Harm Reduction:
Considered and Applied

" Very early in the epidemic those infected and those most intimately affected by AIDS assumed a leadership role not by remaining silent at a time when the disease and those living with it were receiving little attention."
(Laurie Garrett, *The Coming Plague)*

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EXECUTIVE SUMMARY:

The history of HIV since its emergence and recognition in the 1980's contains within it other histories of the responses of infected and affected groups. Within that is the story of the growth and development of tools that were applied to desperate situations, in desperate times. Gay men, accepting that the most immediate danger lay in the hidden nature of sexual encounters, took to the streets with radical position that said, in essence, sex is good, and your sexual identity is fundamental to who you are. Do what you want but do it in a safer way. Gay men and women revealed themselves, and demanded that the rest of the world wake up to a reality that contained HIV.

Similarly, European injection drug users seeing that sharing needles was killing them organized themselves. Needle exchange accompanied by accurate information was not predicated on a position of abstinence from drug use. Action was based on the attempt to understand the complexity of drug use in society. The European concept emigrated to North America, but entered an environment where the "War on Drugs" was raging. Simple pragmatic response to a health issue, became a political minefield, with governmental ministries struggling both with definitions and media messages suitable for the body politic. Harm Reduction morphed into philosophy, perhaps to soften the public reaction to both injection drug use and the fear generated by HIV.

Canadian surveillance and epidemiological data that applies to discrete populations, forecasts an ominous picture for Aboriginal people in general, and for injection drug users in particular. By all measures, HIV poses an immediate threat to individuals and communities. Social determinants associated with HIV seroconversion, unstable housing, injecting with others, imprisonment, coupled with conflicts at the cultural level are thought to re-enforce vulnerability and provoke disease among those already susceptible. Had the history of other illnesses like tuberculosis, among Aboriginal people in Canada not taught such shameful lessons, it would be possible to apply Harm Reduction tools **to** communities. Messages contained in such action would re-enforce the position that these are desperate, depressed people, needing expert and extreme response, not citizens capable of understanding and acting on their own behalf. Similar to the action of gay men in the '80s and European injection drug users, the impact is best felt when responses come from those most immediately affected.

Utility of Harm Reduction measures, as they may apply to harms existing in specific contexts have been considered within this work. Aboriginal people are generally characterized as mobile and marginalized, with mobility assumed as characteristic of the geographic location of Aboriginal people in Manitoba. The majority of the Aboriginal population is concentrated in the major urban center in the south, in identifiable neighbourhoods with widely dispersed populations living north and south, on reserve, in rural and Metis communities. In some communities, up to one third of the population is away from their stated residence. But mobility itself has not been accurately measured, either qualitatively or quantitatively. Considered historically, the meaning and value of mobility could emerge as a quality of sustainable and resourceful communities. Similarly, marginalization is a con-

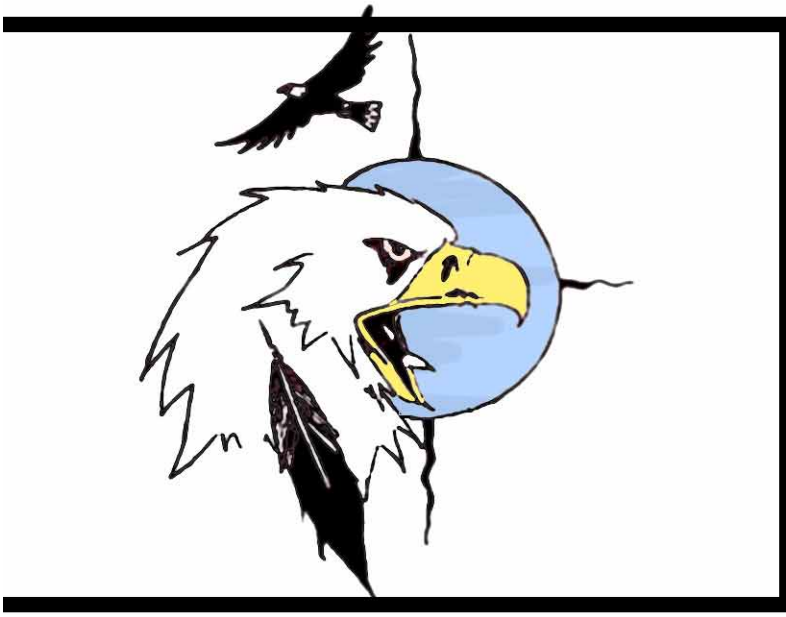
cept that characterizes Aboriginal people as outside of the mainstream culture. This same designation has been applied to injection drug users, street involved youth, sex trade workers, etc.... without consideration to the origin of the concept, who applies the designation, and what it has meant to the lived experience of people themselves.

Accessibility and acceptability guided exploration of the primary question of the barriers to Harm Reduction within Aboriginal communities, urban, rural and reserve, and for incarcerated Aboriginal people. Analysed from Key Informant interviews, themes emerged which were used as the focal point for understanding. Taken at face value, the definition of Harm Reduction seems to contain a paradoxical message; terms may be perceived as confounded or illogical in other contexts. Overall, initiatives identified as helpful and necessary to the integrity of individuals, reinforcing the connection between individuals and families, and the integration of communities were acceptable. Imposition of solutions to problems identified through means considered "outside" the community with externally defined harms, could receive unfavourable reception, as repeats of historical approaches now considered harmful.

While Harm Reduction as a theoretical position may be questioned, the principles underpinning program development could be more congruous with those guiding Aboriginal communities in development. Harm Reduction, as defined by individual organizations and ministries, contains goals and objectives for implementation, consistent with precise mandates and agendas. For example, the goal developed by Health is to reduce the harm from blood borne pathogens, like HIV and HCV; as such, it is consistent with the primary prevention goal of Public Health. The **principles** of Harm Reduction, (respect for individual integrity, the authority of individual choice, a value neutral stance in the face of available information about drug use and associated harms), may be better mediators between individuals, communities, and the range of currently available tools, constructed for prevention and management of infectious diseases, than simplistically applied definitions.

The ideas for consideration come from that vantage point, and include seed strategies to address the information needs of people who may be mobile; incorporation of Harm Reduction principles within treatment centres serving this population; mobile sexual health clinic, responsive to the need for STD diagnosis and treatment in a confidential environment. Development of even the most rudimentary of these ideas requires functional and accountable partnerships, that cross real and conceptual barriers thrown up by jurisdiction, distance and politics.

It is clear that resilience has been built up in Aboriginal communities, based on years of hardship and experience, and the leadership role of Aboriginal people is essential to any action. Recognizing this does not let any of the others sharing responsibility off the hook. Respectful attitudes in general, valuing individuals for who they are now, not only for their potential, communication that recognizes silence as important to insight, the lessons learned from the history of Aboriginal people in Manitoba, must be the grid for the development of any structures designed to assist Aboriginal people in combating HIV and Hepatitis C.



Introduction

This work rests of the principles of Community Development. The authority to take this approach comes from my history of working in communities considered "difficult, at risk, and marginalized." It recognizes that most of these places are none of those things in themselves. The designations come externally. These are people's homes, wherever they are, and regardless of how they came to be. It has been my intention to come to them courteously, as a guest and a visitor, knowing that as an outsider, I am limited in my ability to see and to understand completely.

Introduction

The AIDS epidemic has moved through populations. Emerging in North America as it did among gay men, HIV moved into injection drug users in cities where drug use and injection drug use were thought to concentrate, into the heterosexual population via unprotected sex, likely riding on the vulnerability created by sexually transmitted diseases. In tracking the history of an infectious disease like HIV, called by some a "modern plague", it is possible to track the parallel history of concepts and strategies developed to address the myriad problems thrown up by the disease itself. The response of gay men and women to AIDS as it affected their friends and lovers led the way forward in challenging accepted methods of delivering classically medically-driven health care. Patients frequently came to doctors better informed than the doctors themselves about HIV, unwilling to passively accept a role as "compliant, and good" patients. They demanded and were able to engage in partnerships with health care providers, where the terms were negotiated. Hence the evolution of the concept "client centered care" in an environment of " radical social activism".

The successes of previous prevention efforts in the gay community were thought to rest on key elements:

- Access to the technical means-information, safer sex materials (condoms, lubricants), education, awareness, public discussion, etc..
- A favorable environment-public campaigns, massive interventions in specific locations, human rights campaigns, creation of safer sex as a social norm, etc…
- Approaching individuals in the context of their environment- individual support, group work, personal messages, counselling, etc…
- The direct inclusion of users in the conception, creation and evaluation of prevention interventions-peer education, participatory research, etc…

A more profound occurrence was toward public discussion about sex, sexual identity, sexual expression. There was extreme danger "in the closet" and the hidden nature of gay sex contributed directly to the epidemic. The accepted concept of "safer sex" is evidence of the discussion that took place initially among gay people, and then adapted to the sexual discourse encouraged within groups thought to be at particular vulnerability to HIV/AIDS.

Though skilled medical care was indeed necessary for care and treatment of infected individuals, the work of prevention required skill and creativity from other disciplines and a connection to and co-operation with communities that was radically different prior to the AIDS crisis. The precise and specific skills of communication technology, media relations, community development, psychology, anthropology and history were recruited to apply to a problem understood as impacting communities in an altogether new way.

The recent "rebound" in new HIV cases among young gay men has been understood to result, in part from relaxation of complex prevention efforts, coupled with over-investment of hope in new pharmaceutical tools, heralded at the time of their development as a sign of the imminent cure for AIDS.

As HIV migrated through social networks in populations, considered marginalized from the conventional mainstream, new concepts were developed to address prevention, and Harm Reduction with its complexity and challenge entered the lexicon. Initial needle exchange programs were developed by injection drug users in Amsterdam as a means to prevent Hepatitis B, common among users who shared needles. Harm reduction evolved as a set of practical strategies to prevent the illnesses associated with drug use. From that early stage, Harm Reduction principles have guided the development of Needle Exchange programs throughout the world, encountering through their development varying degrees of understanding, acceptance, and success. But the actual *term* "Harm Reduction" followed the *practice* of supplying injection drug users with the information and tools they needed to protect themselves and their communities from disease, not the other way around. Current application of Harm Reduction often creates synonymous connections between Harm Reduction and needle exchange, which limits both as opportunities for prevention.

The practice of Harm Reduction has evolved from needle exchange and condom distribution to a whole set of strategies thoughtfully developed to:

- identify harms linked to infectious disease transmission,
- understand the nature of the areas/communities where harm occurred,
- consider the range of actions that could result in reduction of harm that would be acceptable within the specific community.

The history of these initiatives in the North American context has run parallel to the "War on Drugs". This "war", with its attendant military language resulted in high incarceration rates of individuals in conflict with the law due to immediate or secondary connection with drugs of all types. The effect has been that another identifiable population with specific and particular profile of HIV prevention and treatment needs has been identified, defined and isolated. The barriers to accessing both safer sex and harm reduction tools within prison populations have been well documented. Limited prevention tools outside of prisons, and their almost complete absence within prisons, with acknowledged much higher rates of HIV and HCV, makes a compelling case for Human Rights challenges to their custodians In populations considered "difficult," prevention initiatives often come under the purview of medicine, focused on individual "behaviour" and offering "education" as the most acceptable benign tool in environments fraught with political positions and public opinion.

Canadian Surveillance data and periodic epidemiological assessments provide substantial information on the incidence and prevalence of HIV/AIDS within the general Canadian population. This information provides the rationale for community health groups and public health officials to plan outreach and public health campaigns whose goals are to reduce the spread of HIV and to treat affected members of their respective communities. As with other descriptors of the HIV/AIDS epidemic, such as gender, age group, and exposure category, ethnicity information on positive HIV tests and reported AIDS cases may assist community health care providers to focus preventative health care more effectively. Though complete and accurate data identifying ethnicity in reported HIV and AIDS cases is still limited, information available: "…suggests that Aboriginal people are infected at a younger age than non-Aboriginal people, that injection drug use is an important mode of transmission, and that the HIV epidemic among Aboriginal people shows no sign of abating." [1]

Rekart(1997) asserts that "Canada's way of viewing and dealing with its First Nations fosters the ideal environment for the spread of STDs and HIV." The Royal Commission on Aboriginal People warned in 1996 that HIV is likely to have a significant impact on Aboriginal communities. Recent surveillance data has introduces a "level of panic" and new infections among Aboriginal people are known to have increased. This is not the first "plague" faced by Aboriginal people, but a catastrophic HIV epidemic is preventable if people from all cultures recognize the danger and orient our efforts to strengthen a collective response. Resilience has been built in Aboriginal communities, based on centuries of hardship and experience, but a clear leadership role for Aboriginal people does not let the rest of us off the hook. When the indications of harm are this clear, "failure to take action constitutes action" [2](Rosenberg, 1989)

Background

National information:

The proportion of Aboriginal AIDS cases increased from 1% before 1990 to 10.8% in 1999 and 8.5% in 2000. The proportions of Aboriginal HIV and AIDS cases that are less than 30 years old, female, or attributed to injection drug use are greater than the corresponding proportions among non-Aboriginal cases. In 1999, an estimated 370 Aboriginal people in Canada were newly infected with HIV; at the end of 1999, an estimated 2,740 Aboriginal people were living with HIV.[3] In 1998, 19.5% of positive HIV tests with known ethnicity were among Aboriginal persons, compared to 25.*% in 1999 and 17.7% in 2000.

The estimated number of prevalent HIV infections among Aboriginal populations was 1,430 in 1996 and 2,740 in 1999, an increase of 91%. In 1999, 5.5% of all prevalent HIV infections in Canada were attributed to Aboriginal people. There were 370 new infections in this group, 64% of which were attributed to the exposure category IDU, 17% were attributed to heterosexuals, and 11% to MSM and 8% to MSM-IDU.[4]

Regional information:

Regional information from provincial and Winnipeg data sources provides a more precise picture of the situation affecting Manitoba Aboriginal people.

WIDE Study:

Sub-analysis of data from this study identifying demographic and drug use behaviours among Aboriginal injection drug users indicate:

- 66.6% (404/609) of study participants self-identified as Aboriginal, with almost equal male to female ratio.
- A higher proportion of Aboriginal cases attributed to IDU category than non-Aboriginal cases: 36.1% among Aboriginal IDU compared to 8.4% among non-Aboriginal users
- 92% of Aboriginal study participants had injected within the previous 2 years.
- 42% of Aboriginal respondents identified the needle exchange program as their major source of new needles
- Cocaine was the predominant drug of choice for respondents, followed by Talwin and Ritalin(Ts & Rs)
- 56% of respondents had moved more than twice in the previous year
- Both Aboriginal and non-Aboriginal have similar rates of lending and borrowing injecting equipment.[4a]

Social Networks Studies:

Allows for characterization of social networks among injection drug users, and sexual partner changes in STD's. The numerous geographic bridges were identified among Aboriginal communities throughout Manitoba. It is established that STD interventions targeting individuals and individual communities may have limited success if the movement of individuals between communities and social/ sexual networks is not considered and understood.[4b]

Manitoba Epi. data:

The distribution of exposure categories in Manitoba has changed drastically since the beginning of the epidemic. The proportion of new infections attributed to injection drug use has been erratic from year to year, with the overall trend being upwards until 1997, a steady decline to 1999, and a slight increase in 2000.

Ethnicity data has only been collected for new HIV+ cases since 1999. The chart below demonstrates an important over-representation of Aboriginal people in new HIV cases, making up 45% of all 1999/2000 cases when those with unknown ethnicity are excluded.

Comparison of Risk Factors

	Prevalence (1996)	Prevalence (1999)	Difference	Incidence (1996)	Incidence (1999)	Difference
Total Infections	40,100	49,800	+24%	4,200	4,200	0%
Women	4,600	6,800	+48%	1,000	1,000	0%
Aboriginal People	1,430	2,740	+91%	350	370	+6%
Attributed to Heterosexual Transmission	5,500	8,000	+45%	700	880	+26%
Attributes to Homosexual Transimission	25,300	29,600	+17%	1,240	1,610	+30%
Attributed to Sharing Injection Equipment	7,100	9,700	+37%	1,970	1,430	-27%

Enhanced STD Surveillance in Canadian Street Youth Study:

- National analysis of the total 1722 youth who consented to participate in this multi-site Surveillance Study, 519 (30%) youth reported their ethnic origin solely or partially as Aboriginal. 66% of youth in the Winnipeg site reported ethnicity as Aboriginal.
- Injection drug use at least once in their lives was reported by 21% of youth. 58% reported using clean equipment all of the time; 16% reported using clean equipment most of the time; 5% reported clean equipment use some of the time or never.
- 1999 data, including screening for Chlamydia and gonorrhea, indicated a total STD prevalence in Winnipeg of 13%; 2001, STD screening indicated an STD rate of 22%.
- Using 1999 data, 5% of total participants were infected with Hepatitis C; 6% of Aboriginal youth participants were found to be Hepatitis C positive.[4c]

STDs in Winnipeg

Demographic Context: Those under the age of 25 make up 34 percent of Winnipeg's population of 650,000. Approximately 7 percent or 45,000 people are defined as Aboriginal using the Statistics Canada definition, and a further 12 percent or 78,000 are defined as visible minorities. Youth aged 24 and under make up 53 percent of the Aboriginal population and 43 percent of the visible minorities. Median income, level of formal education and employment rates are lowest among the Aboriginal population. Most Aboriginal people in Winnipeg live in the four communities listed above (58 percent of total Aboriginals), making up 14 percent of the total core area population (23 percent of Point Douglas, 17 percent of Downtown, 11 percent of Inkster). The visible minority population is similarly concentrated in the inner-city, making up18 percent of the total core area (29 percent of Inkster, 26 percent of Downtown, 14 percent of Point Douglas [Winnipeg Regional Health Authority, 2000].

Inner-city Epidemics: In Winnipeg, STD diagnoses are concentrated in the four inner-city community areas known as Inkster, Point Douglas, (including the North End), Downtown (including the West End) and River Heights (including Mayfair and Osborne Village). Chlamydia and gonorrhea rates for 15 to 19 year old females in Winnipeg are highest in Point Douglas (639 and 120 per 10,000 respectively) and Downtown (574 and 115 per 10,000 respectively). Together, these community areas have rates that are 6 times greater then the national rate of Chlamydia (100 per 10,000) and over 18 times the national rate of gonorrhea (6.5 per 10,000).

Prison Information:

At present, Aboriginal people make up 3% of the Canadian population and 17% of federally incarcerated offenders. In Manitoba 61% of total inmate admissions to federal institutions are Aboriginal[5] .(Boe, 2000) One fifth are incarcerated in maximum security facilities; two thirds in medium security facilities , with the remainder in minimum security facilities. Aboriginal offenders spend more time incarcerated before being paroled, and when they do apply for parole they are judged to be at higher risk to re-offend than non-Aboriginal offenders.[6] (Finn, Trevethan, Carrier, & Kowlaski, 1996) Young Aboriginal people who live in or move to urban centers are at higher risk for being incarcerated than those who remain on reserves or other rural areas. (Finn, et. al., 1996)

Stony Mountain Institution houses 580 federal prisoners, of whom 134 are known HCV positive, and 12 are known HIV positive. Estimates place the number of current or former injection drug users at 40% of the prison population. (Wylie, et. al., 2001) With no legitimate source of needles or injecting equipment available, needle sharing among prisoners is known to be the norm.

Through the Survey conducted with 126 Aboriginal injection drug users in preparation for the development of the Aboriginal Harm Reduction Model (Canadian Aboriginal AIDS Network, 1998) 36% of respondents admitted to sharing needles "on the street", with 73% sharing needles while incarcerated.

Clatworthy and Mendelson (1999) have estimated that youth are 12.4 times as likely to be admitted to youth facilities if they are Aboriginal. Older youth aged 20-24, were calculated to be 11 times as likely to be incarcerated if Aboriginal.[7]

Social determinants of HIV:

Individual experience of the complex lives of people infected and affected by HIV and Hepatitis C with cumbersome regimens of medical care, and no immediate hope for cure, can create panic within communities who may believe and accept themselves to be "at risk." Health researchers and HIV/AIDS epidemiological experts have determined that social determinants are independently associated with HIV seroconversion. These determinants compounding the health determinants of Aboriginal people in Manitoba may be the final piece of information that could result in fatalistic paralysis.

Social determinants independently associated with HIV seroconversion:

- low education
- unstable housing
- sex trade work
- sharing needles
- being an "established" injection drug user- longer that 2 years
- frequent needle exchange program attender
- injecting with others
- previous imprisonment
- cocaine as the drug of choice[8]

The Western biomedical model, predominant and pervasive as it is, is assumed to have universal validity which crosses cultures easily, can be applied uniformly, and will yield positive "health outcomes" in most cases. Yet against HIV, pure application of scientific and medical methods, without consideration of the context in which infection occurs, has had poor results in care and treatment for some discrete populations, including Aboriginal people. This is clearly evidenced by research findings which point to higher incidence and prevalence of HIV among Aboriginal people, more frequent, and earlier opportunistic illnesses associated with AIDS, poor "compliance" with medical treatments.

Further, in many instances the complex work of prevention of illness has been abandoned as too complex to manage well. This same position has been reported within many populations thought to be "difficult, complex, marginalized", most specifically injection drug users and sexually active youth. Education about risk and information (pamphlets, etc) become the only acceptable tools available to communities, despite knowing that both are limited. Information is available. The dynamic context of risk, which may encourage or discourage information to be picked up and used remains poorly understood. "Public health programs which attempt to "teach" inner city residents about condom use, do so in a social and cultural vacuum. Condom use is embedded in the nature of culture-specific, socially-mediated environments……."[9]

Particularly in cultures undergoing culture change, health becomes affected when there is a discrepancy between modern and traditional values, analogous to inconsistency and incongruity relating to social and economic status. "Conflicts at the cultural level can reinforce individual vulnerability and provoke disease among those already susceptible".[10]

" Regardless of whether infectious diseases or social pathologies predominate in epidemiological profiles, we must not lose sight of the fact that biomedical definitions of health and

disease are inextricably linked to larger structures of authority and power. The ability to define and then survey such parameters as "health status" carries with it the power to construct institutions of healing that prescribe, proscribe and regulate behaviour. The creation of the image of Aboriginal communities as socially pathological, as 'desperate, disorganized and depressed', in turn provides the rationale for policies of paternalism and dependency."[11]

Harm Reduction as a Tool for Prevention:

It is in this complex environment that Harm Reduction is being considered. Though not a new concept in North America, and certainly with some significant successes attributed to its practical implementation, Harm Reduction remains, in some environments and with some populations, a theory with minimal practical relevance. Usually conceived as methods to address drug use (Needle exchange) and unsafe sex (condom use), simplistic implementation may result in community rejection and refusal to consider the possibilities of holistic application of the underlying principles. Introduced to communities without articulating a clear goal and purpose, it could be seen as damaging and indeed harmful. Imbalances in perspectives and issues of power can complicate a complex picture further. Simplistically approached, an idea, like client-centered care could result in stand-off positions between care givers and clients. Rather then negotiating the terms of care, power relations are transacted. In some communities, individuals may be seen as the embodiment of harm and actual threats to communities. Harm Reduction applied to a situation like this could result in attempting to rid the community of the individual, rather than considering the range of options that could strengthen the whole community's response to prevention, care and treatment. Within the context of history and through the lessons learned through the experience of other illnesses, the use of harm reduction principles could be powerful tools, utilized to protect citizens and communities. They could mediate between the community context with its specific history and values, and the contemporary scientific Western approach to HIV , bringing both into service with communities

What Has Been Said...:

The literature review as it is, was undertaken for two key reasons:

- to couch the current work which describes this population as mobile and marginalized, within history;
- to understand the "lessons learned" from other epidemics within the same population

In exploring the primary question through this work, two key concepts emerge within the body of work previously done in considering Harm Reduction Models for Aboriginal people. **Mobility** and **marginalization** have been considered as the key characteristics of Canadian Aboriginal people generally, Manitoba Aboriginal people, and of specific subgroups of individual Aboriginal drug users in prisons, within the urban environment and on Reserve. Both have been weighed as problematic to delivery of comprehensive services **to** Aboriginal people both on and off reserve. That these issues have been identified and defined from the "outside" characterizes the present prevalent environment.

The Issue of Mobility:

Ferguson asserts that tuberculosis became a serious problem among western Aboriginal populations only after they were settled on reserves. Forced relocation of Aboriginal people with minimal resources, where people lived in crowded houses and where the children were concentrated in boarding schools, essentially guaranteed their complete and rapid tuberculinization. Increasing tuberculosis mortality in the early 20th Century represented "the whole story of the passing of the Indian from the nomadic to the settled habits of life."[12] managing tuberculosis shifted and followed a pattern of initially concentrating and isolating infected people within sanitoria away from home, to directly observed administration of anti-tuberculosis medications within both rural and urban communities. The application of new and "creative" strategies to deal with "difficult populations" nevertheless resulted in incomplete control and persistent infections despite state of the art therapy. Increasing tuberculosis rates on Canadian Reserves in the early 20th century represented "the whole story of the passing of the Indian from the nomadic to the settled habits of life." (Bryce, 1909:282)

Paul Farmer states, in reference to the emergence and re-emergence of tuberculosis, in identifiable populations: " We cannot understand its marked patterned occurrence without understanding how social forces, ranging from political violence to racism came to be embodied as individual pathology."[13] Lessons can be learned from a similar understanding of the causes and cultural effects of other diseases considered "epidemic", most clearly emerging diseases like diabetes and sexually transmitted infections.

Certainly the mobility patterns of HIV have been discussed through the epidemiological literature- the analogy of HIV shifting into different populations along routes predictable, retrospectively. The concept of mobility is accepted, though not rigorously examined by any discipline with respect to HIV in Aboriginal people. While the historical literature

examines the forced settling of largely nomadic people into settlements and communities and the social and cultural effect of external political and economic decisions, actual measurements of mobility are rare. The meaning applied to movement/travel by Aboriginal people themselves and the motives for moving around are similarly absent.

A more complete research into mobility as a potential factor in HIV transmission has been undertaken internationally. A recent paper prepared by UNAIDS considers the factors influencing mobility, and offers recommendations to mitigate potential harms correlated with mobility and HIV transmission. Mobile people are described broadly as people who move from one place to another temporarily, seasonally or permanently for a host of voluntary (i.e. employment opportunities)or involuntary reasons (i.e. civil war). Mobility in general has increased over the past several years due to increased availability of land and air transport. Further, economic imbalances between communities push people to move in search of better lives or in order to survive. Media and communications widely disseminate images of places of opportunity and/or safety. According to the International Organization for Migration, mobility is seen as a process with stages comprising:

- **source**: where people come from, why they leave, what relationships they maintain at home while they are away
- **transit**: the places people pass through, how they travel, and how they maintain themselves while they travel
- **destination**: where people go, the attitudes they meet when they get there, and their living and working conditions in the new place
- **return**: the communities to which people return, their families, their resources or lack thereof.

Studies on highly mobile groups, e.g. truck drivers, itinerant workers of both sexes, identify travel or migration as a factor related to HIV infection. In many countries reporting higher seasonal and long-term mobility also have higher rates of HIV infection, and higher rates of infection can be found along transport routes. These studies indicate that mobility increases vulnerability to HIV/AIDS- both for those who are mobile and for their partners back home. [14]

Unemployment, low incomes, receipt of social assistance, lack of stable housing, low educational attainment, and mobility have been identified as risk factors in recent studies of HIV/AIDS among Aboriginal people. High transient movement of Aboriginal people between inner cities and rural or reserve communities brings the risk of HIV to even the most remote Aboriginal communities.[15]

From 1993 Health Canada data, it is possible to establish that non-insured health benefits made for medical care to Aboriginal people (including drugs, medical supplies, dental care, vision care, and medical transportation), the second highest expenditure after drugs and medical supplies was on medical transportation. ($114 Million of a total non-insured health benefits budget of $347 million.)

In preparation for the development of Joining the Circle: An Aboriginal Harm Reduction Model (Canadian Aboriginal AIDS Network, 1998), survey respondents were asked : "How often do you visit your home community?" Though acknowledging the limitations of the question, information provided suggested that 79% of Aboriginal injection drug users interact with their home communities; 43% are home at least once a year, and another 36% are visiting less regularly. Further, anecdotal evidence suggests that they may be having sex and/or sharing needles on their Reserves during visits.[16] Obvious questions emerge here: Do people behave differently in different environments? If so, what are the conditions in different environments that contribute to and reduce risk?

In contrast to the positions reached through these sources, in depth analysis undertaken within a rural Manitoba community by anthropologist, Yngve Georg Lithman in 1978, indicates marked cultural difference in the motivation and meaning assigned to mobility among a group of Aboriginal people studied. " Out-migration is often presumed to represent a desire on the part of the Indians(sic) to attach themselves to the mainstream society. While this is occasionally a valid observation, the overwhelming number of such movements can be seen to represent movements within an Indian community, and increased off reserve residency rates should not be seen as an increase in the number of particular individuals permanently living away from the reserve. Instead, they should be seen as a result of a general increase of movements between the center of the Indian community network and its peripheries, which may include urban communities, like Winnipeg, and remote Northern communities." His analysis concludes that migratory movements represent no depletion of the population in the reserve community, although they may result in a lower number of individuals living on reserve at any one particular time. To the individual, the migratory movements are part of the process of staying in the community, not leaving it.[18] Movement is not linear from point A to B, with clear departure and arrival points. Movement/migration is circular, with no easily discernable end or beginning points. This may be consistent with other populations understood to be "nomadic."

A recent study, conducted through the B.C. Centre for Excellence considered mobility and risk factors for HIV. Mobility among injection drug users and continued high risk activity during times of mobility were found to be common. "Findings underscore the need for decentralization of prevention intervention services to reduce the risk of transmission of HIV between injection drug users and their drug using and sexual partners."[19]

Mobility, as a factor contributing to risk, is incompletely explored. While beyond the scope of this work it would be worthwhile to consider this factor from several vantage points, most carefully from the meaning and value assigned to it by Aboriginal people themselves, representing a wide range of geographic circumstances. This could assist with clear characterization of those issues assumed to contribute to risk. A suggested tool to consider the issue of mobility is offered within this work. (Appendix I)

The Issue of Marginalization:

The global history of HIV/AIDS over the past two decades clearly defines features of the epidemic. HIV/AIDS concentrates among those who before the arrival of AIDS were already marginalized, stigmatized and discriminated against within society. And while there is acknowledgement about the factors leading to vulnerability in "target populations", understood as the determinants of health in population health framework, the complexity of the social context confounds precise action. It is the social context that determines the lived realities of people in communities, and determines under what conditions people are accepted or rejected, or marginalized.

Manitoba data reflects broader North American research, in that the urban poor, Aboriginal people and youth are disproportionately affected by HIV. This mirrors rates of sexually transmitted infections which are highest among young people, women, First Nations people, street youth, and those of lower socioeconomic status.[20] Social inequalities based on race, ethnicity, gender and social class have structured the spread of HIV as well as the course of the disease once a person is infected.[21] These marginalized people experience systemic difficulties organizing themselves as a group, rarely participate in debates about themselves, and are more likely to be subjected to coercion and punishment.[22] Indeed, they are the identified "problem" in a problem-centered approach, where authority for solution is taken up by experts on the outside.

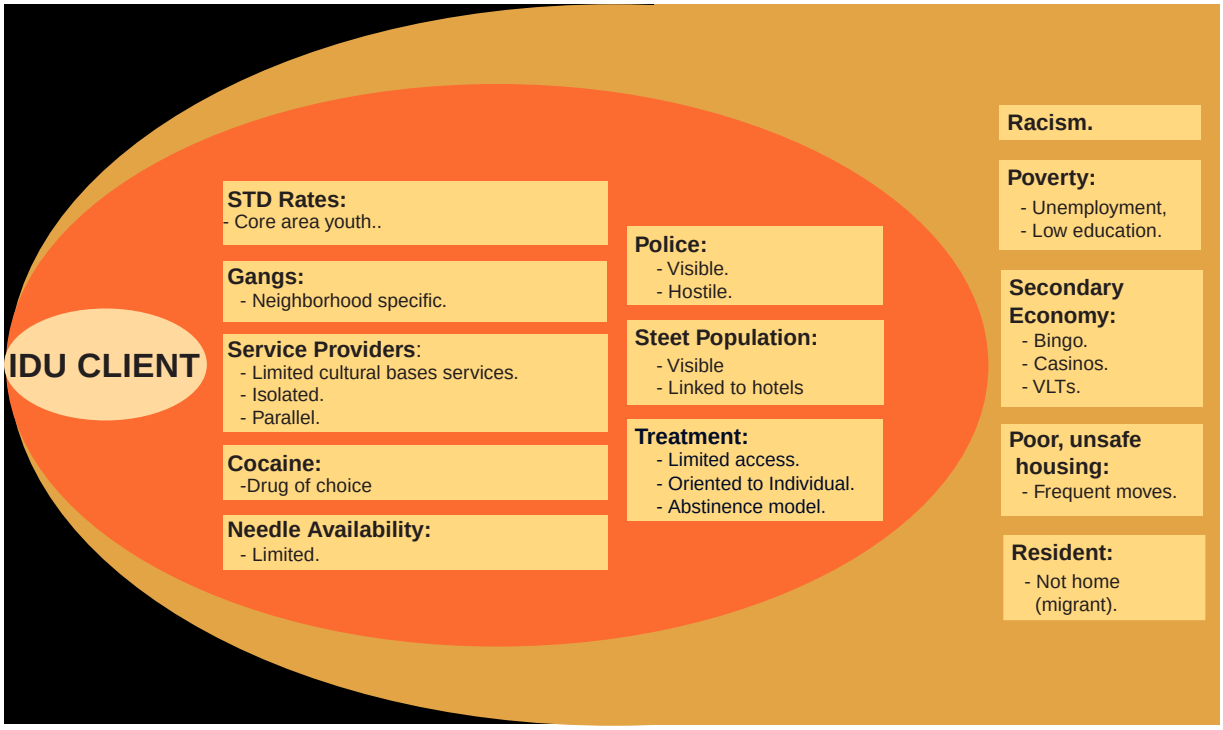
How an individual problem is defined, and who defines it, determines what will be done about it and who will do what. Defined from "the outside", with solutions created from that vantage point may indeed sustain the problem itself. One individual consulted in preparation of this work stated: "Focusing on health disparities (as defined externally) promotes assimilation." The concept of marginalization itself could be considered from questions like: marginalized from what, and by whom? Who defines the term and what criteria are used?

Understanding this concept requires a complete and honest consideration of communities, which goes beyond governmental and economic analysis. The manner in which people live within communities, the values that bind people together and the strengths that provide the resiliency necessary for "vulnerable populations" to become less vulnerable and less "marginalized" would direct the observation. Knowing and responding to deeper societal causes of vulnerability to HIV/AIDS as factors which interfere with people's ability to make and effect free and informed choices about individual and group behaviour is more challenging. The actual story of how individuals and communities used their own tools for prevention could have substantive and sustainable impact on risk factors within groups considered both vulnerable and marginalized. Moreover, how external tools have been applied in the past may give guidance for what to avoid in the future.

A determinants of health analysis may be important to thorough understanding, but it may not be as useful to communities trying to fight the epidemic as a clearer understanding of the "local ecology" that contributes to and prevents that spread might be. According to Dowsett (1999):

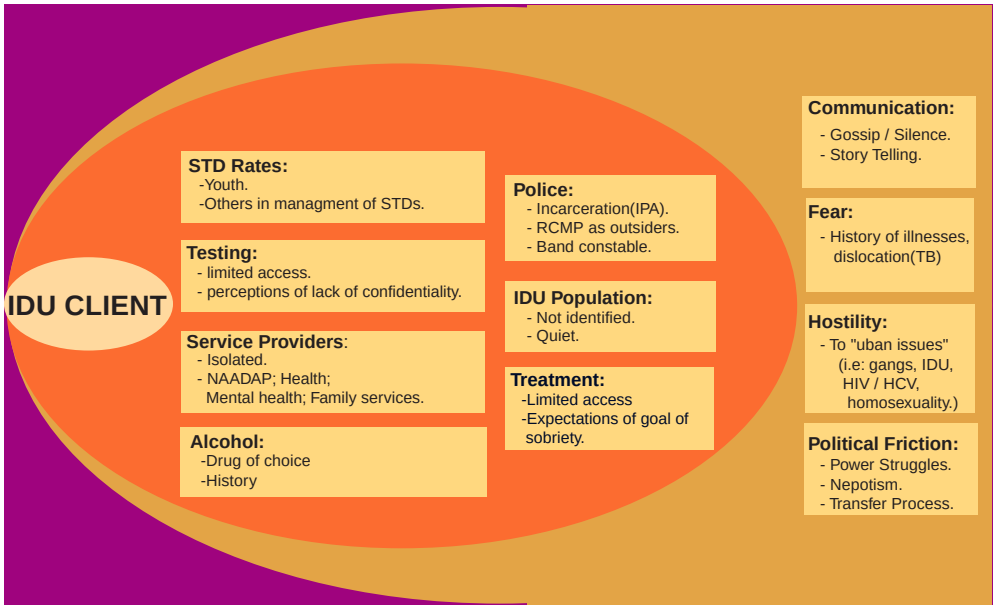
"The challenge is to come up with a macro-social view that adds to a workable response to the pandemic instead of one that overwhelms our capacity to act."[23] Analysis of social and sexual networks is increasingly used to understand the dynamics of infectious disease such as STD and HIV. Individual behaviour can be understood from an interactional perspective in which populations are not simply an aggregate of individuals, but a social unit characterized by structured and systemic interactions mediated by culture. A contextual picture emerges, which can throw light on the ecological system itself. [24] Individual contexts can be developed and understood, not as a method of illustrating complexity, but to assist with understanding the factors impacting on the individual within an environment which may create or indeed mitigate potential for harm. Representational samples of these contexts for injection drug users in particular environments are illustrated in the following conceptual models. Following that, an ecological view of the complex world of youth illustrates a different contemporary model. It situates the individual within personal, interpersonal and social environments.

Aboriginal IDU: Urban Context



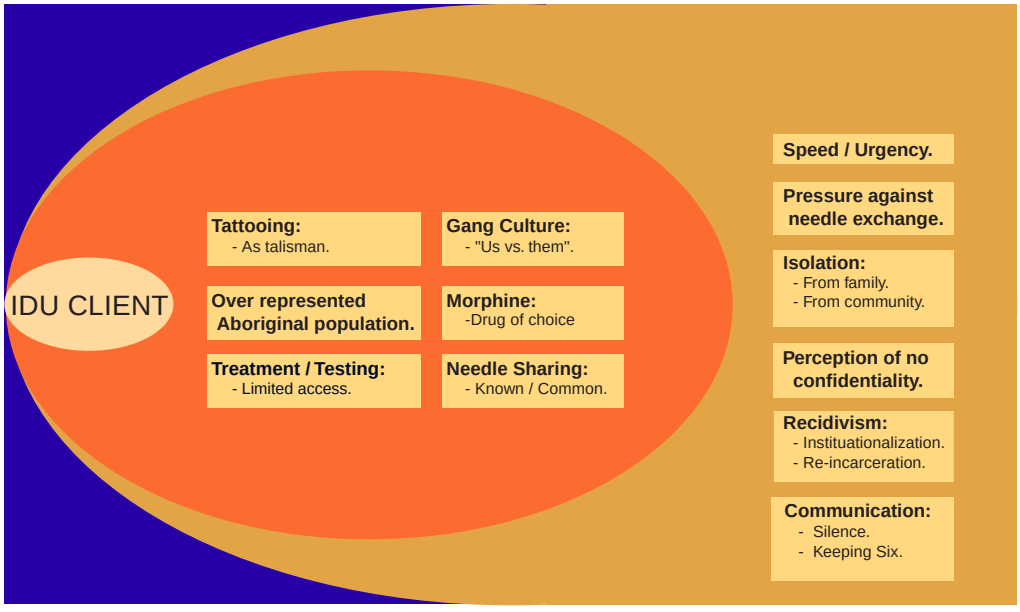
IDU: - Perceived as health, legal, social snd familty services issues.
- Although primarly managed through health care servces

Aboriginal IDU: Rural / Reserve Context

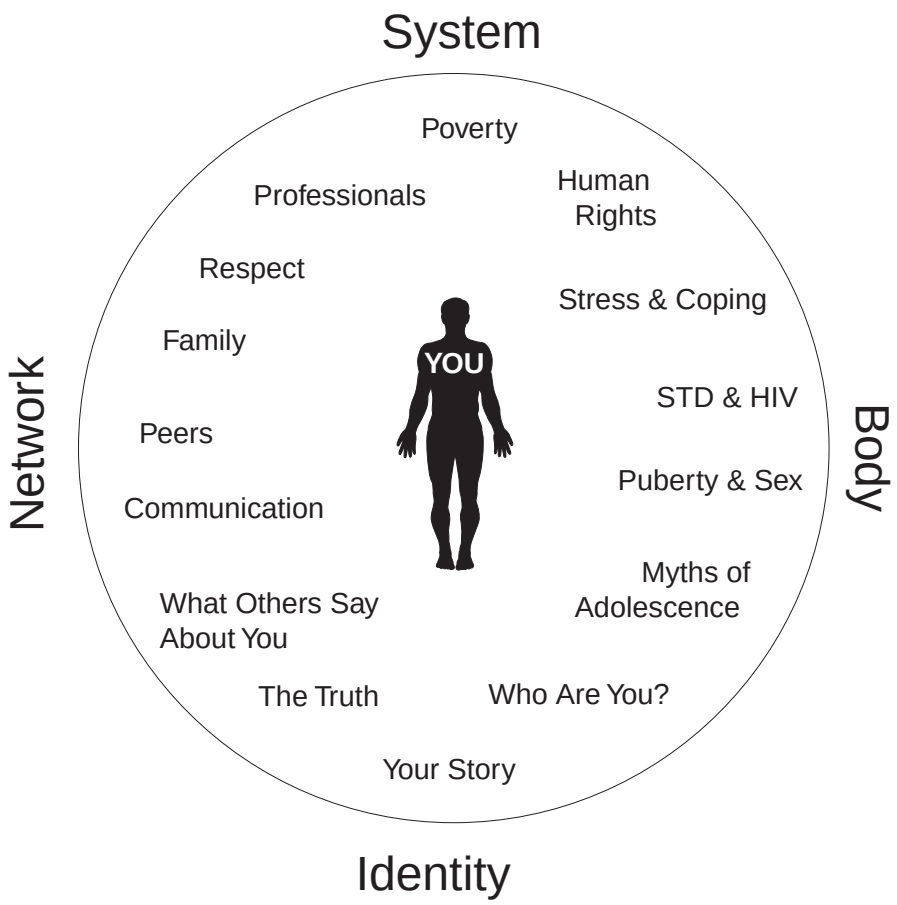


IDU: - (Limited) Perception as health issue.
- (Limited) Managment throught health care services.

Aboriginal IDU: Prison Context



IDU: - Percived as administration, health and labor issue.
- Managed through health care services.



Harm Reduction Defined:

Harm Reduction, as a concept and practice that evolved in Europe and North America, does not seem to have a corresponding counterpart within Aboriginal dialects. It could be understood as an ambiguous concept that self-contradicts. In some circumstances, things are either good for you or they are not, either positive or negative. Strength and utility of an idea are often measured against individual power to select from a range of options. "Take what is good for you and leave the rest." Definitions of Harm Reduction differ across agencies, specific groups and disciplines developing them. They contain particular goals and biases for their own Harm Reduction strategies. The definition utilized through this work is an amalgamation of concepts thought to best apply to the issue being explored:

> ***Harm reduction is a set of strategies and tactics that encourages people to reduce harm to themselves and their communities, through the sharing of relevant information, facts and practical material tools, that will allow them to make informed and educated decisions. It recognizes the competency of their efforts to protect themselves, their loved ones and their communities.***

Within this definition are the principles thought to best integrate the capacities of individuals and communities to identify and incorporate approaches that are **accessible** to individuals and communities and **acceptable** within communities as they work toward own goals. It is clear throughout the history of other failed or poorly incorporated health strat-

egies, that imposed solutions may not only fail, but may contribute to more harm.

Steven Polgar, medical anthropologist, has identified four common errors made in introducing health interventions into different cultural milieus:

Fallacies identified by Steven Polgar

- Fallacy of the *empty vessel*: This assumes that there are no established health customs, only an empty space waiting to be filled up.
- Fallacy of the *separate capsule*: Health beliefs and practices are separate compartments from the larger culture
- Fallacy of the *single pyramid*: All societies are hierarchically organized. All that is necessary in implementing a new concept is to convince the leadership, and the rest follows naturally.
- Fallacy of the *interchangeable faces:* All Aboriginal people are alike![25]

From cultural anthropology come the following general principles for health intervention programs to be successfully integrated

Principals for successful intervention program integration:

- Programs have to be culturally and socially acceptable and appropriate.
- They have to be built on and re-enforce a community's strengths and insights and not contribute to a collective sense of inadequacy or fragility by well-intentioned actions
- Before trying to modify attitudes and behaviors it is important to understand the cultural origins and significance, their present function and their place within community life.
- It is important to assess local perceptions of the relative importance and the degrees of tolerance or intolerance of various problems in a given community.
- The concept of "at-risk group" should be complemented by that of "target conditions", which rise out of a complex web of social and cultural determinants in a given environment[26]. An ecological view of social environments could shift focus and blame away from individuals to social networks.

The following sections contained within this document offer an orderly approach to the primary question, a review of a Harm Reduction approach tailored to the issues, and finally Ideas for Consideration.

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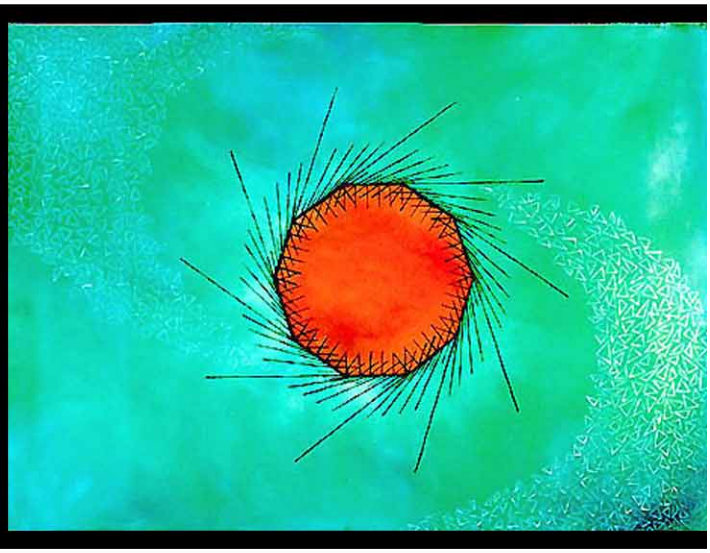

Exploring the Question

“ What are the barriers to Harm Reduction for First Nations People living on and off reserve? What conditions would make Harm Reduction strategies *accessible* to clients and *acceptable* to communities?”

Exploring the Question:

Through the attempt to answer the central question from several points of view, conversations were conducted with 15 individuals selected from urban, rural, and Reserve communities with primary contact with Aboriginal people. Interviews/conversations were conducted through phone (3) and personal contact (12). Individuals selected for interview were known to be particularly knowledgeable about their communities, injection drug use, or programs designed to deliver service or work with communities in organizational capacities. Given the perceived sensitivity of the subject, a conversational approach was thought to be most conducive to creating an environment in which honest and frank discussion could be held. This allowed for exchanging information about concepts of Harm Reduction which, in some cases, were unfamiliar. It was understood that individual communities, urban, rural, and remote, were likely to have varying levels of experience with HIV, Hepatitis C, drug use, specifically injection drug use, and different degrees of familiarity with the principles and practice of Harm Reduction. The issue being explored centered around the barriers to implementation of Harm Reduction strategies, the factors which would limit or increase **accessibility** for clients in need of services, and those which could limit or increase **acceptability** within communities.

Discussion was guided by key questions designed to:

- gauge the awareness of HIV and HCV as concrete issues in communities
- gauge the awareness of the prevalence of drug use, specifically injection drug use, within communities
- understand the groups identified as most in need of prevention initiatives
- shed light on the barriers both individual and systemic to implementing Harm Reduction strategies.

(See Appendix 2)

Data Collection and Methodology:

While no formalized process of consent to interview was provided, individuals were given background and development information, and were informed about the intended purpose of the inquiry and the questions to be used to guide the discussion. Further, individuals were advised that refusal to pursue a line of questioning would be discretionary, and that no attempt would be made to re-word or otherwise distort or lead the conversation beyond exploration of key issues. They were also advised that individual identity would be held as confidential, and that analysis of data gathered throughout contact with communities and individuals would be protected.

Of the 15 individuals interviewed, 10 were female, 5 male. Ethnic identifiers (self-identified) indicate participation of 11 Aboriginal people, 2 Metis individuals, and 2 Caucasians. 5 were located within urban communities, 7 worked and lived in Reserve communities (3 remote, Northern; 4 accessible by road); 2 travelled between rural and Reserve communities in delivering service; 2 clients were interviewed, whose home communities were Reserve communities (1 remote, 1 accessible by road). 5 individuals worked in professional

capacities; 4 were employed within government or other service bureaucracies; 4 were employed as non-professional service providers within communities. Both clients were unemployed at the time of interview.

Notes compiled during discussion were transcribed into a word processing package. Transcript underwent standard content analysis. Patterns and unique textual data were coded, and abstracted into themes. Individual responses were grouped and analyzed according to these themes. Issues that emerged, incongruent with key themes, were considered as "other factors."

Themes were subsequently grouped according to positive, negative, or neutral influence they could have on acceptability and accessibility of Harm Reduction. Though the values were arbitrarily designated, they were selected as useful to complete exploration of the question. Those areas designated as "neutral" were those that contained paradoxical value, that is they were understood as both positive and negative by individuals. They were factors that could be best described as "just the way things are."

Analysis:

Though analysis was guided by weighing emerging factors as having positive or negative force or impact, on accessibility and acceptability, key themes emerged into an "other " category. These factors had neither positive nor negative influence and were reduced repeatedly to the phrase: "Just the way things are." Further analysis of this neutral category may be the key to understanding basic features characterizing communities themselves. This unexpected finding, which confounds standard analysis, has a matter of fact quality, which may underpin both positive and negative values. As such, these factors are presented first to underscore their predominance as characteristics.

NEUTRAL FACTORS: "Just the way things are"

- Political influence on community goals
- Real leadership with vision, " makes things happen"
- Communication mechanics:
  - language style, with tone of voice, gestures, use of silence in communicating
  - taboo subjects- "Some things are never, ever talked about. If you talk about them, then you have to do something."
  - Gossip as common means of giving and receiving information
  - Perception that privacy is misunderstood and personal information is shared
- Lessons learned from history create sense that "new issues" are repeats of old stories, and there is much value in drawing from past experience
- Elders are the best resource for communities as historians and mediators between old and new stories

POSITIVE FACTORS, in order of frequency:

- Programs built on cultural and community strengths
- Influence of respected individuals, with proven commitment to the specific issue
- Programs with the overall goal of integration, both of the individual as a "whole person", and of the individual with the family and the community
- Real, functional partnerships with common understanding and shared strengths
- Programs with a focus on the family, particularly youth and elders

NEGATIVE FACTORS, in order of frequency:

- Harm Reduction perceived as illogical
- Problems "externally" defined, not identified within community
- Political processes perceived as power struggles, both within community and influencing the community from the "outside", resulting in inconsistent services
- Complexity and urgency of issues surrounding HIV and HCV
- Denial of the presence of injection drug use within community
- Perception that "Urban issues" like injection drug use, and gangs, corrupt communities
- Treatment of addiction with abstinence goal and limited time allotted to treatment, not Traditional goal of healing whole person over a long time
- Economic issues as they affect employment, intersect with, and are influenced by power hierarchies within communities
- Limited accountability of systems and services resulting in blaming others for failure to provide service
- Partnerships artificially constructed, "just to have partnerships"; and functional partnerships between disciplines that were perceived as resulting in harm, ie. police and public health (STD)
- Bureaucratic and government structures resulting in " the jurisdictional issue", considered as "an excuse for governments not to do their jobs"
- Punitive approach to issues- health care and justice system, with no understanding of restorative mandates of systems
- **Other issues**: fear of exposure, violence within family, time limitations, influence of religious factions.

The Issue of Acceptability:

With respect to the issue of Harm Reduction within the communities approached, using information obtained through the mechanisms described, it appears that for activities relating to Harm Reduction to be **acceptable to the community,** they must:

1. Be defined and described as critical by the community, and understood as necessary to maintain the integrity of the individual and the integrity of the community
2. Be supported and influenced by and with the commitment of key influential individuals, including elders
3. Be integrated over time with existing positive and accountable programs with a proven track record of service delivery
4. Grounded in accepted community values
5. Seen as a component of a continuum of treatment for substance abuse
6. Goal of Harm Reduction programs must be consistent with overall community goals and understood as helpful to community in meeting its own goals

The Issue of Accessibility:

1. Willingness of influential individuals and systems to support developing initiatives
2. Integration of Harm Reduction as an element for prevention of HIV intoexisting successful programs- well woman's initiatives, youth groups
3. Incorporating key Harm Reduction information into other situations considered to be personal and sensitive-STD screening and treatment, HIV testing
4. Considering HIV and STD testing as ideal opportunities for prevention of illness, not merely opportunities for diagnosis
5. Highly sensitive and respectful communication which enhances engagement between people
6. Re-enforcing management of confidential information through clear policies, and with consequent action for proven breach
7. Recognizing travel and mobility as a characteristic to be considered in program design
8. Recognizing the value of practical and emotional support as valuable and necessary to improve health
9. Shifting from initiatives narrowly focused on individual behaviour, to a broader perspective of functional social networks, where information travels

Summary:

The language surrounding Harm Reduction is the most immediate barrier, carrying with it a concept that seems illogical. The principles guiding Harm Reduction are accessible and more possible to ground within the real experience of communities. The central principle of respect and valuing the strengths of people should be the focal point of initiatives undertaken. Initiatives intended to integrate the components of the individual as a whole person, and to connect the person with the community are welcomed. However, the imposition of externally perceived solutions to externally defined problems are likely to garner hostility, as a repetition of historical patterns detached from the goals of the community itself.

Exploring The Practice

Exploring the Practice:

In reflection of these findings, it is possible to suggest key elements which may guide any consideration of their incorporation of Harm Reduction into practice. They are not new, and have been suggested as the characteristics and qualities, which contribute to sustainable and resilient communities. Further, this section is not intended to serve as a template for action. It may act merely as a guide.

Principles:

1. **Respect** for individuals and communities will guide action
2. Information and evidence that is **clear, honest and correct** will be used
3. Individuals and communities are **capable** of integrating new information into their own stories.
4. Individuals and communities want to be and strive to be **healthy in a whole way**
5. **Dignity**, both of individuals and communities is recognized
6. Talking and listening includes **silence**
7. **Courage**: People look for and find their own path. Searching for it may be risky
8. Communities are collections of **interdependent** individuals, who rely on each other for support and help

Strengths of Harm Reduction approach:

1. Accepting of whole person and whole community
2. Allows for choices on a continuum that is value neutral
3. Encourages and relies on respectful communication
4. Operates on the reality of the issue as defined and understood by the individual and the community
5. Can be applied obliquely- an issue indirectly connected to the main concern can be the focus of attention
6. Can be incorporated within existing services and initiatives
7. Practical approach to prevention of illness or harm

Limitations of Harm Reduction Approach:

1. Concept confounds logic.
2. May appear to encourage harmful behaviour
3. Requires thoughtful integration into programs
4. Demands time
5. Involves talking about and accepting issues that have been denied or not mentioned
6. Results of work may be slow to appear
7. Demands that real partnerships with common goals be developed
8. Requires that accurate information (about drugs, sexual activity) be openly considered

Key Messages Guiding Prevention:

While the practice of Harm Reduction as identified with Needle Exchange programs and other initiatives commonly understood to be based on an understanding of Harm Reduction, Key Messages can be incorporated within any and all initiatives, regardless of levels of sophistication. These messages may be articulated through a number of mechanisms that reflect individual and community needs:

Key Messages

- Respect means treating all people the way I want to be treated
- Something in another person's story might be like my story
- People are valuable now, not only for what they might become
- Hepatitis C and HIV are preventable illnesses
- Hepatitis C and HIV are both viruses sometimes connected to injection drug use
- Hepatitis C is easier to "get" than HIV
- Drugs are not all the same. They don't act the same, or affect the body the same way
- Women who have Hepatitis C can have babies and breast feed safely, without hurting their babies
- Women who have HIV can have babies safely and reduce the possibility of their babies being infected
- Some people with Hepatitis C get rid of it without any treatment
- Treatment of Hepatitis C works for some people
- It is possible to have an STD without knowing it
- It is possible to have HIV without knowing it
- It is possible to have Hepatitis C without knowing it
- It might be good to know things about yourself. It might help you. It might help people you care about.
- Racism hurts people
- Isolation hurts people
- Needing things and not being able to get them hurts people
- Consent means knowing about and allowing something to be done to you and for you
- Experience is a good teacher- education is about learning from school and experience
- Silence does not mean that I agree with you.
- Trust is built when I do what I said I would do
- Having an STD makes it easier for a person to get HIV
- Having HIV makes it easier to get other infections.
- Human rights can't be given or taken away by anyone.
- Friends are good for you

The GOAL of Harm Reduction practice:

Harm reduction practices, regardless of their application as Needle Exchange programs, educational initiatives that focus on drugs or disease is based within an ethical principle: **to mobilize and maintain services necessary to assist people before they harm themselves or others.** The manner in which this initiative is undertaken sets the overall goal.

Such goals may include:

- Preventing isolation of members of the community
- Prevent the spread of preventable illnesses
- Enhance the opportunities for people to be healthy in a complete way, and integrated within the community

A clear knowledge of the goal would indicate the practice needed to reach it, allowing for a deeper consideration of how the specific harm is known, its impact, and how best to reduce it. This process moves the focus away from drugs and sexual activity to the community itself and how it develops to meet the needs of its citizens. It may allow:

- people to be seen and related to as whole people, not one aspect of who they are
- the distinction to be made between what a person can do now and what might be possible
- respect for the complexity of lives: all people react to acts of treatment, caring and human kindness
- for slow progress not to be seen as doing nothing
- for attention to basic needs of people within communities
- for clarification of the most important issues

The Pillars of Harm Reduction:

The strength of a Harm Reduction approach is thought to rest on its concrete practice. Usually seen as programs for injection drug users, the principle position of this paper is that a broader application allows for the strengths of a Harm Reduction approach to act as the mediator between the strengths and goals of the community and those available to people in general. While needle exchange may be seen as necessary in some communities, who may recognize injection drug use as an issue, to make needle exchange an absolute goal overall may create another ideological and practical barrier.

Throughout the 1997 document, Joining the Circle, developed by the Canadian Aboriginal AIDS Network, as a groundbreaking initiative to recognize the urgency of issues facing Aboriginal People in Canada, four major "Pillars of Harm Reduction" were described and evaluated. These pillars included:

1. Needle Exchange
2. Methadone Maintenance Programs
3. Condom distribution
4. Counselling

Application of these pillars within the Manitoba Aboriginal context previously described in Section I of this work, may have limited possibilities for benefit. As shown here, another approach may have more promise in application.

Application Of Harm Reduction...

The Harm Reduction assessment tool focuses specifically on the possibilities of using concepts contained within a Harm Reduction approach in prevention initiatives. While the principles of Harm Reduction can be applied across the whole spectrum of needs, for purposes contained here, utility is based on being applied as a tool for the development of prevention services. The infrastructure or pillars, which support action, must be arrived at through comprehensive understanding. This complex of issues can be conceptualized as follows, and is finished with the ability to concretely answer the 3 central questions highlighted:

	Client needs	**Service provider needs**	**Community needs**
Support	-From key individuals. -A safe environment.	-Policy development. -From Organization. -From Community	-To obtain information. -To develop acceptable plan.
Information	-About drugs. -About safer use. -About HIV, HCV. -Services in and out of community.	-Current research -About drugs. -Harm Reduction. -Available resources (ie: treatment)	-What is the problem? -What has helped? -What has contributed to problem? -What has been successfully done already? How? Has a Harm Reduction approach been used with other issues in the community- ie: diabetes.
Tools	-Privacy/confidentiality. -Needles/supplies. -Access to counselling. (maybe)	-Confidentiality policy -On-going resource development. -Training and support	-Confidence. -Ownership. -Skill.
Key Questions	**Do the needs of the individual who injects drugs conflict with service provision or the community?**	**Does service provision conflict with or assist the client who injects drugs or the community**	**Does the "community" conflict with the individual who injects drugs or service providers to him/her?**

The themes offered here may be more easily applied within a community development framework, recognizing the primary reponsibility and governance of Aboriginal people within communities at varying stages of Transfer on Reserve, off Reserve and within an urban milieu.

They are consistent with an ecological, holistic framework such as the Teaching Turtle prepared by the Manitoba Aboriginal Task Force, offers.

Pillars of Harm Reduction in Practice:

1. Respectful communication with and between individuals, and communities
2. Ownership of issue
3. Position of valuing all people for who they are and what gifts they have to offer
4 Concrete support for citizens
5. Accessible tools including information

Exploring Ideas

Exploring Ideas:

The ideas contained here are offered as possible suggestions for consideration. They DO NOT focus exclusively on Harm Reduction as the opportunities to conduct either needle exchange or condom distribution, usually identified with Harm Reduction initiatives. Rather, they are conceptualized to reflect the Principles of Harm Reduction and to mediate and integrate differing strengths. Further, they are concrete examples of action that reflects the conceptual "pillars" of Harm Reduction in practice.

The basic framework for these initiatives is contained in an **outreach** model. The opportunities exist to:

- measure the concepts of both mobility and marginalization
- increase access for populations considered to be mobile and marginalized
- to be acceptable resources for community development and health promotion

Outreach could provide the venue to:

- increase the opportunities for information to reach specific populations- youth, injection drug users whose immediate needs may not be evident
- improve access to specific tools and services- prevention information, condoms, etc
- Allow for assessments of needs of specific groups which could be incorporated into service profiles
- Increase the opportunities to engage with individuals who may be unseen and unheard
- develop services with a clean slate, unconnected to histories that may reinforce the belief in lack of confidentiality or poor service accountability
- mediate access to services provided to mobile populations in different locations (Rural with urban; prison to community; supportive drop-in services with conventional services)

A FRAMEWORK FOR PREVENTION, utilizing an outreach model, and incorporating principles of Harm Reduction could include:

1. Information for Travellers
2. Development of "CHR model for urban/rural populations"
3. Development of Mobile Clinic: as a community education resource/ STD, Hepatitis C, and HIV testing site
4. Incorporation of concrete community liaison and support for individuals on the continuum of care for treatment of substance abuse
5. "Translation" and dissemination of contemporary research findings into accessible and acceptable tools for information
6. Enhance the opportunities and quality of HIV testing in Nursing Stations through incorporation of principles of Harm Reduction
7. Story telling: as Health Promotion practice

INFORMATION FOR TRAVELLERS

RATIONALE:

Built on the cultural understanding of circular movement around and between communities. Up to 1/3 of the population of some communities is living off reserve, but travel home with some regularity. There is an unmeasured "mobility factor" among Aboriginal people in Manitoba.

GOAL:

- To prevent the increase of infectious diseases among mobile people

OBJECTIVE:

By raising the awareness of the potential for HIV and Hepatitis C in different geographic locations for individuals travelling throughout Manitoba, risk will be lowered.

METHOD:

- Target "travel services" for display of information posters in public washrooms

PARTNERSHIPS:

- Tribal Councils
- Manitoba Health (Public Health) * *key responsibility*
- Health Canada- FNIHB
- MRAWG
- Department of Transport (Province of Manitoba)

TOOLS:

Posters(4) designed containing one primary key message. Existing poster designed as a communication tool by Kali Shiva AIDS Services could serve as the template for pilot testing. Once mobility is more thoroughly understood, this initiative could be expanded to include the "end points" of travel as they come to be known. These may include medical services, shopping venues, casinos and bingo halls.

(See attached)

CHR MODEL

for Mobile People Travelling Between
Urban, Rural and Prison Communities.

RATIONALE:

CHRs trained as skilled individuals beginning in the 1960's have been recognized as community resources through multiple community changes since the model was conceived. The majority of CHR positions in Manitoba, have been "transferred" to First Nations Band Authority as a component of Phase II of the Health Transfer process. In most cases, CHR's are seen as a long-term, constant and trusted presence within communities, sustained through multiple political and organizational changes.

This model may contain the established credibility for adaptation to urban and prison environments where outreach for *mobile populations* could be facilitated by individuals able to act as brokers between communities.

GOAL:

- To develop skilled and trusted personnel for further outreach prevention initiatives

OBJECTIVES:

- To provide the pool of skilled and acceptable individuals as a sustainable personnel resource for prevention
- To enhance the human resource capacity of individuals previously trained through "peer initiatives"
- To refine the existing CHR model, tested through rural/reserve experience, to meet the needs of populations considered marginalized, mobile and at risk for HIV, HCV, and STDs
- To extend the opportunities for health education and promotion within communities- rural, urban, remote and within prisons
- To begin to build the appropriate team for (proposed)mobile testing sites

RECRUITMENT:

- Trained "peers" from other sources (Four Doorways, Sunshine Initiative, Youth Working Group)
- Kali Shiva HIV + Women's Support Group
- Aboriginal Health and Wellness Centre, Employment Training Initiative
- Individuals selected/recruited through Tribal Councils
- Individuals sponsored through agency partners, ie Mamawiichiitata, Manitoba Metis Federation, Native Friendship Centres

CORE TRAINING SCHEDULE:

- · Communication for Prevention
- · HIV 101
- · HCV 101
- · STD 101
- · Understanding the Law
- · Harm Reduction: Principles and Application
- · Resources for Communities
- · Principles of Health Promotion and Prevention

PARTNERSHIPS:

- · Regional Health Authorities, including WRHA
- · Manitoba Tribal Councils
- · Health Canada, (FNIHB, PPHB)
- · Aboriginal Health And Wellness **key leadership/co-ordination*
- · Red River Com College/Assiniboine Com. College
- · John Howard Society
- · Nine Circles Community Health Centre
- · Manitoba Metis Federation

Pilot testing of model as human resource component of Mobile Clinic, with systematic process and outcome evaluation.

MOBILE SEXUAL HEALTH CLINIC

RATIONALE:

Based on the successfully implemented mobile Sexual Health Clinic in the Battleford Health Region of rural Saskatchewan, implementation of this model could increase access to sexual health services including testing for individuals poorly connected to existing health services due to mobility or marginalization from community resources. With capacity to act as an anonymous testing site for HIV in the pilot phase of this Manitoba Health initiative, the opportunity exists to develop a model for anonymous testing "from the ground up." It may prove capable of bridging resources for populations considered at "high risk"- youth, two-spirited men, injection drug users.

This model recognizes issues considered prevalent within communities:

- perceived confidentiality difficulties
- high STD rates, with known barriers to diagnosis, treatment and follow-up
- limited resources for Health education within communities

GOAL:

- To prevent HIV through improved access to STD, HIV and HCV testing and treatment

OBJECTIVES:

- To improve access to STD testing and treatment
- To develop acceptable models for reaching marginalized people at risk of acquiring and transmitting STDs through sexual and injecting drug users networks
- To establish a trusted service based on respect and proven confidentiality
- To provide acceptable skilled resource people for health education and prevention initiatives in communities
- To pilot test anonymous testing initiative
- To establish bridges with existing services for residents of rural, remote, prison, and urban communities
- To allow for assessment of mobility and marginalization
- To create a forum for discussion with communities

DEVELOPMENTAL METHOD:

- Build partnership between Health Canada, Regional Health Authority, Manitoba Health and Saskatchewan Health to assess methods for adapting Sexual Health Clinic to Manitoba context
- Identify key communities open to the core idea
- Build partnership framework with communities
- Build and develop mobile "team"
- Develop policies for testing and treatment (ie. urine based testing, anonymous HIV testing)
- Develop off-site recording system
- Set target dates, overall workplan, with developmental milestones for implementation

TEAM:

- Co-ordinator, program manager, skilled in Research Methods
- Nurse(s), trained in expanded role
- CHR(s), trained in Health Education, Health Promotion
- Social Worker/counsellor
- Administrative support- off site, accessible
- MOH- off site, accessible

PARTNERSHIPS:

- Assembly of Manitoba Chiefs
- Tribal Council (specific)
- Manitoba Metis Federation
- University of Manitoba, Northern Medical Unit
- Regional Health Authority (specific), Public Health *key part.
- Community representatives, Elders
- Health Canada, FNIHB, PPHB
- Aboriginal Health and Wellness Centre
- Manitoba College of Nurses
- Cadham Provincial Lab

LIAISON WITH ADDICTIONS TREATMENT SERVICES

RATIONALE:

- Treatment of substance abuse is known to be limited in meeting a goal of abstinence. Evaluations of Treatment models and those responsible for establishing and co-ordinating services for people with substance abuse problems, indicate high rates of return to substance use, and high rates of harms associated with substance use and abuse- suicide, violence within families, trauma, etc.
- Incompletely explored information from knowledgeable individuals report reluctance of some treatment centers to accept individuals known to be infected with blood borne pathogens, like HIV and Hepatitis C into programs, because of fear that the health of other participants or staff may be put in jeopardy.
- Conventional treatment models adapt programs based on treatment of alcohol addiction. While some common features are known, this approach ignores the specific properties of other substances, which may respond to different interventions.
- Re-integration into communities requires the long term support of trusted community members. Traditional healing approaches currently used within Federal Correctional Institutions, recognize the need for continued support of skilled healers after individuals are released from prison. Connection with respected healers is thought to result in reduced likelihood of return to harmful lifestyles, improved re-integration into communities, and lower rates of re-offence and re-incarceration.

GOAL:

- To enhance opportunities for prevention of HIV/HCV through integration of testing and support with programs providing treatment of substance abuse.

OBJECTIVES:

- To incorporate prevention messages associated with HIV, HCV and STD's into substance abuse programs in strategic ways
- To increase opportunities for HIV/HCV and STD testing in healing environments
- To increase HIV knowledge of those providing treatment for addictions to reduce fear among staff and residents
- To increase knowledge of the character and harms connected with specific substances, particularly those which are injected
- To provide support for those individuals re-integrating into communities with substance abuse histories

METHODS:

- Traditional Healing methods, based on acceptance and respect will guide the conceptual model
- Through partnership development, educational initiatives will be undertaken to develop a skilled core of addictions specialists for Aboriginal people in Manitoba, knowledgeable of the nature of the factors resulting in substance use and abuse, specific addictions, and the relationship of drug abuse to HIV and HCV.
- Introduce Harm Reduction principles and concepts into existing treatment services
- Develop a multi-disciplinary team working toward a commonly accepted goal of re-integrating people back into communities
- Health promotion, which could include confidential testing, as a key component of treatment services.

PARTNERSHIPS:

- First Nations Communities (Mental Health, CHR's)
- Traditional Healers/ elders
- Community members/clients
- NAADAP
- Addictions Foundation of Manitoba
- Corrections Canada/Manitoba Justice
- Sunshine Initiative
- Regional Health Authorities
- Health Canada, FNIHB (as nursing liaison)

ENHANCED HIV/STD TESTING INITIATIVE

RATIONALE:

Testing for illness, using laboratory methods is the usual result of history taking and risk assessment. Usually precipitated by an "event", testing becomes the entry point into services tailored to cure or ameliorate symptoms. Opportunities exist within HIV, STD testing processes to enhance primary prevention initiatives, by incorporating Harm Reduction principles into testing approaches. Shifting the focus to the prevention of harms associated with sexual behaviour or drug using can relieve the anxiety usually connected to testing procedures. Engagement with the client within a safe and supportive environment could better arm the client with tools for prevention. Further, health information that could be transmitted to others within the individuals social and sexual network, could result in broader improvment in access to testing.

GOAL:

- To reduce HIV, HCV, and STDs through enhanced testing

OBJECTIVES:

- To improve access to testing opportunities
- To reduce the fear usually associated with diagnostic procedures
- To improve access to harm reduction messages and practical tools
- To increase engagement between health care providers and clients who may be vulnerable to infections connected to behaviours considered unacceptable within the community
- To improve the perception of confidentiality within health care services

METHODS:

1. Nursing staff of Health Centres and Nursing Stations will receive comprehensive training in Harm Reduction methods
2. Primary health care personnel will receive comprehensive training in common drug use, including:
    - pharmacology of specific agents, both street drugs and prescription drugs
    - the physiology of addictions
    - quick assessment
    - first steps in Harm Reduction
3. Creative consideration to opportunities for harm reduction messages, that indicate a respect for the privacy of the individual. Though not blatantly endorsing needle exchange programs, subtle opportunities may exist to offer individuals

access to tools they may require to reduce harm to themselves and their communities.

4. By developing "program partnerships" with other services considered successful within the health service, increased opportunities for HIV testing may be evident. Connecting Harm Reduction messages to Well Women clinics, introducing urine based testing into pre-natal clinics, etc……

PARTNERSHIPS:

- Health Canada (FNIHB)
- Nursing staff
- RHA's

(SEE Conceptual model, Appendix 4)

STORY TELLING WITH YOUTH
HEALTH PROMOTION THROUGH STORIES

RATIONALE:

Stories, personal and impersonal, both for the teller and the listener can create the environment for reflection on individual lives and the lives of others. Stories, or narratives, are powerful ways of conveying experience. The story has meaning for the teller and the listener. People learn from one another and build knowledge from the experience of others. Health Promotion initiatives consider the use of stories as important to advocacy. Stories, related in a place where there is time for silence and reflection,can have a major impact on the lives of others

GOAL:

- To reduce vulnerability to HIV, STD's by strengthening individual capacity through connection with the experience of others.

OBJECTIVES:

- To reduce marginalization of youth in communities
- To strengthen connections between youth and others who are respected by them
- To provide the opportunities to consider private information in a safe place
- To use available information networks as a Pathway for prevention messages
- To allow for information to be shared in a safe, respectful way

METHODS:

- Sharing Circles in neutral environment, where all forms of communication, including silence, are respected.
- Youth or recreation programs could incorporate Story Telling into existing programs, with the intention of promoting health

PARTNERSHIPS:

- Youth
- Elder/group facilitator
- Mental Health
- NAADAP

CHR's