research.

Some of the strategic goals are to increase awareness, to increase knowledge, to change attitudes, or to change behaviours. Surveys, repeated periodically, will help people to see whether or not the desirable outcomes are increasing among members of the population.

### 4. HIV/AIDS SURVEILLANCE

The “bottom line” for any plan to prevent HIV and AIDS is, of course, whether or not the rate of occurrence of new cases of HIV infection or AIDS is decreasing among Aboriginal people in BC. The Task Force congratulates the BC Centre for Disease Control Society for its highly developed HIV/AIDS surveillance system which is capable of monitoring the Aboriginal, and other, populations. The Task Force wants to help disseminate the surveillance report on a regular basis to the Aboriginal public and to Aboriginal community leaders.

An area which requires further research is on migration trends and patterns of HIV among BC’s Aboriginal population. Further discussions are also required on regional reporting and reporting in areas of low numbers. Many Aboriginal communities have requested more detailed breakdown of overall numbers of infections into local areas. There is mixed opinion on appropriateness of confidentiality concerns within the Aboriginal community. More discussion on meanings attached to confidentiality within Aboriginal communities and its appropriateness within an Aboriginal context is required.





# THE BC ABORIGINAL HIV/AIDS TASK FORCE

## PARTICIPANTS

**The BC Aboriginal HIV/AIDS Task Force is comprised of one representative from each of the following:**

Aboriginal People living with HIV/AIDS - Female  
Aboriginal People living with HIV/AIDS - Injection Drug Use  
Aboriginal People living with HIV/AIDS - Male  
Aboriginal People living with HIV/AIDS - Transgender  
Aboriginal People living with HIV/AIDS - Youth  
Aboriginal Health Association of B.C.  
B.C. Association of Aboriginal Friendship Centres  
B.C. Aboriginal AIDS Awareness Program  
Chiefs Health Committee  
Community Health Associates of B.C.  
Elders  
First Nations Treatment Directors of B.C.  
Healing Our Spirit, B.C. First Nations AIDS Society  
High Risk Project Society  
On-reserve Brighter Futures Community Development Worker  
Tillicum Haus Friendship Centre  
Tri-City Metis & AIDS Awareness Society  
United Native Nations  
Vancouver Native Health Society  
Vancouver Police & Native Liaison Society  
Women's Hospital & Health Centre B.C.  
Others as appropriate

**In Partnership with:**

Aboriginal Health Division, Ministry of Health  
Correctional Services Canada  
Health Promotions and Programs Branch, Health Canada  
Indian & Northern Affairs Canada  
Medical Services Branch, Health Canada  
Ministry of Attorney General  
Ministry of Health and Ministry Responsible for Seniors

Additional representatives or alternate members may attend meetings of the BC Aboriginal HIV/AIDS Task Force at the discretion of the member organization.





# THE B C ABORIGINAL HIV/AIDS TASK FORCE

## STRATEGY ROLES AND RESPONSIBILITIES

The following roles and responsibilities shall apply:

1. Establish links with Aboriginal AIDS Service organizations, AIDS Service organizations and others providing programs and services to Aboriginal people affected and infected with HIV/AIDS.
2. Develop appropriate working groups.
3. Develop and guide the implementation and evaluation of the B.C. Aboriginal HIV/AIDS Strategy.
4. Ensure that the goals of the B.C. Aboriginal HIV/AIDS Task Force Work Plan are carried out.
5. Establish and maintain a working relationship with the appropriate municipal, regional, provincial and federal government agencies and foundations.
6. Identify processes within the government to facilitate the successful implementation of the B.C. Aboriginal HIV/AIDS Strategy
7. Develop an accountability framework to ensure program and financial accountability to both the Aboriginal organizations/community and the provincial and federal governments.
8. Identify and secure appropriate opportunities for proceeding with the implementation of the B.C. Aboriginal HIV/AIDS Strategy.
9. Ensure that the B.C. Aboriginal HIV/AIDS Strategy is implemented in an efficient and effective manner through planning and coordination.
10. Advise on policy and programming on the following: education, training, care, treatment, support, prevention & funding with appropriate agencies.





# THE BC ABORIGINAL HIV/AIDS TASK FORCE

## ABORIGINAL CO-CHAIRS ROLES AND RESPONSIBILITIES

The following roles and responsibilities shall apply:

The B.C. Aboriginal HIV/AIDS Task Force will have two Aboriginal co-chairs appointed by the members of the B.C. Aboriginal HIV/AIDS Task Force, at least one of whom will be HIV+.

The co-chairs will:

- Provide direction to the Coordinator for preparation of meeting agendas.
- Ensure that time lines are set and completed.
- Maintain rules of order.
- Ensure the flow of information and communication.
- Facilitate discussion.
- Represent the B.C. Aboriginal HIV/AIDS Task Force at various meetings.
- Provide instruction and direction to the Coordinator between meetings of the B.C. Aboriginal HIV/AIDS Task Force.
- Facilitate the work of the working groups.
- Ensure the participation of Elders in meetings. Ensure that the Elder is provided with an honorarium.
- Receive reports from the coordinator.
- Ensure that all ministries are informed and invited to participate in the meetings of the BC Aboriginal HIV/AIDS Task Force.

In order to increase continuity of programming, the term of the co-chair persons is set at two years. Renewal is at the option of the Co-Chairperson and upon the consensus of the members present at the vote or on a rotating basis.





# THE BC ABORIGINAL HIV/AIDS TASK FORCE

## COMMITMENTS FROM THE MEMBERS OF THE BC ABORIGINAL HIV/AIDS TASK FORCE

1. All members are to provide their vision and expert opinion in helping to develop the B.C. Aboriginal HIV/AIDS Strategy.
2. All members will speak on behalf of their organization and/or the needs of their community.
3. All members are responsible for working in cooperation within the B.C. Aboriginal HIV/AIDS Task Force and its members.
4. All members are responsible for meeting the time lines of reports and tasks as determined by the B.C. Aboriginal HIV/AIDS Task Force.
5. All members are responsible for attending full meetings of the B.C. Aboriginal HIV/AIDS Task Force or ensuring that fully informed alternates attend in their place.
6. Advocate and lobby governments to provide funding for transportation, accommodation and expenses to attend meetings.

## DECISION MAKING PROCESS

The strategic directions are made by consensus of those present. In the event that there is no consensus, 63% of a vote equals the consensus of those present.

## ADVISORY MEMBERS

The participation of non-voting advisory members will be sought on an as needed basis.



# GLOSSARY

**ABORIGINAL:**

Indian, Metis and Inuit people (Constitution Act, 1982)

**ABORIGINAL COMMUNITY/COMMUNITY:**

A group of Aboriginal people who share similar beliefs, traditional and culture. These groups exist through shared political, cultural, spiritual identity and/or organized for the purposes of jointly improving the quality of life for Aboriginal people in the community. Aboriginal communities include First Nation/Aboriginal communities, Metis people, Friendship Centres, Aboriginal urban-based organizations, and political organizations.

**ABORIGINAL FAMILY:**

Children, parents and their extended family, which may include blood and adopted relatives, in-laws and significant others.

**ABORIGINAL LEADERSHIP:**

The formal Aboriginal leadership consists of Grand Chiefs, Chiefs and Band Councils and Boards of Directors and Executive of Aboriginal Organizations. Informal Aboriginal leadership includes matriarchies, Elders, and influential individuals and/or families in Aboriginal communities.

**ACCOUNTABILITY:**

A process through which a person is responsible for his or her actions to a designated group or body. In terms of appointments and representation, it involves the nomination of a person by a group and a reporting relationship between the parties.

**ADDICTIONS:**

Obsession of the mind coupled with a compulsion of the mind to substances like drugs, alcohol, solvents, or behaviours like sex and eating.

**ADVOCATE:**

A person who contributes to the empowerment of persons living with HIV/AIDS and promotes respect for their rights, freedoms, autonomy, and dignity.

**AGENCIES:**

Includes programs and services both within and outside Aboriginal communities and governments.

**AIDS (Acquired Immune Deficiency Syndrome):**

A group of diseases (a syndrome) that result from a breakdown in the body's disease defence system (immune system). With AIDS, the immune system is attacked by a virus called the human immunodeficiency virus (HIV).





# GLOSSARY

**CLIENT ADVOCACY:**

Assisting a person by speaking on his or her behalf or explaining his or her wishes with respect to health care and community support systems.

**COMMUNITY SUPPORT SYSTEM:**

Refers to non-health services, i.e. housing education, social services, etc.

**DISABILITY:**

Limitation on everyday living.

**FIRST NATION:**

An Aboriginal community, also known as a band under the Indian Act, with or without a land base.

**GOVERNMENT:**

Aboriginal, municipal, provincial or federal governments.

**HEALTH (see wholistic health):**

Health has traditionally been conceptualized by Aboriginal people as an integral part of all aspects of life and as a reflection of individual and collective relationships to the natural, social and spiritual environment.

**HEALTH EMPOWERMENT:**

The personal sense of control over health and health-related issues to individuals or group of individuals. An individual or group's sense of control over health and health related issues.

**HIV (Human Immunodeficiency Virus):**

The virus believed to cause AIDS. Having HIV is not the same as having AIDS. Some people who have the virus are healthy, and have none or only a few symptoms. Even if a person does not have symptoms, they are able to pass on the virus. A person may have HIV for several years before AIDS-related diseases appear. It is important to receive treatment early on in HIV infection in order to stay well longer.

**HIV ANTIBODY TEST:**

A blood test that detects HIV antibodies, indicating that a person has been exposed to HIV and now carries the virus.

**HOSPICE:**

Provision of a supportive environment for a person in the last stages of a terminal illness.



# GLOSSARY

**HOSTEL:**

A place where client and/or their families stay when accessing health services away from their community.

**MEDICAL INTERPRETER/TRANSLATOR:**

A person who explains the meaning of health information to patients or their families and who may also translate information from one language to another.

**MOH:**

Ministry of Health

**PHA:**

People living with HIV/AIDS

**PREVENTION:**

Programs and services aimed at groups at risk of ill health or already affected by a health or social condition.

**PROMOTION:**

Activities which focus on improving or maintaining the health of the individual, family or community before the presence of a health condition.

**RESPITE CARE:**

Temporary or short term support provided to a person who is caring for someone who is elderly, terminal, disabled or recuperating from treatment.

**RESIDENCY:**

The place where an Aboriginal person lives, including on reserve or off reserve, in rural or urban communities.

**SAFER SEX:**

Sexual activities that help prevent the spread of HIV and other sexually transmitted diseases (i.e.: correct use of a latex condom, non-penetration, etc.).

**STD (SEXUAL TRANSMITTED DISEASES):**

A bacteria, virus or infection that may be passed from one individual to another by sexual contact. Also referred to as V.D. (venereal disease) Examples of S.T.D.'s are; herpes, syphilis, gonorrhoea, chlamydia, HIV.

**TRADITIONAL MEDICINE:**

Herbal or other preparations used by a traditional healer for healing purposes.





# GLOSSARY

## TRADITIONAL HEALER/MEDICINE PERSON:

An Aboriginal person who assists the healing of a person or group using traditional medicines, ceremonies, counselling and other means, and is recognized as a traditional healer by the Aboriginal community.

## TRADITIONAL TEACHINGS:

The values, beliefs, customs and instructions with respect to ways of living passed from generation to generation.

## TRAINING:

The development of required knowledge, skills and attitudes needed to develop, implement, deliver and evaluate effective health programs and services. Training ranges from basic training to ongoing professional development.

## TRANSGENDER:

These are individuals who live in a gender other than the one assigned to them at birth on the basis of their biological sex. For instance, individuals who were born male, but who live as women. Transgenderists usually take hormones to live in their chosen gender.

## TRANSSEXUALS:

Transsexuals also live in a gender other than the one assigned to them at birth. Like transgenderists, they take hormones to change their physical appearance. Hormones change the physical structure of the body, including secondary sex characteristics like facial hair, skin tone, and voice pitch.

## TREATMENT:

Active intervention to diagnose, treat or care for an illness.

## TWO-SPIRIT PEOPLE:

gay, lesbian, bi-sexual, and/or transgendered Aboriginal people

## WELLNESS:

The balance of physical, mental, emotional, social environments and spiritual aspects of being.

## WHOLISTIC HEALTH:

Physical, mental, emotional and spiritual aspects of the human being.

# TABLE 1: POPULATION OF BRITISH COLUMBIA

1996 Census, 20% sample data

Age Groups:	Total	0-14 yrs	15-24 yrs	25-44 yrs	45+ yrs
Total BC population	3689755	735055	483065	1212930	1258710
Total Aboriginal population[a]	139655	44805	24790	45410	24650
North American Indian single response[b,c]	107370	35490	19245	34675	17965
Metis single response[c]	25575	7355	4365	8465	5390
Inuit single response[c]	745	270	120	275	65
Multiple Aboriginal responses[c]	1200	370	185	390	255
Other Aboriginal response[d,e]4765	1320	870	1600	970	
Yes, member of a Band/First Nation[d]	94870				
Yes, Registered Indian [e]	93835				
Total Aboriginal pop. - On/Off Reserve [b]	139655				
Living on reserve	42455				
Living off reserve	97200				
Total Aboriginal pop. - Vancouver [f]	31140	8670	5470	11580	5415
Total Aboriginal pop. - Victoria [f]	6570	2090	1180	2270	1020

[a] Yes to Question 18 of Form 2B, "Is this person an Aboriginal person, that is, North American Indian, Metis, or Inuit (Eskimo)?" AND/OR Yes to Q 20, "Is this person a member of an Indian Band/First Nation?" AND/OR Yes to Q 21, "Is this person a Treaty Indian or a Registered Indian as defined by the Indian Act of Canada?"

[b] In the 1996 Census, a total of 17 Indian reserves and settlements in BC were incompletely enumerated and are not included in the census counts. Based on the previous (1991) Census and 1993 band member counts maintained by Indian and Northern Affairs Canada [reference 3], the estimated on-reserve population of these 17 communities is 2,275 persons.

[c] Response to Question 18 of Form 2B, "Is this person an Aboriginal person, that is, North American Indian, Metis, or Inuit (Eskimo)?"

[d] Includes Indian Band/First Nation members (Q 20, Form 2B) who did not give a Yes response to Question 18.

[e] Includes Registered or Treaty Indians (Q 21, Form 2B) who did not give a Yes response to Question 18.

[f] Census Metropolitan Area.

Data Source: Nation Series Package No. 5: Aboriginal (data products: The Nation: 1996 Census of Population). Statistics Canada Catalogue No. 93F0025XDB96000 [Diskette].

## TABLE 2: ABORIGINAL POPULATION OF REGIONAL DISTRICTS IN BRITISH COLUMBIA

REGIONAL DISTRICT	TOTAL POPULATION		ABORIGINAL POPULATION			NORTH AMERICAN INDIAN		METIS		MULTIPLE & OTHER *	
	number	% of BC	number	% of BC	% of region	number	% of Total	number	% of Total	number	% of Total
East Kootenay	55,975	1.5	2,110	1.5	3.8	1,330	63.0	745	35.3	40	1.9
Central Kootenay	57,535	1.6	1,350	1.0	2.3	845	63	470	35	35	2.6
Kootenay Boundary	32,535	0.9	525	0.4	1.6	250	48	270	51	10	1.9
Okanagan-Similkameen	75,205	2.0	2,040	1.5	2.7	1,490	73.0	510	25.0	30	1.5
Fraser Valley	218,750	5.9	9,090	6.5	4.2	7,115	78.3	1600	17.6	375	4.1
Greater Vancouver	1,813,935	49.2	31,140	22.3	1.7	21,280	68.3	8150	26.2	1715	5.5
Capital	313,605	8.5	6,920	5.0	2.2	5,005	72.3	1630	23.6	290	4.2
Cowichan Valley	70,525	1.9	5,655	4.0	8	4,805	85.0	660	11.7	185	3.3
Nanaimo	120,785	3.3	4,230	3.0	3.5	2,950	69.7	965	22.8	320	7.6
Alberni-Clayoquot	31,435	0.9	3,690	2.6	11.7	3,170	85.9	395	10.7	120	3.3
Comox-Strathcona	97,385	2.6	4,220	3.0	4.3	3,375	80.0	690	16.4	155	3.7
Powell River	19,760	0.5	845	0.6	4.3	685	81	95	11	55	6.5
Sunshine Coast	24,785	0.7	1,120	0.8	4.5	940	84	110	10	60	5.4
Squamish-Lillooet	29,315	0.8	2,430	1.7	8.3	2,210	90.9	180	7.4	45	1.9
Thompson-Nicola	117,980	3.2	9,985	7.1	8.5	8,205	82.2	1315	13.2	460	4.6
Central Okanagan	135,280	3.7	2,785	2.0	2.1	1,695	60.9	975	35.0	105	3.8
North Okanagan	70,845	1.9	2,300	1.6	3.2	1,630	70.9	575	25.0	100	4.3
Columbia-Shuswap	47,765	1.3	1,745	1.2	3.7	1,060	60.7	525	30.1	165	9.5
Cariboo	66,225	1.8	5,895	4.2	8.9	4,705	79.8	890	15.1	295	5.0
Mount Waddington	14,590	0.4	2,460	1.8	16.9	2,225	90.4	110	4.5	125	5.1
Central Coast	3,915	0.1	2,175	1.6	55.6	2,095	96.3	30	1.4	50	2.3
Skeena-Queen Charlotte	24,705	0.7	8,120	5.8	32.9	7,515	92.5	165	2.0	445	5.5
Kitimat-Stikine	43,445	1.2	10,210	7.3	23.5	9,495	93.0	285	2.8	430	4.2
Bulkley-Nechako	41,510	1.1	5,660	4.1	13.6	5,000	88.3	340	6.0	315	5.6
Fraser-Fort George	98,505	2.7	6,355	4.6	6.5	4,070	64.0	1880	29.6	405	6.4
Peace River	56,205	1.5	5,135	3.7	9.1	2,970	57.8	1875	36.5	290	5.6
Stikine	1,390	0.0	560	0.4	40.3	540	96	10	2	15	2.7
Fort Nelson-Liard	5,855	0.2	890	0.6	15.2	715	80	125	14	50	5.6
British Columbia	3,689,755	100	139,655	100	3.8	107,370	76.9	25,575	18.3	6,710	4.8

Prepared by: BC STATS

Source: 1996 Census of Canada

\* Multiple & Other includes Inuit, Multiple Aboriginal, and others who are Registered Indians or members of an Indian Band.



# TABLE 3: FERTILITY RATES IN BRITISH COLUMBIA

1987-1994

Age Groups:	Total 15-44 yrs	15-19 yrs	20-29 yrs	30-39 yrs	40-44 yrs
Status Indian population, female [a]	23866	4081	9144	7901	2740
Total live births 1987-94	23254	4670	14179	4273	132
Live births/1,000/year	121.8	143	193.8	67.6	6
Total Fertility Rate (Live births/1,000) [b]	3336				
BC population, female [a]	789259	108434	262803	291993	126029
Total live births 1987-94	356712	19840	198121	134095	4656
Live births/1,000/year	56.5	22.9	94.2	57.4	4.6
Total Fertility Rate (Live births/1,000) [b]	1632				

[a] Estimated mean population for eight-year period 1987-1994.

[b] Expected live births in a cohort of 1,000 women followed for 30 years from ages 15 through 44 years, based on age-specific fertility rates 1987-94.

Data source: Analysis of Status Indians in British Columbia, Updated Report, 1987-1994. Victoria, BC: Division of Vital Statistics, Ministry of Health and Ministry responsible for Seniors, Province of British Columbia, 1996.

# TABLE 4: EDUCATIONAL ATTAINMENT OF ADULTS IN BRITISH COLUMBIA

1991

	Population	Grade 8 or less	Grades 9-13	Some Post-secondary	Post-secondary Certificate/diploma	University degree
BC, total, age 15-44 yrs	1,537,060	2.8%	43.1%	16.7%	25.2%	12.2%
BC, Aboriginal, age 15-49 yrs	55,110	10.2%	51.1%	14.9%	20.7%	2.7%
North American Indian	51,230	10.6%	51.1%	15.0%	20.5%	2.5%
On-reserve	15,900	16.0%	51.1%	14.0%	17.9%	0.6%
Off reserve	35,355	7.8%	51.0%	15.4%	21.7%	3.3%
Metis	4,830	5.3%	51.6%	12.1%	26.1%	4.5%
Inuit	200	[a]	62.5%	[a]	[a]	[a]
Vancouver [b], Aboriginal, age 15-49 yrs	15,400	6.3%	46.5%	15.4%	26.0%	5.6%
Victoria [b], Aboriginal, age 15-49 yrs	2,405	6.4%	47.2%	23.1%	18.5%	[a]

[a] Census data suppressed to protect privacy.

[b] Census Metropolitan Area

Data source: 1991 Census and 1991 Aboriginal Peoples Survey

## TABLE 5: TOTAL ANNUAL INCOME OF ADULTS IN BRITISH COLUMBIA

1991

Population	Less than \$2,000	\$2,000 to \$9,999	\$10,000 to \$19,999	\$20,000 to \$39,999	\$40,000 or more
BC, total, age 15+ yrs 2,585,525	13.1%	19.7%	22.2%	27.9%	17.0%
BC, Aboriginal, age 15+ yrs 65,645	22.9%	31.0%	22.6%	17.5%	6.0%
North American Indian 60,695	23.4%	31.3%	22.6%	16.9%	5.7%
On-reserve 20,140	25.7%	36.9%	21.9%	12.6%	2.9%
Off reserve 40,565	22.2%	28.6%	23.0%	19.1%	7.1%
Metis 5,925	16.8%	27.0%	19.9%	25.3%	11.0%
Inuit 205	48.8%	[a]	[a]	[a]	[a]
Vancouver [b], Aboriginal, age 15+ yrs 17,490	19.2%	30.7%	24.0%	20.4%	5.8%
Victoria [b], Aboriginal, age 15+ yrs 2,870	22.0%	25.6%	24.6%	20.6%	7.0%

[a] Census data suppressed to protect privacy.

[b] Census Metropolitan Area

[c] Total income from all sources in the past year.

Data source: 1991 Census and 1991 Aboriginal Peoples Survey

**TABLE 6: UNEMPLOYMENT AND SOCIAL ASSISTANCE OF ADULTS IN BRITISH COLUMBIA**

1991

Population	Labour Force Participation [c]	Unemployment Rate [d]	Employment Rate [e]	On Social Assistance [f]
BC, total, age 15+ yrs 2,585,525	67.6%	10.3%	60.6%	not available
BC, Aboriginal, age 15+ yrs 65,645	61.9%	27.8%	44.7%	28.1%
North American Indian 60,695	61.8%	28.2%	44.4%	29.3%
On-reserve 20,140	54.7%	33.8%	36.2%	35.5%
Off reserve 40,565	65.4%	25.9%	48.5%	26.2%
Metis 5,925	63.5%	19.1%	51.4%	12.2%
Inuit 205	[a]	[a]	[a]	51.2%
Vancouver [b], Aboriginal, age 15+ yrs 17,490	63.9%	29.0%	45.4%	30.3%
Victoria [b], Aboriginal, age 15+ yrs 2,870	65.2%	19.5%	52.5%	20.9%

[a] Census data suppressed to protect privacy.

[b] Census Metropolitan Area

[c] Percent of population aged 15 years or older that was employed or actively seeking employment.

[d] Percent of labour force that was not employed.

[e] Percent of population aged 15 years or older that was employed.

[f] Percent of population aged 15 years or older that received social assistance anytime in the past year (not including Family Allowance or the Child Tax Credit.)

Data source: 1991 Census and 1991 Aboriginal Peoples Survey

**TABLE 7: NEW HIV-POSITIVE TESTS IN CANADA  
JAN. 1, 1995 TO DEC. 31, 1995**

	Total N (%)	Male N (%)	Female N (%)	Unknown gender N
HIV-positive tests in Canada	3,093	2,279	541	273
HIV-positive, gender known	2,820(100%)	2,279(100%)	541(100%)	
Age 0-14 yrs	50(2%)	24(1%)	26(5%)	
Age 15-19 yrs	24(1%)	9(0%)	15(3%)	
Age 20-29 yrs	669(24%)	485(21%)	184(34%)	
Age 30-39 yrs	1,241(44%)	1,008(44%)	233(43%)	
Age 40-49 yrs	565(20%)	511(22%)	54(10%)	
Age 50+ yrs	219(8%)	197(9%)	22 (4%)	
Age unknown	52(2%)	45(2%)	7(1%)	
HIV-positive, risk factors known	1,756(100%)	1,417(100%)	323(100%)	16
Injection drug use (IDU)	416(24%)	293(21%)	117(36%)	6
IDU & sex trade	0			
IDU & two-spirit people	74(4%)	68(5%)	4(1%)	2
Two-spirit people	822(47%)	820(58%)	0(0%)	2
Heterosexual contact	274(16%)	159(11%)	113(35%)	2
Other risk factor(s)	170(10%)	77(5%)	89(28%)	4
Blood/blood products	41	27	14	0
Perinatal	47	14	31	2
All other	82	36	44	2
Risk factors unknown	1,337	1,000	262	75

Data source: HIV in Canada: Surveillance report for the period 1985-1995. Division of HIV/AIDS Surveillance, Bureau of HIV/AIDS and STD, LCDC, Health Canada, 1996.



## REFERENCES / NOTES

- A now called the BC Aboriginal AIDS Awareness Program
- B now called the First Nations' Chiefs Health Committee
- C Two-Spirit = Gay/Bi-sexual/Transgendered.
- D previously called Health Units
- E Status Indian persons living on the bands' reserves, from Indian and Northern Affairs Canada, based on 1993 band membership lists.
1. Form 2B (received by 20% of households), 1996 Census of Canada
  2. Ibid., Question 17
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