A Strategic Plan For the Years 2001 - 2006

Ontario Aboriginal HIV/AIDS Strategy

LaVerne Monette, Provincial Coordinator
43 Elm Street, 2nd Floor
Toronto, Ontario
M5G 1H1

Telephone: (416) 944-9481
1-800-743-8851
Fax: (416) 944-0541
E-mail: strategy@2spirits.com

TABLE OF CONTENTS

1.0 PREAMBLE

In 1995, the Ontario HIV/AIDS Strategy was implemented. As a result of an evaluation of the Strategy undertaken in 1999, and in consideration of the changing face of HIV/AIDS in the Aboriginal community, this document was developed.

The Ontario Aboriginal HIV/AIDS Strategy has been successful in that it has raised the profile of the disease both within the Aboriginal community and the larger Ontario population. It has been successful because it is a strategy that is Aboriginal controlled, responsive to our unique needs and implemented by Aboriginal people.
The Province of Ontario respects the ability of the Reference Group and facilitates the Strategy by providing supportive funding and expertise. The partnership that has been created with the Province is a critical factor in the success of the Strategy.

Many other partnerships have been established through the Strategy with: mainstream HIV/AIDS service providers, local and regional Aboriginal organizations, educational institutions, various levels of government (from municipal to federal) and with our own 2-Spirited People of the 1st Nations. Without the continuous support of these key partners little progress can be made.

There are a number of hurdles and issues that continue to impede the work of the Strategy. The Aboriginal community and the Aboriginal leadership have largely viewed HIV/AIDS as non-threatening to the Aboriginal population. The disease is often characterized as non-Aboriginal, gay and urban-based. There are issues related to homophobia, a lack of tolerance for alternative lifestyles and judgmental attitudes that very likely have resulted from residential schools and other culturally denigrating experiences. It is important that Aboriginal communities recognize the threat HIV/AIDS poses to this and future generations and prepare to care for Aboriginal people in their communities of origin. The First Nation at Wikwemikong provides an excellent example of a caring community organizing themselves to take responsibility for the care of its people living with and affected by HIV/AIDS. It is only by strengthening partnerships with Aboriginal communities and the leadership that the Strategy can continue to make progress.

This document articulates the issues related to HIV/AIDS in the Ontario Aboriginal community and sets out strategies to address these issues. The progress that is made when we once again evaluate the Strategy in 2005 will depend on the demonstrated commitment of the Aboriginal community and the support of our partners.

2.0 OVERVIEW of HIV/AIDS

Issues and Trends in the Ontario Aboriginal Community

In 1995, when the Reference Group proceeded to implement the Strategy it all seemed simple. If we merely accomplished the goals and objectives outlined in the Strategy everything would be fine.

Looking back, it did seem as if we had it all laid out. If we achieved everything we set out to do, we would be a long way towards functioning healthy Aboriginal communities.

We have done a great deal of work but we have a great deal more to do before we can rest.

What is the rate of HIV in the Aboriginal community in Ontario? Data on race and ethnicity with respect to HIV have not been collected consistently across Canada. In Ontario, we have extremely limited information because the province does not collect ethno-cultural HIV data. The information which follows is based on information from Health Canada's Laboratory Centre for Disease Control HIV/AIDS Epi Update. **(1)**

We do know that in the provinces in Canada that report ethnicity (British Columbia, Alberta, Saskatchewan, Manitoba, Yukon, Newfoundland, Nova Scotia, Prince Edward Island), the proportion of HIV diagnoses attributed to Aboriginal people was 19.4% in 1998 and 24.8% in 1999 with a significant increase in the numbers of Aboriginal women.

The Laboratory Centre for Disease Control notes an increase in the proportion of Aboriginal AIDS cases, as a proportion of all newly diagnosed cases, from 1% before 1990 to 15% in 1999. Ethnic origin is identified in just over half of the AIDS cases reported to the Laboratory Centre for Disease Control. We must recognize the fact that these data probably seriously under-represent the real numbers, that these numbers only reflect known Aboriginal AIDS cases, and that the number of Aboriginal people living with HIV is much higher.

Aboriginal AIDS cases are younger than non-Aboriginal AIDS cases (28.6% vs 17.1% were diagnosed at less than 30 years of age). The proportion of women among Aboriginal AIDS cases is higher than among non-Aboriginal AIDS cases (22.2% vs 7.7%). The proportion of AIDS cases attributed to injection drug use as an exposure category is higher among Aboriginal persons than among non-Aboriginal persons (24% vs 4.2% for men, 58.5% vs 18.1% for women.)

We also know that HIV did not pass over Ontario's Aboriginal communities. As a matter of fact, many people came to Ontario for information and assistance because of its advocacy experience with HIV and AIDS. They came for access to HIV primary care physicians and for access to the first AIDS service organizations, including 2-Spirited People of the 1st Nations, which was the first Aboriginal AIDS service organization in Canada.

The Laboratory Centre for Disease Control data also makes determinations of infection trends (which risky activities may be responsible for HIV transmission). Since the information collected comes from areas of Canada where ethno-cultural data is collected, the

HIV infection trends enumerated in the data do not likely reflect the infection trends for the Aboriginal population in Ontario. From our discussions with non-Aboriginal AIDS service organizations in Ontario, we have determined that the transmission trends in Ontario differ from other provinces in Canada. For example, injection drug use is seen as a major transmission method in British Columbia. In Ontario, while injection drug use is a factor, it does not represent the major transmission trend. About 24% of HIV infections in the northern part of Ontario and 15% of HIV infections in Ottawa are in injection drug users. This is significantly higher than the 6.2% of infections in Toronto. For non-Aboriginal AIDS service organizations and from the information that the Strategy and 2-Spirited People of the 1st Nations have gathered, gay and two-spirited men continue to be the most adversely impacted by HIV in Ontario. Recent information in Ontario indicates that gay men still account for almost half of all new infections each year.

Why is this important? Transmission trends are used to determine funding priorities and criteria for proposals at all levels of governmental and non-governmental funding. If we do not have a true picture of the epidemic in Ontario's Aboriginal community, we may be forced to set priorities or undertake projects which are not timely or relevant merely to be able to obtain funds. Aboriginal AIDS service organizations have been in this position for years. Most of the funding priorities and criteria have been based on the data and priorities of non-Aboriginal AIDS service organizations. It has only been in the last few years that we have been able to influence funding priorities and criteria for the major governmental funders. We need appropriate and accurate information to design and deliver relevant programs and services to not only prevent the further transmission of HIV but also to address the needs of those Aboriginal people who are currently living with HIV/AIDS.

To this end, 2-Spirited People of the 1st Nations, one of the Strategy's member organizations, recently completed a survey of the knowledge, attitudes, beliefs/behaviours of two-spirited men across Canada in order to determine what prevention and health promotion messages might be accessible and appropriate for two-spirited men. We will use this information to design and deliver prevention and health promotion messages and to update and improve our programs and services.

HIV Testing:

Even if Ontario collected ethno-cultural data, there are other barriers to determining the numbers of Aboriginal people who are HIV positive. Generally, Aboriginal people do not get tested for HIV. There are many reasons for this. Many Aboriginal people continue to believe that HIV is a gay, urban disease and if you are not gay or if you live in an isolated community, you will not get HIV or AIDS. Anonymous HIV testing is not accessible to the vast majority of Aboriginal people in Ontario. HIV testing may be available in the local Aboriginal health center or at the nurse's station in the community, but it may be a relative or someone the individual knows who does the testing, so there is a fear that confidentiality is not protected if you are tested at these sites. We have heard and confirmed many stories from our clients about breaches of confidentiality so this is a very real fear. There are health professionals in rural communities who are not knowledgeable about HIV and consequently do not suggest an HIV test until all other options have run out. This is one of the reasons that Aboriginal people are diagnosed with HIV later and receive treatment at later stages in their illness than others living with HIV/AIDS.

Any strategies to promote testing in the Aboriginal community must also address these broader issues such as accessibility to testing sites, lack of or perceived lack of confidentiality in Aboriginal communities which do HIV testing, racism in mainstream health services, and the availability of counselling and support services in Aboriginal communities.

These obstacles are common to many groups of people within Canada. However, testing and confidentiality issues must be examined with a recognition that Aboriginal people have lived within a context of colonization, oppression, racism and cultural denigration. These issues have contributed to the over-representation of Aboriginal people in many of the most marginalized groups: poor people, prisoners, injection drug users, sex trade workers and homeless people. Ill health is also a common factor to these groups and this also contributes to being vulnerable to HIV.

While we would like accurate up-to-date information on the rate of HIV in Aboriginal communities in Ontario, we would only support obtaining this data with full and informed consent of the individual, guarantees of confidentiality and the availability of culturally appropriate counselling and support services.

Aboriginal Women:

According to the limited data which we have, it is abundantly clear that Aboriginal women are at increased risk for HIV infection. Cases of AIDS and new HIV diagnoses have risen among Aboriginal women more rapidly than among Aboriginal men and non-Aboriginal women. From the data, two of the key routes of transmission for Aboriginal women are injection drug use and heterosexual sex. **(2)**

Social conditions brought on by the legacy of oppression, racism and sexism-such as poverty, poor health, high rates of STDs and sexual violence, have disproportionately placed Aboriginal women at risk for HIV and AIDS. The myth in many communities, and in Aboriginal communities that HIV is a gay, male disease, has exposed Aboriginal women to further risk. Generally, women have been ignored in HIV/AIDS research, policy and services and Aboriginal women have been almost invisible. Women have continued to be seen as "vectors of disease" through prostitution or pregnancy and their own health has been seen as inconsequential compared to that of the men with whom they have sexual contact and that of their unborn children. Very little attention has been paid to how women's position in society has affected clinical research, diagnosis, treatment, and health care. Lack of understanding of HIV-related symptoms as they affect women has led to delayed diagnosis and treatment, counselling and support and care to HIV positive women which contributes to higher mortality rates among women living with AIDS. Given the poverty and poor health of most Aboriginal people, this lack of attention has been a key factor in the rapid increase of HIV among Aboriginal women.

Aboriginal women living with HIV/AIDS place themselves last on their agendas. Many are single parents and are trying to survive on social assistance. The vast majority of their time is spent on obtaining basic needs-food, shelter, clothing, and transportation for their children and then for themselves.

Their fear for the future of their children can be overwhelming. Who will take care of their children? When they become ill will their children be taken away by the same child welfare agencies who scooped Aboriginal children from their communities in the 1960s?

Aboriginal women living with HIV/AIDS are extremely vulnerable. Disclosing HIV status to a partner can expose her to violence and abuse. If she discloses to her home community, she can face rejection, emotional, physical, mental and sexual violence from friends, family members and other community members. This is especially true for Aboriginal women living in remote and rural communities where shelters or HIV/AIDS services and programs are not available.

Many Aboriginal women also feel they cannot disclose their HIV status in their home communities because they fear violence against their children. These fears are not groundless. We have heard many stories of threats and violence against HIV positive Aboriginal women and their children. As one Aboriginal women living with HIV put it: "I cannot protect my children 24 hours a day. I had to leave my community".

We need to develop specific messages, services and programs for Aboriginal women which take into account their special needs and we need to act very quickly.

Aboriginal Prisoners:

A very sad development in Aboriginal communities has been the exclusion of certain people from the circle. Aboriginal people who use alcohol or drugs, who are two-spirited, who are living with HIV/AIDS or who are in the corrections system have been excluded from or unwelcome in the community. This happens in rural, remote, isolated and urban Aboriginal communities. One of the most marginalized groups has been Aboriginal prisoners.

Prisons have been acknowledged as HIV incubators. Estimates of the rate of HIV among prisoners vary from 1% to 4% in men and from 1% to 10% in women. The rate of HIV is ten times higher in prisons than it is in the general population. Often their imprisonment and their HIV infection are strongly associated with injection drug use and many continue to inject while in prison. In a federal prison survey in British Columbia, 67% of prisoners reported injection drug use either in prison or outside, with 17% reporting drug use only in prison. In a 1995 prisoner survey conducted by the Correctional Service of Canada, 11% of 4285 federal prisoners reported injection drug use since arriving in the institution.

Injecting drugs, tattooing and piercing activities continue in prisons. Unsafe sexual activities continue in prisons. Since all of these activities are illegal in a prison environment, corrections authorities feel justified in not initiating needle exchange programs, and safe tattooing and piercing projects. Methadone maintenance is limited in most institutions to prisoners who were on methadone prior to their incarceration. Access to condoms in a confidential and dignified manner is not widespread throughout the system and unsafe sexual activities continue. Bleach may be available but its efficacy in preventing hepatitis C and other diseases is questionable.

Aboriginal people are over-represented in prison populations. While they represent 2% of the Canadian population, they represent an average of 14% of the federal prison population.

Some provincial prisons have Aboriginal incarceration rates of up to 75%. According to a survey of Aboriginal injection drug users completed by the Canadian Aboriginal AIDS Network, 36% of the respondents reported sharing needles on the street and 73% reported sharing needles in prison.

Prisoners living with HIV/AIDS are not in a supportive environment mentally, emotionally, physically or spiritually. Access to expert health professionals in the area of HIV is not often available. Appropriate nutrition, counselling, access to elders and healers is not readily available. Often other prisoners and corrections officers wrongly feel at risk for HIV by the mere presence of individuals living with HIV in the prison which can make day to day life stressful if not outright dangerous.

We need to advocate much more strongly with and on behalf of Aboriginal prisoners to enable them to have the tools to protect themselves from HIV and to ensure that they have appropriate access to nutrition, treatment and culturally appropriate programs and services when they are living with HIV/AIDS. The Strategy is currently involved in an Aboriginal Action Committee which is working on a National Aboriginal HIV/AIDS Corrections Strategy and activities which we hope will begin to address the HIV crisis in prisons.

Substance Use

The legacy of colonization, poverty and racism has contributed to an overwhelming sense of loss in the Aboriginal community. The use of alcohol, drugs and other substances to alleviate the pain of all of this loss is endemic in the Aboriginal community. The loss of lives, the violence, the low self-esteem which results should not need to be analysed and repeated again and again.

Substance use and its impact on risk for HIV infection have also been documented in countless research studies and reports. This holds as true for Aboriginal people as for other Canadians. Health Canada reports that injection drug use accounts for 17.6 % of the AIDS cases among Aboriginal men and 51.3% of those among Aboriginal women. This compares to 3.5% of the AIDS cases among men and 18.1% among women in the non-Aboriginal community. Aboriginal people represent between 25% and 75% of the people using various urban needle exchange programs and counselling/referral services.

What is lacking in Aboriginal programs and services which attempt to address the social impacts of substance use is a philosophy of harm reduction. All Aboriginal treatment centers are based on a philosophy of abstinence. The non-Aboriginal treatment centers and programs available are not culturally appropriate for the majority of Aboriginal substance users. For those people who cannot quit drugs or alcohol, there seems to be nothing available.

The high rate of mobility of Aboriginal people between urban, rural and reserve communities means that HIV is not restricted to pockets of injection drug users in the cities. Aboriginal people have sex and share needles in all of their communities.

We need to focus on the fact that Aboriginal people will continue to use substances. How they use the substances may expose them to HIV (sharing needles) or may impair their

judgment in critical situations (unsafe sex). Abstinence-based programs do not work for the majority of substance users.

Harm reduction does not take a stand on substance use or judge the user, it is a response to the very serious issues of HIV infection. Many substance users eventually quit. What we need to focus on is how to protect them and others from HIV while they are using. The 2-Spirits survey on two-spirited men and the Canadian Aboriginal AIDS Network study on Aboriginal injection drug users report a high sense of personal commitment of the respondents to stopping the spread of HIV and a high awareness of HIV risk.

We need to focus on harm reduction measures which will inform the substance user about risk and how to protect themselves and their loved ones. We need to deal with Aboriginal people where they are and provide them with culturally-appropriate HIV/AIDS programs and services whether or not they are using. The goal is to empower Aboriginal users to make changes in their behaviours which will reduce their risk of HIV infection and prevent the further spread of the virus.

Leadership and Networking:

There continues to be a major sense of denial in the Aboriginal community about the risk of HIV despite the evidence that HIV is on a rampage in all of our communities. Aboriginal leaders continue to be absent in public debate on this issue. HIV/AIDS continues to be at the bottom of the Aboriginal health agenda.

There continue to be a very small group of dedicated Aboriginal people who are working in the HIV/AIDS field with inadequate human and financial resources, and with very little support from Aboriginal leadership at all levels. There is a great deal of burnout among staff in Aboriginal AIDS service organizations. Often we rely far too much on Aboriginal people living with HIV and AIDS to travel around the country and tell their stories to small groups of people at risk to their own health. The people who attend our HIV/AIDS workshops and conferences may already be convinced of the threat that HIV poses to all of our communities. We have made few inroads in the Aboriginal populations which need to be convinced the most-heterosexual men, our leaders and elders.

Homophobia continues to prevent our important messages from reaching the hearts and minds of people who need to take action with us. Anti-drug and alcohol sentiment in Aboriginal communities continues to allow people to feel that they can judge others and blame them for their HIV infection. Prisoners must have committed a crime or they would not be in prison so who cares if they die there of AIDS.

These sentiments are not traditional to Aboriginal peoples. Our traditions speak of caring and sharing and taking care of our people who are not well. HIV is the disease, not the people living with it.

We will continue to work hard to inform our communities and to take care of our people living with HIV and AIDS. And we will continue to dream of a time when there is a cure.

1. Epi Update, Laboratory Centre for Disease Control, Health Canada.

www.hc-sc.gc.ca/hpb/lcdc/bah/epi/aborig_e.html

2. Native Social Work Journal, HIV/AIDS: Issues Within Aboriginal Populations, Volume 3, September 2000

3.0 VISION STATEMENT

In the development of an HIV/AIDS Strategy for Ontario, the Ontario Ministry of Health and Long-Term Care recognized the distinct needs and concerns of Aboriginal people in Ontario and committed to support the creation of a distinct strategy developed and driven by the Aboriginal community.

The Ontario Aboriginal HIV/AIDS Strategy will continue to operate distinctly and in parallel with the vision, goals and objectives of the Canadian Strategy on HIV/AIDS and the Ontario HIV/AIDS Strategy.

The Ontario Aboriginal HIV/AIDS Strategy also shares a common Vision with the Aboriginal Health Policy.

VISION STATEMENT OF THE ABORIGINAL HEALTH POLICY:

> "The Ontario provincial Aboriginal Health Policy exists in the context of the inherent right of self-government.
>
> Aboriginal health is wholistic and includes the physical, mental, emotional and spiritual aspects of life. Through this understanding of self, a vision of wellness which balances body, mind and spirit is promoted throughout the healing continuum.
>
> Committed partnerships of Aboriginal and non-Aboriginal people and governments will recognize and respect the diversities in lifestyles and traditions of Aboriginal people regardless of residency and status."

Goal of the Aboriginal Health Policy:

> "To improve the health of Aboriginal individuals, communities and nations through equitable access to health care, improved standards of care, the provision of culturally appropriate health services and promotion of a healthy environment. Self determination in health will be supported by appropriate levels of financial and human resources for Aboriginal designed, developed and delivered programs and services that respect and promote community responsibility, autonomy and local control."

Goal of the Ontario Aboriginal HIV/AIDS Strategy:

> "To provide culturally appropriate, inclusive education and prevention programs, and support and care strategies, consistent with harm reduction principles, to Aboriginal people living with and affected by HIV/AIDS."

4.0 PRINCIPLES

The Ontario Aboriginal HIV/AIDS Strategy will be a joint undertaking by the Aboriginal Community and the Ontario Ministry of Health and Long-Term Care and must:

1. Respect Aboriginal individual, family and community autonomy and diversity, regardless of status, age, residency, gender, or sexual orientation.

2. Be Aboriginal community-based in design, development and delivery and have direct participation by male and female Aboriginal youth, Aboriginal Elders, and/or Aboriginal Spiritual leaders and which respects and promotes positive Aboriginal traditional history and values.

3. Directly involve Aboriginal 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 directions.

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 political, religious, geographic and socio-economic restraints.

6. Promote networking, coordination and sharing of information and resources among Aboriginal individuals, families, caregivers, agencies, service providers, communities, leadership on and off reserve, and spiritual/religious leaders.

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 Reference Group to assess the implementation and delivery of the Strategy.

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 to make decisions concerning their own development, healing and care.

11. Recognize that caring for those living with HIV/AIDS must be a shared responsibility for both men and women.

12. Support an individual's right to engage in activities that reduce harm to themselves and others.

13. Provide opportunities and encourage communities to establish supports that are safe and secure for people living with and affected by HIV/AIDS.

5.0 BACKGROUND

The Ontario Aboriginal HIV/AIDS Strategy Steering Committee was established in 1993 to develop an HIV/AIDS plan for off-reserve Aboriginal people. In 1995, the Reference Group, which is comprised of the Ontario Metis and Aboriginal Association, the Ontario Native Women's Association, the Ontario Federation of Indian Friendship Centres, 2-Spirited People of the 1st Nations, the AIDS Bureau and the Aboriginal Health Office of the Ontario Ministry of Health and Long-Term Care, implemented the Strategy.

The goal of the Strategy at the time of implementation was to design, develop and deliver a comprehensive plan for an effective and accessible continuum of physical, mental, emotional and spiritual care, support and education for Aboriginal individuals, families and communities living with and/or affected by HIV/AIDS. The following strategic directions were designated: programs and services, delivery supports and networking and coordination.

The Strategy, which is presently 100% funded by the AIDS Bureau, Ontario Ministry of Health and Long-Term Care, is governed by the Reference Group and the staff consists of the Provincial Coordinator located in Toronto and the equivalent of 7.5 HIV/AIDS Workers. Strategy Workers are located in strategic locations in Northern, Central, and Southern Ontario. Each worker is located within a host site and is managed by the Provincial Coordinator and supervised on day-to-day basis by a supervisor within each site.

It was determined that in year four of the Strategy, an evaluation would be undertaken so that in year five a new Strategic Plan would be developed based on recommendations for improvement and growth. The evaluation was completed in April, 1999 and over the course of a year the Reference Group implemented a number of recommendations. In addition the Reference Group developed new Strategic Directions to guide the work of the Strategy over the course of the years 2001 to 2006.

5.1 The Reference Group

To ensure that Reference Group members share the same level of commitment to the Strategy the Group agreed to affirm the following criteria for membership;

Reference Group members should:

(a) Demonstrate commitment to addressing issues related to HIV/AIDS and particularly harm reduction strategies.

(b) Possess a high degree of comfort with all issues related to HIV/AIDS and as a result, become an advocate and be willing to design and undertake proactive approaches to problems.

(c) Act as a team player within the Reference Group, never competing with the Strategy but rather promoting the best interests of the Strategy.

(d) Possess an understanding and sensitivity to Aboriginal communities and their cultures.

(e) Possess knowledge and understanding of the roles and responsibilities necessary to take a leadership position.

(f) Willing to share specific views and expertise both organizational and cultural.

(g) Actively identify key partnerships, potential funding sources, and supportive initiatives/opportunities to support the strategy.

In addition to the above, Reference Group members agreed that the membership should reflect the perspectives of women, Metis, off-reserve and urban Aboriginal people, two-spirited people, youth and elders.

Finally, it was agreed that members should bring their unique perspectives to an Aboriginal issue which crosses all barriers and political groups with a view to building a consensus toward resolving critical issues. Members, therefore, should not be representing a certain group or organization but rather should bring that perspective forward to support a collective voice.

Membership - will be primarily comprised of Aboriginal people to a maximum of ten members as follows:

1 Member - Ontario Metis and Aboriginal Association (OMAA) or Alternate
1 Member - Ontario Native Women's Association (ONWA) or Alternate
1 Member - Ontario Federation of Indian Friendship Centres (OFIFC) or Alternate
1 Member - 2 Spirited People of the 1st Nations or Alternate
1 Member - Aboriginal Member at Large or Alternate

1 Member - Aboriginal Youth (under 30) or Alternate
1 Member - Elder or Alternate
1 Member - Aboriginal Person Living with HIV/AIDS (PHA) or Alternate
1 Member - AIDS Bureau or Alternate
1 Member - Aboriginal Health Office or Alternate

Roles and Responsibilities

The Strategy Reference Group has the following roles and responsibilities:

IMPLEMENTATION:

- Oversee the implementation of the Ontario Aboriginal HIV/AIDS Strategy.
- To establish appropriate links with other joint initiatives, such as the Aboriginal Health Policy, the Aboriginal Family Healing and Wellness Strategy, Long-Term Care Reform etc.
- To seek and make provisions to secure available funding from relevant ministries for areas of the Strategy for which appropriate linkages are not readily available.
- To identify any potential legislative barriers to implementation and propose alternate directions which are consistent with Aboriginal community needs, culture and governance structures.
- To identify and secure appropriate opportunities for proceeding with implementation of the Strategy.
- Ensure that the Strategy is implemented in an efficient and effective manner through planning and coordination.
- Develop and implement processes for allocating funding under the Strategy based on community capacity, readiness, and existing resources.
- Develop an accountability framework to ensure program and financial accountability to both the Aboriginal organizations and the government.
- Identify processes within the government to facilitate the successful implementation of the Ontario Aboriginal HIV/AIDS Strategy.
- Identify and establish appropriate links with First Nations programs and services.

OPERATIONS:

- To identify and address operational issues related to implementation of the Strategy, including the development of appropriate funding mechanisms and proposing effective and appropriate linkages with other initiatives.
- To address immediate funding needs in a manner which is equitable and respects the internal processes of the Aboriginal organizations/communities.

- To share information, comments and recommendations with other constituents and communities whether or not they are affiliated with the organizations represented on the Strategy Reference Group.
- To promote and support communication and networking between communities, organizations, service providers, agencies etc.
- Identify ways to better coordinate existing approaches.
- To provide instruction, support and counsel to an employed coordinator on an ongoing basis.
- Provide an annual report to the province and Aboriginal representatives on funds spent, programs funded by the organization and location, services delivered, and the number of jobs created by the Strategy.
- Design and manage an evaluation process.
- Promote coordination of related services.

5.2 Host Sites / Organizations

In developing the 2001 - 2006 Strategic Plan, the Reference Group recognized the need to expand the number of sites across Ontario (if resources become available). However, to ensure that the Strategy is successfully implemented in new locations, site selection criteria has been developed. Host organization/sites entering into a partnership with the Strategy should meet certain criteria as follows:

(1) Location

- Priority should be given to an urban community with a significant Aboriginal population.
- Consideration should also be given to the number of Aboriginal people living with HIV/AIDS and the appropriateness of existing service organizations and supports.

(2) The Host Organization/Agency should:

- Provide a Board Resolution expressing the need for the service and recognizing the skills of the Strategy Worker to do the job.
- Be a multi-service organization that has the demonstrated support of the community and is financially viable.
- Be willing to sign an MOU agreeing to work in partnership with the Strategy, facilitate the flexibility required by the Strategy Worker and supportive of the fact that 100% of the Worker's time will be spent on the Strategy.
- Be willing to have the Worker train the staff of the host agency and have a plan to integrate Aboriginal HIV/AIDS issues into the organization.
- Have a non-discrimination policy in place.
- Recognize the diversity among Aboriginal cultures, traditions and values.
- Be easily accessible, protect confidentiality, provide an appropriate workspace and demonstrate a high comfort level with issues related to Aboriginal peoples and HIV/AIDS.

6.0 Strategic Directions - Goals and Strategies

Strategies have been developed and designed based on the need to continue certain important programs and services and the identification of new approaches to issues related to HIV/AIDS. While research continues to be critical to the effectiveness of an Aboriginal HIV/AIDS Strategy for Ontario, it has been incorporated throughout the Strategic Plan as opposed to having a discrete section.

Strategic Directions include:

Promotion
Prevention
Treatment/Rehabilitation
Palliative Care
Delivery Supports
Linkage with Aboriginal Prisoners
Operations/Management
Evaluation

6.1 Promotion

DEFINITION:

Aboriginal designed, developed and delivered education and primary prevention approaches that promote awareness of HIV/AIDS and related issues. These approaches include identifying choices for healthy living.

GOALS:

1) to increase awareness on HIV/AIDS and promote safer sex.
2) to increase awareness of healthy sexuality, healthy relationships and alternative lifestyles.
3) to provide opportunities to increase awareness and understanding of Aboriginal traditional teachings within the Aboriginal community.
4) to provide opportunities to increase awareness and sensitivity in the non-Aboriginal community regarding Aboriginal culture, beliefs and values.

OVERALL STRATEGIES:

(a) Develop and implement a communications strategy that is responsive to all Aboriginal audiences including, women, youth, elders etc.
(b) Design a web site to support the strategy and to provide current information on issues and trends related to HIV/AIDS in the Aboriginal community.
(c) Produce a brochure that promotes the expertise and services available through the strategy.

Goal #1: To increase awareness of HIV/AIDS and promote safer sex.

A. Continue to develop Aboriginal specific messages and information on HIV/AIDS for the Aboriginal community.

B. Develop promotional presentations and resources on HIV/AIDS testing with a list of where to get pre/post-testing counselling, support, and follow-up services. Include identification of high-risk behaviours.

C. Continue to promote Aboriginal initiatives during AIDS Awareness Week.

D. Continue to develop, maintain and publicize regional Aboriginal HIV/AIDS hotlines and promote it in communities to make people aware that it exists.

E. Continue to develop and sponsor local workshops, conferences, speakers etc. on such topics as Aboriginal women and HIV/AIDS, violence and AIDS, etc.

F. Continue to develop basic HIV transmission information sheets in both polite and common wording, and in appropriate Aboriginal languages.

G. Develop an AIDS information/resource booklet for use by Aboriginal communities/others. This booklet should include AIDS information, lists of educational materials, such as videos, pamphlets, support services for PHAs and others and their availability.

H. Secure funding to support the development of a training module for use with leadership, youth and elders to change negative attitudes related to two-spirited people and HIV/AIDS in the Aboriginal community.

I. Seek the support of two respected elders as Reference Group members and educate and involve elders in promoting positive HIV/AIDS harm reduction messages in the Aboriginal community.

J. Continue to develop, maintain and promote lists of Aboriginal HIV/AIDS resource people.

K. Continue to develop messages on how to treat Aboriginal PHAs with sensitivity, and share these messages with communities. Where possible, have Aboriginal people living with HIV/AIDS also present the information directly in communities, schools etc.

   Encourage organizations to develop policies around AIDS in the workplace, ensuring the sensitive, equitable treatment of PHAs in their employ.

L. Develop a promotional package/other approaches that recruit men to increase their involvement in identifying the problems that HIV/AIDS presents for communities. Such approaches could be:

   - distribution of materials at sporting events
   - obtaining support from male controlled organizations, as in sports teams
   - asking prominent men in the community (elders, political leaders, musicians, actors, political figures etc.) to speak out about AIDS.

M. Design, develop and deliver awareness programs to better prepare and equip personnel of Aboriginal organizations and agencies to promote prevention of HIV/AIDS. This approach might include developing promotional packages on work done by Aboriginal people living with HIV/AIDS in their communities which could be distributed to the National Aboriginal organizations.

N. Develop and participate in community events to share HIV/AIDS information.

O. Provide open forums between all community members (i.e., practitioners of western/Traditional medicine, Aboriginal/Christian denominations etc.), to discuss how to deal with homophobia, condom use, high-risk behaviour and sexual abuse.

P. Develop HIV/AIDS awareness and sensitivity workshops for Aboriginal and non-Aboriginal people working in the chemical dependence treatment continuum.

Q. That intergenerational (i.e., between different age groups) discussions be encouraged at the community level to address homophobia and HIV/AIDS related issues.

Goal #2: To increase awareness of health sexuality, healthy relationships and alternative lifestyles.

A. Ensure that any HIV/AIDS programs developed by and for Aboriginal people promote healthy lifestyles, self-sufficiency and self-government.

B. Develop culturally specific and cross-cultural HIV/AIDS and sexuality programs for Aboriginal students and faculty at both Aboriginal and non-Aboriginal schools.

C. Assist in developing parenting programs to help parents educate themselves, their children and their communities about HIV/AIDS. Included in this would be a component on coping skills.

D. That the full range of safer sex alternatives be positively examined and promoted.

E. Develop Aboriginal sexuality education programs that focus on promotion of empathy for people living with HIV/AIDS and of people living alternate lifestyles, in a manner appropriate to the community.

F. Assist in engaging youth to develop their own approaches to promoting healthy sexuality and healthy relationships.

G. Promote same sex benefit packages in all Aboriginal organizations and non-Aboriginal organizations who employ Aboriginal people across the province.

H. Promote a greater understanding among Aboriginal women of pre and post-natal transmission risks.

I. Provide leadership and assertiveness training opportunities for women and practical skills to negotiate safer sex and to promote education and information exchange in a non-judgmental way.

Goal #3: To provide opportunities to increase awareness and understanding of Aboriginal traditional teachings within the Aboriginal community.

A. Develop opportunities for Aboriginal communities to access Aboriginal traditional teachers perhaps utilizing the Healing Lodges available to them.

B. Develop opportunities to research the history and teachings on Aboriginal sexuality, two-spiritedness, traditional roles of men, women, children and Elders.

C. Design, develop and deliver education and awareness programs to better prepare and equip Aboriginal elders to understand and be tolerant of harm reduction strategies.

D. Develop opportunities for traditional Elders to pass on traditional teachings, thereby promoting choices for healthier lifestyles and decreasing the spread and transmission of HIV/AIDS.

E. Encourage Aboriginal employers to provide paid compassionate and cultural leave which recognizes Aboriginal spiritual values and which recognizes the diversity of Aboriginal cultures and families.

Goal #4: To provide opportunities to increase awareness and sensitivity regarding Aboriginal culture, beliefs and values in the non-Aboriginal community.

A. Encourage the development of Aboriginal cultural sensitivity and awareness workshops and provide opportunities for non-Aboriginal service providers and caregivers to access this training.

B. Encourage non-Aboriginal employers to recognize and provide paid cultural/compassionate leave that recognizes Aboriginal family systems for Aboriginal employees without penalty.

C. Encourage Aboriginal communities/agencies to identify supportive non-Aboriginal individuals or service providers and recognize their contribution towards Aboriginal communities.

6.2 Prevention

DEFINITION

Approaches and measures that assist in reducing the transmission of HIV among Aboriginal people.

When designing education and prevention programs all appropriate links between HIV/AIDS and other issues faced by the Aboriginal community must be considered; these include sexual assault, incest, alcohol, drug and solvent use, teen pregnancy, birth and STD rates and suicide.

Goal #1: To develop general and focused awareness and prevention programs. Focused awareness programs include: people in the addiction continuum, both residents and staff, injection drug users, substance users, sex trade workers and other hard to reach groups.

Strategies

A. Provide staff and clients throughout the substance use treatment continuum with complete and accurate information regarding HIV transmission, infection, and risk reduction behaviour on a continuous basis with regular evaluations and updates. AIDS awareness, harm reduction techniques and healthy sexuality should be standard components of substance use treatment.

B. Develop awareness and support projects and plans for urban Aboriginal street outreach.

   - These approaches might include the hiring of street outreach nurses, integrating HIV education/condom and needle distribution into street patrols.

C. Strengthen partnerships with "outreach providers" to ensure that messages and strategies are culturally appropriate.

D. Strengthen partnerships with IDU prevention initiatives and develop culturally appropriate harm reduction strategies that are based on emerging trends.

E. Work with others to ensure that harm reduction programs educate their clients about the risk of the chosen behaviour in a non-judgmental manner.

F. Work with others to increase access to methadone treatment in all urban settings province-wide.

G. Work with Aboriginal Health Access Centres to increase needle distribution services and education about safe needle disposal in community settings.

H. Work to engage the communities in an HIV/AIDS prevention planning process.

I. Undertake community-based knowledge, attitude, behaviour/belief studies so that targeted messages can be developed.

Goal #2: To develop HIV/AIDS awareness and prevention programs for presentation in educational facilities attended by Aboriginal people.

A. Develop HIV/AIDS awareness, prevention and risk reduction programs with Aboriginal youth which address and promote self-esteem and life skills.

B. Encourage school, college and university boards to invite Aboriginal community leaders, service organizations, high profile role models including Aboriginal youth living with HIV/AIDS to participate in education, prevention and healthy sexuality programs.

C. Design and develop creative methods to raise awareness, advocate and provoke discussion related to HIV/AIDS.

- Create a CD ROM for wide distribution.
- Create an installation that can travel province wide.

D. Keep abreast of new effective messages and share information with others.

E. Organize focus groups to measure the effectiveness of current messages and brainstorm new approaches.

6.3 Treatment/Rehabilitation

DEFINITION

Treatment/rehabilitation has been defined as "accessible, affordable and culture/community based methods of physical, mental, emotional, spiritual healing and aftercare which allow individuals to maintain or regain optimum levels of wellness."

Goal#1: To develop and promote culture/community-based traditional treatment and rehabilitation programs and services while ensuring improved access to western medical approaches.

Strategies

A. Provide more information to Aboriginal people living with HIV/AIDS on alternative medicines and treatments, and this information should be available in all appropriate languages particularly through Aboriginal Health Access Centres.

B. Provide space for and access to traditional ceremonies in hospitals, hospice facilities and clinics; wherever an Aboriginal person requests this service.

C. Promote traditional medicines and herbs as legitimate approaches to managing HIV/AIDS. Also efforts should be made to complement Western medical approaches to treatment and rehabilitation with traditional Aboriginal healing practices.

D. Facilitate improved cooperation and networking of traditional Aboriginal healers and Western physicians and other medical caregivers, i.e. nurses, psychologists, psychiatrists etc., wherever possible.

E. Promote HIV/AIDS harm reduction strategies/measures with Aboriginal Health Access Centres, Healing Lodges and other events for example Health Conferences and Annual General Meetings of Aboriginal Organizations.

F. Establish partnerships and assist them in developing Aboriginal appropriate addiction treatment service models that are based on harm reduction.

G. Continue to influence drug treatment approaches by establishing, maintaining and strengthening partnerships with resources such as CATIE and OHTN.

H. Promote non-discriminatory and timely access to substance use treatment centres by HIV positive Aboriginal people who require the service.

I. Assist in developing measures to prevent the penalization of Aboriginal people living with HIV/AIDS who experience work or medical absenteeism caused by HIV/AIDS related illness.

J. Provide for appropriate individual and systematic advocacy services to allow Aboriginal people living with HIV/AIDS to take action against those individuals and facilities which practice discriminatory behaviour on the grounds of race, sexuality or AIDS-phobic beliefs.

K. Educate health care professionals who prescribe medicines or therapies for Aboriginal people living with HIV/AIDS to complement and take into account other factors such as substance use/addiction histories, etc.

L. Advocate for the numbers of HIV/AIDS sensitive Aboriginal health liaison workers in hospitals to be increased.

M. Provide Aboriginal translators for Aboriginal people living with HIV/AIDS and their families/partners who require translation in order for them to understand medical information presented to them.

N. Continue to seek opportunities for cross training with CAMH HIV program and other partners.

Goal #2: To develop and provide adequate and sensitive social support systems and services to Aboriginal people living with HIV/AIDS, their families, partners and significant others.

<u>Strategies</u>

A. For many Aboriginal people living with HIV/AIDS the disease can lead to isolation from the community, often because of community fear. Providing for a range of social supports for Aboriginal people living with HIV/AIDS is an integral part of emotional and mental healing. Continue with approaches that include;

- Establishing drop-in centres,
- Coordinating social events, feasts, movie-nights, which are for or include Aboriginal PHAs
- Organizing and coordinating regular friendly visiting
- Phone-checking
- Talking circles
- Assisting with food preparation
- Grocery delivery/prescription pick-up
- Escorting people to medical appointments

B. Provide for the inclusion of family members/partners/significant others in any treatment consultations (at the request of the Aboriginal PHA).

C. Provide for the development of individual (legal, medical and employment) advocacy services for Aboriginal people living with HIV/AIDS.

D. Partner to ensure that treatment, rehabilitative and palliative care contingency plans be developed by Aboriginal people and communities to ensure the best care and support of Aboriginal people living with HIV/AIDS and their families and partners.

E. Partner to ensure that additional financial assistance programs be provided for Aboriginal people living with HIV/AIDS who are on low or fixed incomes and that this assistance be extended to cover alternative therapies or other recommended treatments.

F. Partner to ensure that resources be provided to Aboriginal organizations/service providers to enable them to provide for the emergency medication, travel or crisis intervention needs of Aboriginal people living with HIV/AIDS and their family/partners.

G. Partner to ensure that there be a review of income security options for people living with HIV/AIDS and all relevant legislation and policies, to increase access to disability payments.

H. Partner to ensure that all legislation is amended which bars same-sex partners from claiming any of those benefits currently available to other forms of family.

I. Advocate for an Ontario wide consultation with Aboriginal communities to make medications required by Aboriginal people living with HIV/AIDS fully accessible.

J. Examine the coordination of drug benefits provided to Aboriginal people by the Ontario government and the federal government, identify issues and propose solutions.

K. Advocate for health transportation funding (Northern Health Travel Grants) to allow for Aboriginal people living with HIV/AIDS who require access to treatment and rehabilitative services (including those offered by healers and elders) to travel to the most appropriate centre for service, regardless of location.

6.4 Palliative Care

DEFINITION

The provision of physical, mental, emotional and spiritual care of Aboriginal people living with HIV/AIDS in the final journey of life. Personal choices of care by people living with HIV/AIDS must be respected.

Goal #1: To provide culture/community based palliative care services and facilities which allow Aboriginal people in the final stages of HIV/AIDS related illness to live in the surroundings of their choice.

Strategies

A. Advocate to ensure that supportive home care services and equipment is available for those Aboriginal people living in the final stages of AIDS wherever that service is required. Such an approach would require;

   - The development of a network of Home-Care nurses who are culturally sensitive and are experienced and trained in HIV/AIDS related palliative care.
   - Increased recruitment of Aboriginal people into Home Care programs.
   - Increased flexibility around program eligibility.

B. Advocate to ensure that where required, Care-Team/Palliative care coordinators are employed in appropriate Aboriginal agencies to assist in the development, coordination, and training of care teams.

C. Encourage and assist communities be encouraged and assisted in the development of care teams to respond to the needs of those living with HIV/AIDS related illness.

D. Partner with hospice providers and transitional housing facilities to provide supportive environments for Aboriginal people living with HIV/AIDS.

E. Ensure that appropriate accommodation is available for loved ones who wish to be with an Aboriginal person living with HIV/AIDS while they are attending a facility for treatment, counselling or tests.

F. Promote the appropriate use of universal precautions by all people who provide HIV/AIDS health care and relative services when working with people living with HIV/AIDS.

G. Actively involve traditional Elders and medicine people with Aboriginal people who request their involvement.

- This approach would require all hospital facilities to ensure close links with Aboriginal communities and be in contact with Aboriginal resource centres/health centres for appropriate assistance.

H. Provide for Aboriginal designed, developed and delivered palliative care services to be delivered for Aboriginal people living with HIV/AIDS who are in non-Aboriginal hospices or hospital facilities.

I. Ensure that people living with AIDS not be denied pain medication regardless of their past history with substance use. Rather this element should be taken into consideration with regard to appropriate dosage in light of possible tolerance to drugs. Consultation with client/patient and care team members is reiterated.

6.5 Delivery Supports

6.5.1 Training

DEFINITION

Culture-based experiential activities that develop the necessary knowledge, skills and attitudes for the provision of programs and services related to the Ontario Aboriginal (off-reserve) HIV/AIDS strategy. Included in training are opportunities for on-going professional development.

Goal #1: To increase access and support for Aboriginal people living with HIV/AIDS who wish to pursue education, employment and training opportunities.

Strategies

A. Continue to provide opportunities to access upgrading/employment training for Aboriginal people living with HIV/AIDS who wish to upgrade their employment skills. Suggested approaches could include:

- Educating employment counsellors to increase their sensitivity to people living with HIV/AIDS to ensure that PHAs are given an equal opportunity to enter the work force.
- Ensuring that Aboriginal organizations/service organizations/counsellors and agencies are made aware of and promote existing Aboriginal training and educational opportunities.

B. Provide information, lobbying and advocacy for Aboriginal people living with HIV/AIDS who require support in their efforts to secure resources to access education and/or employment training.

C. Encourage teachers, staff, parent/teacher associations and Aboriginal education counsellors to conduct HIV/AIDS awareness and education in their workplaces.

Goal #2: Develop and provide opportunities for training and curriculum development for Aboriginal HIV/AIDS programs and services

Forward: In many cases English will not be the first language of the caregiver or educator, therefore, the training and curriculum must be translated into Aboriginal languages.

Strategies

A. Training for health care professionals and volunteer care teams working with Aboriginal people living with HIV/AIDS and their families must

include: in-service education emphasizing team approach to case management, formal courses, educational videos etc.

B. Undertake training needs assessments with Strategy Workers to ensure that their knowledge of HIV/AIDS emerging trends and issues as well as new drug treatments is current to facilitate continuous improvement of program and service delivery.

C. Identify and train appropriate advocates to be knowledgeable in relevant health and human rights legislation and about the programs and services offered by HIV/AIDS organizations, governmental bodies, and federal, provincial and municipal health authorities.

Goal #3: To recognize and acknowledge the experience and training of Aboriginal people working in traditional or western health programs or services related to HIV/AIDS.

Strategies

A. Identify Aboriginal community members who are knowledgeable and skilled in responding to HIV/AIDS and create opportunities to promote and support them. Such approaches could include:

- development of an Aboriginal HIV/AIDS educators/speakers register
- maintenance of the register through a central data-bank identified in the networking and coordination system

Goal #4: To develop and provide training opportunities for program management and leadership development.

Strategies

A. Provide leadership and assertiveness training opportunities to youth to promote peer-based HIV/AIDS safer sex education and information.

B. Provide program management training opportunities for Program Directors and Executive Directors of Aboriginal urban or rural service delivery agents on the responsibilities of delivering an Aboriginal HIV/AIDS program or service.

C. Provide policy development training to Boards of Directors of Aboriginal urban or rural service agencies who have responsibility for overall management of Aboriginal HIV/AIDS programs or services.

- For example, designing, developing and assisting in implementing policies, procedures and protocols around HIV/AIDS in the workplace and community.

Goal #5: To develop and provide for the on-going education and training of people who provide HIV/AIDS health care and related services to Aboriginal people living with HIV/AIDS and their families/partners.

Strategies

A. Review and update, as needed, training programs for community based workers.

B. Provide Aboriginal people working in the HIV/AIDS health care and related fields, where they exist, opportunities to receive instruction/training on all HIV/AIDS issues.

- For example, one such approach would be to encourage all new healing and wellness initiatives to include HIV/AIDS awareness training for staff.

C. Increase the focus on issues of sexuality, cultural awareness and sensitivity in all continuing education and health degree programs developed in universities and colleges. Suggested approaches could include, but are not limited to:

- Ensuring that appropriate college, university and training facilities/departments establish links with Aboriginal community recognized individuals/agencies competent in issues of HIV/AIDS. Ensure that efforts are made to include such individuals in developing classes, holding workshops and making presentations.

D. Support the development and delivery of cross-cultural training for health care professionals and other people currently providing support to Aboriginal people living with HIV/AIDS, including: physicians, nurses, psychologists, mental health workers, home care workers, social assistance workers, social workers etc.

E. Develop and provide training opportunities for Aboriginal justice and correction workers on HIV/AIDS and related issues and how they impact the justice and correctional system.

6.5.2 Support to Families and Caregivers

DEFINITION

Care and support opportunities required to assist families and caregivers who are involved in the design, development and delivery of Aboriginal HIV/AIDS programs and services or who are directly impacted by HIV/AIDS.

Goal #1: To provide opportunities for the care and support of families and caregivers who are involved in the design, development and delivery of Aboriginal HIV/AIDS programs and services.

Strategies

A. Acknowledge and support the role of families/caregivers including Strategy workers working with Aboriginal people living with HIV/AIDS and their families/partners.

B. Provide finances, materials and equipment for families, caregivers and service providers, as required.

C. Provide respite care for people providing care services to Aboriginal people living with HIV/AIDS.

D. Provide opportunities for culture based, wholistic healing for families, caregivers and service providers that includes, but is not limited to: stress reduction/control, burnout prevention and loss/grief/bereavement counselling.

E. Provide support, encouragement, assistance and advocacy as requested by Aboriginal people living with HIV/AIDS, their families, partners, volunteer caregivers and/or their powers of attorney.

F. Where required, provide travel and accommodation assistance to families and partners who wish to visit relatives/partners who are living with HIV/AIDS who are in hospitals/hospice facilities in other parts of the province.

G. Provide for the development of hostels for families and/or partners who require extra assistance when visiting their relatives/partners in hospitals and/or hospice facilities.

Goal #2: To provide support and appropriate care for Aboriginal people who are directly impacted by HIV/AIDS.

Strategies

A. Develop approaches that address the unique needs of Aboriginal women and children impacted by HIV/AIDS including orphaned children.

B. Identify potential partners and facilitate dialogue on the most appropriate way to care for children directly impacted by HIV/AIDS.

C. Incorporate messages related to the needs of Aboriginal families directly impacted by HIV/AIDS into the communications strategy.

D. Develop approaches that facilitate the testing of Aboriginal women who want to be or who are pregnant with their specific informed consent.

6.5.3 Supportive Housing

DEFINITION

Safe, accessible, affordable and supportive housing for Aboriginal people living with HIV/AIDS, their families and/or partners.

Goal #1: To create opportunities for safe, accessible, affordable and supportive housing for Aboriginal people living with HIV/AIDS and their families/partners.

Strategies

A. Make provision for the identification of supportive housing needs of Aboriginal people living with HIV/AIDS, their families and partners.

B. Provide supportive urban and rural Aboriginal community housing for Aboriginal people living with HIV/AIDS and their families/partners. Priority should be placed on securing Aboriginal-specific housing for Aboriginal PHAs.

C. Provide housing advocacy and support workers, such as home-care workers, for Aboriginal people living with HIV/AIDS who require supportive and affordable housing.

    - Where required, 24 hour care must be available on-site.

D. Establish partnerships to provide for the development of alternative housing arrangements to existing hospices where the need is identified.

E. Ensure that temporary accommodation is available for Aboriginal people living with HIV/AIDS and their families/partners when travel to another city is required for treatment/diagnosis.

F. Develop HIV/AIDS support service awareness and education programs for Aboriginal housing authorities and for non-Aboriginal housing authorities where necessary, to promote the need for safe, affordable, accessible and supportive housing for Aboriginal people living with HIV/AIDS, their families and partners.

G. Examine the full range of housing needs of Aboriginal PHAs, develop practical options to address these needs and design a business plan to be incorporated into a housing fundraising strategy.

6.5.4 Research and Planning

DEFINITION

Activities that are designed to assist Aboriginal off-reserve communities in researching and assessing individual, family and community needs, setting priorities for ongoing resource development and management.

Goal #1: Promote and provide for community needs assessments, research on HIV/AIDS and Aboriginal sexuality, identification of priorities and planning for ongoing resource development and management.

Strategies

A. Conduct an assessment of research needs by summarizing and critiquing existing research and identifying gaps.

B. Partner with other Aboriginal community stakeholders, various levels of government and the research community itself on necessary research related to Aboriginal people and HIV/AIDS.

Goal #2: Ensure that appropriate and ethical Aboriginal driven data collection and seroprevalence studies are developed.

Strategies

A. Design an appropriate and confidential data collection method related to Aboriginal people living with HIV/AIDS.

B. Ensure that specific information is collected on Aboriginal children living with HIV/AIDS.

C. Where appropriate and financially feasible, undertake knowledge, attitude and behaviour studies to facilitate planning, designing, implementing and evaluating HIV/AIDS programs and services.

D. Undertake HIV seroprevalence studies within Aboriginal communities, utilizing methods and approaches which are ethical and have been approved, designed and/or supported by the Aboriginal community.

E. That a strategy for encouraging voluntary HIV antibody testing for Aboriginal people be designed, developed and delivered following examination and discussion of issues related to:

- Barriers to Access: personal and psychological, transportation and financial (access to confidential and free HIV testing), social discrimination, and;

- Organization of testing and health services: criteria for establishing testing sites, counselling services, personnel, method of specimen collection.

F. Provide for the development of Aboriginal community agency internal guidelines and protocols for confidentiality with respect to service provision and ensure that suitable sanctions for breaches of confidentiality are included.

6.5.5 Working with Leadership

DEFINITION

Developing appropriate relationships with Aboriginal, municipal, provincial and federal government leadership and promoting concentrated lobby and advocacy efforts with and on behalf of Aboriginal people living with HIV/AIDS, their families, partners and communities.

Goal #1: To develop appropriate relationships with Aboriginal, municipal, provincial and federal government leaderships.

Strategies

A. Linkages to all levels of government (including Aboriginal governments) should be strengthened and maintained to ensure that opportunities are identified, policy decisions are understood and responded to, and, regulatory and/or legislative issues are understood as they affect Aboriginal people and HIV/AIDS.

B. Support the education of leadership to become positive role models promoting acceptance of alternative lifestyles in order to effectively face the challenges presented by HIV/AIDS and in order to break down barriers such as homophobia.

C. Support the Ontario Aboriginal HIV/AIDS Strategy Reference Group's work with Aboriginal organizations and leadership to develop advocacy strategies and gain political support from governments.

D. Advocate that key public service positions (Federal/Provincial/Territorial/Municipal) responding to HIV/AIDS or general health should be occupied by Aboriginal people wherever the population warrants.

Goal#2: To promote concentrated lobby and advocacy efforts with and on behalf of Aboriginal people living with HIV/AIDS, their families, partners and communities.

A. Educate Aboriginal leadership about the full implications of HIV/AIDS and recognize, include and support Aboriginal people living with HIV/AIDS in their struggle to address care, support and treatment issues.

B. Advocate for leadership to provide increased time, energy and priority to lobby and advocate for increased funding, particularly for remote and northern areas.

C. Lobby and advocate for supportive care systems for Aboriginal people living with HIV/AIDS in correctional facilities and in the substance use treatment continuum.

D. Continue to impress upon leadership that HIV/AIDS is a political issue as well as a medical issue, and therefore, in this context, it is important to deal with HIV/AIDS in the context of large issues such as self-government and the transfer of responsibility for health care.

E. Assist leadership in addressing cross border issues, particularly promoting awareness of the transport of sacred medicine bundles across the U.S./Canadian border by Aboriginal people, and advocate for the protection of Aboriginal peoples from invasions upon their sacred properties.

6.6 Linkages with Incarcerated Aboriginal People

DEFINITION

Programs, Services and Advocacy activities that respond to the needs of Aboriginal People who are in correctional facilities and who are affected by HIV/AIDS.

Goal #1: To ensure that relevant aspects of the Ontario Aboriginal HIV/AIDS Strategy are provided to Aboriginal prisoners.

Strategies

Promotion

A. Provide ongoing HIV/AIDS education and prevention activities in prisons. Drug use and sexual activity do continue in these institutions and there is a need for specific programs/approaches which involve Aboriginal prisoners in responding to HIV. Such approaches might include peer led workshops/videos etc.

    - In order to effectively support the development of peer-led HIV/AIDS education/prevention activities in prisons, the number of Native Inmate Liaison workers would have to be increased to adequately cover all provincial correctional facilities.

B. Continue to work with the National Aboriginal Corrections Strategy on HIV/AIDS.

C. Link to Provincial Corrections Authorities, Attorney General and the Solicitor General to strengthen the Aboriginal presence and to promote the unique needs of Aboriginal PHAs who are prisoners.

D. Strengthen partnerships with existing organizations such as Prisoners with HIV/AIDS Support Action Network (PASAN).

Prevention

A. Provide prisoners and correctional staff with mandatory, complete and accurate information regarding HIV transmission and infection and risk reduction behaviour on a continuous basis, with regular evaluation and updates. Particular efforts must be made to dispel myths concerning transmission and decrease AIDS-phobic beliefs. Make HIV/AIDS education a standard component which should begin at the time of admission as part of the general orientation process.

B. Provide an entry kit to all inmates containing HIV/AIDS information materials. The kits should contain condoms, water-based lubricant and HIV information materials and must also be made available in a free, accessible and confidential manner through the medical unit on the facility.

C. Advocate that bleach, sterilized water, alcohol swabs and needles be made available in an anonymous and accessible manner in all correctional facilities.

- One approach to needle distribution could be through utilizing the Native Inmate Liaison Workers and Native court workers in tandem with Aboriginal health/AIDS educators. These workers may be able to introduce needle and condom distribution into facilities in a confidential and non-judgmental manner. Such an approach would require increasing the number of Native Inmate Liaison officers and changing corrections policy.

D. Provide culturally appropriate HIV/AIDS prevention/education materials in a variety of forms (video, written presentations) for use by Aboriginal prisoners. The materials should be sensitive to language needs and literacy levels.

E. Make resources available for Aboriginal HIV/AIDS educators, elders/healers to attend correctional facilities to conduct prevention and wholistic healing with Aboriginal prisoners. One task that such people could perform would be utilizing the existing knowledge and resources in the population and encouraging the development of peer support/education initiatives.

F. Upon release from incarceration advocate for the provision of exit kits containing condoms, water-based lubricant and HIV/AIDS awareness materials. In addition, a second exit kit should be available upon request which also contains bleach, needles, sterilized water and information on safer injection practices. These kits could be requested from Native liaison workers or other agencies that offer these kits free of charge.

<u>Treatment /Rehabilitation</u>

A. Provide access for Aboriginal prisoners living with HIV/AIDS in correctional facilities to traditional Aboriginal healers, healing ceremonies, traditional medicines and other supportive Aboriginal care systems, in addition to improving access to existing Western medical approaches.

B. Facilitate a process whereby Aboriginal prisoners living with HIV/AIDS be given access to Aboriginal or culturally sensitive individuals and services "on the outside". This access or "link" should be pragmatic; either bringing

the individual to the resource or the resource to the individual. In this way, the support system is in place before the individual is returned to the community.

Training

A. Ensure that Strategy Workers are equipped to work with prisoners and corrections staff through specific training initiatives.

B. Identify the training needs of corrections officers related to Aboriginal people and HIV/AIDS and facilitate appropriate training for corrections staff.

Working with Leadership

A. Advocate that leadership support and advocate for same sex conjugal visits for Aboriginal people in prison.

6.7 Management, Operations, Evaluation

DEFINITION

Activities undertaken by the Strategy Coordinator, the Workers, the Host Organizations and the Reference Group to ensure the effective and efficient management of the Ontario Aboriginal HIV/AIDS Strategy.

Goal # 1: To ensure that the Strategy Coordinator and the Workers carry out their activities in supportive environments.

Strategies

A. Negotiate with Host Organizations to ensure that they meet the criteria developed by the Reference Group and are willing to sign an MOU detailing their commitment.

B. Educate co-workers within the Host Organizations about HIV/AIDS in the Aboriginal community and assist them in integrating HIV/AIDS issues into the organization.

C. Build an understanding and recognition within the Host Organization and the Aboriginal community about the need for sensitive, trained and committed HIV/AIDS workers in lieu of credentials.

Goal # 2: To ensure that appropriate policies and procedures are in place to guide the operations/management of the Strategy.

Strategies

A. Undertake a periodic review of policies and procedures, identify gaps and recommend changes to the Reference Group.

B. Whenever possible, document best practices and share these with the Coordinator, Workers and the Reference Group.

Goal # 3: To plan and undertake an Evaluation of the Strategy in Year Four.

Strategies

A. Develop an evaluation framework to determine what activities will be measured, what results are expected, and what indicators will be used to evaluate progress.

B. Develop a consistent approach to collecting data that are relevant to the evaluation framework and complete "roll-ups" on an annual basis.

C. Where quantitative data is not available as an indicator, document anecdotal evidence.

D. Identify ways to improve the strategy on an annual basis and take action where possible.

7.0 GLOSSARY

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

ABORIGINAL COMMUNITY/COMMUNITIES:
A group of aboriginal people who share similar beliefs, traditions and culture. These groups exist through shared political, cultural, spiritual identity and/or are 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, ONWA locals, aboriginal urban-based organizations, and political organizations.

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

ABORIGINAL (COMMUNITY) HEALTH ACCESS CENTRE
These centres are similar to community health centres, most of which currently operate in cities in Southern Ontario. They offer culturally appropriate primary care to Aboriginal people. Programs may include pre- and post-natal care, nutrition, health education, disease prevention, counselling and traditional healing. There are currently 10 Aboriginal Health Access Centres in various stages of design and implementation.

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.

AIDS (Acquired Immune Deficiency Syndrome)

"Acquired" means you get the condition at some point in your life. "Immunodeficiency" is a weakness in your immune system. "Syndrome" is a combination of symptoms and/or diseases. AIDS is not a disease. It is a syndrome associated with HIV infection, decreased numbers of T4 cells and one or more opportunistic infections.

ANONYMOUS TESTING
The name or identity of the person being tested is not requested, recorded or reported. The test is ordered using a code known only to the person being tested. Epidemiological information (e.g. age, sex, risk factor) is collected and reported. The person is responsible for notifying partners, but can ask the counsellor for assistance. Pre- and post-test counselling is a requirement at anonymous test sites.

ALTERNATIVE SERVICE PROVIDER
Is an agency/organization established to provide HIV/AIDS related services to the general public and is not "Aboriginal specific".

CASEY HOUSE
A palliative care hospice in Toronto.

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 and federal governments.

HARM REDUCTION
There are no moral, legal or medical judgments made about drug use. There are no moral judgments made about the injection drug user because drug use is not seen as immoral or irresponsible. The dignity and value of all human beings is respected. The concern is the potential harm from injection drug use. The focus is the problem of reducing the potential for HIV infection among injection drug users. The Harm Reduction approach provides options in a non-judgmental and non-coercive way. The focus is not on abstinence. Harm reduction accepts that injection drug users may continue to use drugs. Abstinence can be part of the program for injection drug users who want to quit using drugs, but it is not the goal: reducing harm from drug use is the goal. Harm reduction recognizes that injection drug users are competent to make choices and change their behaviours.

HEALING LODGES
Healing lodges offer traditional healing approaches to the treatment of sexual assault, physical abuse, addictions, and family dysfunction. Some of the treatment centres focus specifically on addictions affecting youth. Usually a continuum of care from prevention to aftercare is available for individuals and families either on a residential or day basis. Education and community outreach are often integrated into programming and traditional healers and elders provide essential culture-based skills and knowledge.

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. A person may have HIV for several years before AIDS-related diseases appear.

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.

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 this information from one language to another.

NON-NOMINAL TESTING
The physician orders the test using the patient's initials or a code and takes responsibility, with the patient, for notifying partners who may have been exposed. The local medical officer of health will check with the physician about the case and, if satisfied that partners have been notified, will not ask for the person's name.

NOMINAL TESTING
The physician orders the test using the person's name. If the test is positive, the physician is legally obligated to report the name to the local medical officer of health. Under the Health Protection and Promotion Act, the medical officer of health is legally obligated to safeguard the person's confidentiality. The medical officer of health is also legally responsible for ensuring that the person's sexual and drug use contacts are notified.

OMOH
Ontario Ministry of Health and Long-Term Care

OPPORTUNISTIC INFECTION
When your immune system is damaged, you can get sick from germs that would not normally cause diseases. These germs take advantage of the opportunity created by your weakened immune system to cause an infection.

PHA
Person/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 (SEXUALLY 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 STD's are; herpes, syphilis, gonorrhea, chlamydia, HIV.

T4 CELLS
These are the white blood cells most likely to decrease in people with HIV and play an important role in controlling infections.

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

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 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-SPIRITED
Gay, lesbian, bisexual and transgendered Aboriginal people.

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

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

ACRONYMS

ACAP	*AIDS Community Action Program*
AHAC	*Aboriginal (Community) Health Access Centre*
AIDS	*Acquired Immune Deficiency Syndrome*
AZT	*Zidovudine, a drug used to fight HIV disease; effective at interrupting mother to child HIV transmission.*
CAAN	*Canadian Aboriginal AIDS Network*
CAMH	*Centre for Addictions and Mental Health*
CAS	*Children's Aid Society*
CATIE	*Community AIDS Treatment Information Exchange*
CHN	*Community Health Nurse*
CHR	*Community Health Representative*
HCT	*Heterosexual Contact*
HIV	*Human Immunodeficiency Virus (the virus that causes AIDS)*
IDU	*Injecting Drug Use, Injecting Drug User*
LCDC	*Laboratory Centre for Disease Control*
MSB	*Medical Services Branch (Health Canada)*
MSM	*Men who have Sex with Men*
OHTN	*Ontario HIV/AIDS Treatment Network*
PASAN	*Prisoners with HIV/AIDS Support Action Network*
PHA	*Person/People Living with HIV/AIDS*
STD	*Sexually Transmitted Disease*
TB	*Tuberculosis*
TPFN	*2- Spirited People of the 1st Nations*