



Hands Across the World: An Indigenous Peoples Forum



Canadian
Strategy on
HIV/AIDS
Prévention

La Stratégie
canadienne
sur le VIH/sida
La prévention



Health
Canada

Santé
Canada

Final Report July 17, 1999 AIDS Impact Conference

Prepared by Blue Moon Consulting

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Introduction

In 1986, during the World AIDS Conference in Vancouver, British Columbia, the first ever Indigenous People's Forum was held, drawing delegates from all over to discuss the affect of HIV/AIDS on the world's Indigenous populations. In 1996, a bid on behalf of the Canadian Aboriginal AIDS Network (CAAN) to hold another Indigenous People's Forum at the Geneva World AIDS Conference failed, partially due to lack of funding and limited time lines. However, in CAAN's operational proposal and work-plan for Non-Governmental Organization (NGO) funds from the Canadian Government, a clear need to investigate another international gathering was highlighted and approved. In 1997, CAAN representatives attended a small forum at the Human Right's Commission Of Canada, where the special needs of Indigenous people's in Mexico, South Africa and Canada were being discussed. Again, it became clear that the needs and issues of Aboriginal people in Canada and of those Indigenous people's in other countries were both similar to each other and different from their colonizing populations. Yet it was not until 1999, during the planning of the 4th International AIDS Impact Conference, that CAAN was approached by Health Canada to facilitate another Indigenous people's forum as an official satellite to the larger conference being held in Ottawa, Canada.



AIDS Impact

This AIDS Impact International Conference is the fourth of its kind to be held in the past eight years. This four-day conference allows professionals, volunteers and people living with HIV/AIDS to gather and explore the biological, psychological and social aspects of HIV infection. Over the past eight years AIDS Impact conferences have been held in Amsterdam, Brighton (England) and Melbourne (Australia). These international conferences have provided an excellent opportunity for individuals from different disciplines to engage in dialogue about HIV disease. Hosted on this occasion by the Canadian Psychological Association (CPA), over one hundred workshops ranged from the psychological effects of HIV/AIDS medication to poetry readings and the effects of AIDS on children. For more information on the next AIDS Impact Conference, or the proceedings and final report of this past, contact The Canadian Psychological Association at (613) 237-2144.



Indigenous People's Forum

Hands Across the World

The Indigenous People's forum was an official satellite to the AIDS Impact Conference, and was held in Confederation Room One of the Westin Hotel in Ottawa on July 17th, 1999. Bringing together over 135 participants and those interested in Aboriginal AIDS issues for a full day of International presentations and discussion, the theme of the forum was *Hands Across The World*, an attempt to symbolize the unity of Aboriginal people regardless of the country of origin. The goal of the forum was to examine the struggle against HIV/AIDS by Indigenous peoples in an international context.



Canadian Aboriginal AIDS Network Executive Summary

As Canada's only national Aboriginal AIDS organization, the Canadian Aboriginal AIDS Network is a nonprofit organization that provides support, advocacy and education to Aboriginal people in Canada affected and infected by HIV/AIDS regardless of where they reside. Since its national incorporation in 1997, CAAN has sponsored and created many national Aboriginal initiatives, including an annual skills building forum, designed to bring Aboriginal people working in the AIDS field across Canada together to share their strength, knowledge and information. In 1997 CAAN sponsored *Joining the Circle: An Aboriginal Harm Reduction Model*, exploring harm reduction methods within an Aboriginal focus. Other projects included a national social marketing and aboriginal needs assessment, national community discussions on Canadian Aboriginal AIDS funding issues, and joint projects and partnerships with Aboriginal and non-Aboriginal organizations in Canada, and the creation, sponsorship and country-wide promotion of an annual National Aboriginal AIDS Awareness Week.

CAAN has long seen a need for international dialogue on HIV/AIDS between the world's Indigenous peoples. *Hosting Hands Across The World* is just one more step in the creation of a communications network between Aboriginal people the world over. By sharing our vision, our knowledge, and the similarities of the progression of the disease among Aboriginal people, we now have one more tool in fighting HIV/AIDS within our diverse communities. It is our hope that the international dialogue that was created at the Indigenous People's Forum will continue. We hope to see more Indigenous People's Forums on HIV/AIDS, especially at the next World AIDS Conference in Durban, South Africa in the year 2000.



Indigenous People's Forum Planning and Acknowledgments

Since the funding for the AIDS IMPACT Indigenous Peoples Forum was approved by Health Canada in May of 1999, many individuals and committee's were responsible for getting the project off the ground. The Canadian Aboriginal AIDS Network (CAAN) organized all the initial planning for the conference, assembled a steering committee to provide vision and direction, and hired two consultants from Blue Moon Consulting, a firm based in Ottawa, to organize the logistics of the conference. The members of the steering committee were:

Sandra Greene	Executive Director, CAAN.
Renée Masching	Vice Chair, CAAN and Executive Director, Atlantic First Nation AIDS Task Force.
Darcy Albert	Chair, CAAN and Executive Director, Two-Spirited People of the First Nation.
Jeff Dodds	Health Promotions and Programs Branch, Health Canada.
Lyse Bolanos	Medical Services Branch, Health Canada.
Darren Greer	Indigenous Peoples Forum Coordinator, Blue Moon Consulting.
Kim Thomas	Indigenous Peoples Forum Coordinator, Blue Moon Consulting.

The Steering Committee met throughout May and June to choose the theme for the conference, the location and settle on the international representatives that would be presenting. A terms of reference was developed and utilized. The Canadian Aboriginal AIDS Network staff and Blue Moon Consulting then put the Steering Committee's plan into action.

The Canadian Aboriginal AIDS Network would like to thank the Canadian Psychological Association for their help and support during the planning of this forum. The organizers of the larger AIDS Impact Conference worked closely with CAAN staff and the Indigenous Peoples Forum coordinators to make sure that the forum was a success. In particular, we would like to thank John Service, Executive Director of CPA, and Bill Coleman, the president of the AIDS Impact Planning Committee, without whom this forum could not have happened. Also, thanks to the Indigenous Peoples Forum staff, Bernie Rourke, for her hard work and dedication in the office over three months and Cindy Ashkewe and Jacky Struyk for additional office support, and Jake Linklater for impeccable visions and countless support. Last thanks to the CAAN board members (Listed in Appendix D.)



Process Of Scholarships

Along with the funding for the forum, CAAN was also given money to bring to the event a number of Aboriginal people infected and affected by HIV/AIDS in Canada. Criteria for scholarships was developed by CAAN and the steering committee and scholarship forms were faxed out to every Aboriginal agency in the country. Deadline for scholarship application was June 25th, 1999. 39 people were accepted on full scholarships, 8 people on partial, and 13 had registration covered. The total attendance at the forum, not including the four international presenters, numbered at 127. (For a complete participant list, see Appendix C) In addition, there were many last minute registrations, by those in other countries who had received an information package in their native countries and registered before the forum. For more information on scholarships to future CAAN events, (In Canada Only) contact the Canadian Aboriginal AIDS Network at 1-888-285-2226.



Summary Of Proceedings

The forum opened on Saturday Morning at 9:00 AM in the Westin Hotel in Ottawa. Opening ceremonies were conducted by Paul Skanks, a Mohawk elder from Quebec. The opening address was given by Sandra Greene, executive director of the Canadian Aboriginal AIDS Network, who also served as the days Master Of Ceremonies. After the opening address, Ms. Greene introduced the panelists, each of whom spoke for a half an hour followed by question and answer periods. In the morning the Canadian And Australian Presenters officiated, and the Mexican and American in the afternoon. The forum was closed by the elder.

As part of the larger AIDS Impact conference, and evening feast was held in the Westin Hotel, hosted by the Canadian Aboriginal AIDS Network and featuring Aboriginal entertainment, included the Young Eagle Women Drum Group and Dancers, Inuit throat singers and mask dancers, Sabor Tropical, a Mayan Dance Troupe, and Laura Langstaff, a Métis singer/songwriter. The keynote address was given by Tomson Highway, internationally renowned novelist and playwright. Mr. Highway drew fascinating and enlightening comparisons between Aboriginal and Christian Creation stories, and the resultant clash between these two ancient mythologies in the context of European colonization of the Americas. Over 400 people from the Indigenous Peoples Forum and AIDS Impact attended this dinner. Special thanks to Jake Linklater for organizing such a wonderful and entertaining event. Also thanks to Renée Masching and Gary Carbonnell, for introducing the entertainers and evening speakers.



International Panelists

Debra Ann Reid -Tasmania

As the Chair of the Indigenous Sexual Health Working Party Deb has been responsible for the implementation stage of the National Indigenous Australians' Sexual Health Strategy 1996-97 to 1998-99. She was a committee member of the working party during the strategies development and has worked as an educator on the issues of HIV/AIDS and sexually transmitted diseases as well as a counselor in Tasmania and Australia.

Ms. Amaranta Gomez Xuchitan in Oaxaca state (Mexico).

Ms. Gomez works with the "Frente de Lucha Contra el SIDA de Oaxaca", an Non-Governmental Organization, working with her own Zapotec peoples in Juchitan in Oaxaca state. Mrs. Gomez is an HIV/AIDS educator and a Muxe.

Ron Rowell U.S. A

Mr Rowell is a citizen of the Choctaw Nation of Oklahoma, and is of Choctaw, Kaskastia and Chickasaw descent. He received his master's degree in public health from the University of California at Berkeley in 1978. He is the founder and current Executive Director of the National Native American AIDS Prevention Center, Oakland, California. His previous public health experience includes health planning, refugee resettlement, and managing the HIV antibody testing program at the San Francisco Department of Health. He is Chairman of the board of directors of the Friendship House Association of American Indians, San Francisco, and a member of the board of the United Indian Nations Community Development Council in Oakland. He also serves on the Public Policy Committee of AIDS

Action Council in Washington, D.C., the editorial advisory committee of *AIDS In The World*, Harvard University, and on the editorial board of *Current Issues In Public Health*. He is the past national caucus member of the Woodcraft Circle of Native Writers.

Darcy Albert - Canada

Chair of the Canadian Aboriginal AIDS Network and Executive Director of Two-Spirited People of the First Nations, Mr. Albert has been at the forefront of the national Aboriginal AIDS movement in Canada for many years. He is one of the co-founders of CAAN. He is also an HIV/AIDS educator, working with infected and affected Aboriginal two-spirited people in Toronto, Ontario. He also serves on the Aboriginal Working Group for the Canadian Laboratory Center for Disease Control, and on many other Aboriginal boards and committees.

Australia

PREPARED AND PRESENTED BY
DEBRA-ANN REID, CHAIR
INDIGENOUS SEXUAL HEALTH WORKING PARTY

This paper will look at Aboriginal and Torres Strait Islander needs in HIV/AIDS and how these needs are being addressed in Australia. It looks at what happened in the past in Australia and how change has come about for the future.

The Past

Over the last eleven years Australia has had three national HIV/AIDS strategies. Within the first and second strategies, Aboriginal and Torres Strait Islanders were identified as a Special Needs Group.

In the first strategy from 1989-90 to 1992-93, Aboriginal and Torres Strait Islander organizations were able to access Commonwealth Government funding to work in their communities offering programs about HIV/AIDS. These programs were:

- Education for Prevention, Treatment, Care and Support
- Support for Positive People
- Support for Injecting Drug Users (IDU)
- Support for Women
- Theatre/Concert Productions
- Training
- Media in HIV/AIDS
- Streetwise Comics
- Research
- Literature

An evaluation of these programs was conducted in August of 1995. This came at the time when the second National Strategy Commonwealth Government advisory body the Australian National Council on AIDS, was looking at establishing a Working Party on Indigenous Australians' Sexual Health.

The review was to be one of the processes of gathering information to assist the Working Party in looking at developing a Strategy for

Indigenous Australians' Sexual Health.

In the second national HIV/AIDS strategy 1993-94 to 1995-96, Aboriginal and Torres Strait Islander communities focused on education and prevention programs about HIV/AIDS, with a broader sexual health context. The Commonwealth Government funding process involved the funds going to the States and Territories to disseminate to Aboriginal and Torres Strait Islander community organizations.

During the second national HIV/AIDS strategy the Australian National Council on AIDS (ANCA), which was the principle advisory body to the Commonwealth Government in Australia on HIV/AIDS, was concerned about the growing problems in the sexual health of Aboriginal and Torres Strait Islander people.

The outcome of that concern was for ANCA to convene a forum of Aboriginal and Torres Strait Islanders and other workers involved in working with and for Aboriginal and Torres Strait Islander people or organizations. This forum was held in Alice Springs, with the establishment of the ANCA Working Party on Indigenous Sexual Health being one of its outcomes.

The Change

The Working Party had the responsibility of developing a Strategy for HIV/AIDS or Sexual Health, for Aboriginal and Torres Strait Islanders that would be owned and accepted by them. The Strategy was developed by using many varied processes to ensure input from Aboriginal and Torres Strait Islander people, but also from non-Aboriginal groups within Australia working in the area of HIV/AIDS.

The Strategy was developed through some 54 consultations across Australia in rural, urban and isolated Aboriginal and Torres Strait Islander communities, calling for submissions and drawing on past lessons. The community meetings held during the consultation process were organized and run by working party members. It took about twelve months to develop the Strategy for launch.

In March 1997 the National Indigenous Australians' Sexual Health Strategy 1996-97 to 1998-99, was presented to Dr. Wooldridge,

Australia's Federal Minister of Health. That day Dr. Wooldridge presented the Strategy and the Government's response to Federal Parliament.

At the time of the development of the Strategy the data on HIV/AIDS cases and AIDS related death rates for Aboriginal and Torres Strait Islander people was very limited. The data that was available gave figures of 128 HIV notifications, of that 106 were males and 22 female. The AIDS diagnoses totaled 50, with 44 male and 6 female. The deaths following AIDS have been 34, of that 29 being male and 5 female, this data is from 1985 up to 31 December 1996.

The table of exposure for this data, gives an indication as to whether Aboriginal and Torres Strait Islander people who have been tested are within the following categories of homosexual, bisexual, heterosexual.

The problems with this data is that status of individuals (as to whether people are Aboriginal of Torres Strait Islander) had not been collected in all Australian States or Territories.

Implementing the Change

The Strategy implementation is having to happen in a number of stages. These stages are at the local, state and national level.

The first part of the strategy is implemented at the local level. The implementation of this new Strategy has meant a whole new means of working in the area of HIV/AIDS and Sexually Transmitted Diseases for Aboriginal and Torres Strait Islander organizations. This is due to the Strategy identifying, that the best option for dealing with these issues for Aboriginal and Torres Strait Islander people is through effective primary health care services through their own community based health services.

To say that we changed primary health care services and just left it at that is not how the implementation of the Strategy has happened. It has required that States and Territories identify the most effective and accepted way for primary health service delivery, whether it is through general screening programs or other identified options of providing

services in the area of Sexual Health.

These service changes are also taking into consideration whether people live in urban, rural or isolated areas, as this is a factor in how service provision needs to happen.

The national requirements has brought about an agreement between the National Aboriginal Community Controlled Health Organization and the Australian Federation of AIDS Organizations, in how they can work together in providing services for Aboriginal and Torres Strait Islander people. That agreement had been developed over an eighteen month period and was signed earlier this year (1999).

The training for health workers incorporating a national centre for their skill development has some states and territories assessing what training has happened for sexual health workers, if this is relevant and how it may be further developed. So some states and territories have good training for Aboriginal and Torres Strait Islander worker in sexual health and it is important to recognize this.

Health worker training in general in Australia is going through major changes and this will continue for the next few years. The health worker work force is also under review and experiencing changes in Australia at this time too.

The data development that is need in Australia is going to take time. This is due to ensuring that concerns over individual confidentiality being protected, but also allowing that data can be collected and is used to assist Aboriginal and Torres Strait Islander organizations and other services to plan for future requirements in the area of sexual health.

The treatment, care and support for Aboriginal and Torres Strait Islander HIV positive people was identified within the Strategy, where information was needed for not only Aboriginal and Torres Strait Islander service providers, but for other providers also. This has been addressed through developing a manual to assist any service provider when working with Aboriginals and Torres Strait Islanders. This document will be in services before then end of the year.

There are still a number of areas that have to be addressed under this

Strategy, one of them being Aboriginals and Torres Strait Islander in prisons and the service support they require for sexual health issues.

The Indigenous Australians' Sexual Health Strategy took twelve months to develop, almost twelve months to negotiate a new way of providing sexual services in our country. So, really it has only had twelve months of operation and considering it is a three year Strategy that was to finish at the end of June this year, there is still a long way to go.

The Strategy is about to under go a mid-term review and once that is completed, I would not like to predict the outcome of the review, but it would be hoped that in Australia's next HIV/AIDS Strategy there will be an Indigenous Sexual Health Strategy.

Canada

PREPARED AND PRESENTED BY
DARCY ALBERT, CHAIR
CANADIAN ABORIGINAL AIDS NETWORK

Good morning everyone.

On behalf of the Canadian Aboriginal AIDS Network I would like to take this opportunity to welcome you to the Indigenous Peoples' Forum. This Forum is the result of a collaborative effort between the Canadian Aboriginal AIDS Network and the Planning Committee of AIDS Impact. The theme of the Forum is "Hands Across the World" and is meant to recognize that Indigenous people are present on every continent around the world. Despite the fact that we come from different countries and continents there are many aspects of our lives that are common among us as Indigenous people. The issue of HIV/AIDS is no exception. Issues of discrimination and oppression of our people has significantly impacted our efforts to effectively address the issue of HIV/AIDS in our communities.

Historical Overview

In speaking about the issues of HIV/AIDS from the Canadian Aboriginal perspective we must first provide a historical overview, as our history plays a vital role in our lives today. Since the initial contact of 1492, Aboriginal people in this country have seen the loss of their livelihood, land, culture and language to name a few.

The most significant effects on Aboriginal people have been the result of legislation that has been imposed on us as early as the Royal Proclamation of October 7, 1763. This proclamation defined an area referred to as "Indian Territory". As early as 1850 the settlers began entering into treaties between the federal government and the Indian people. This was the beginning of the slippery slope of diminishing Indian powers of self-determination, and rights to lands and resources. For much of the history, the constitutional law was not concerned about whether a piece of legislation might visit vicious, corrupt or hurtful acts upon citizens, but whether it was Parliament or a provincial legislature that had the power to do it.

The late 1800's and early 1900's saw the most rapid development of legislation that continued to diminish the rights and title of land of the

Indian people. The post-Confederation numbered treaties were very similar to each other in taking cessions of Aboriginal title, promising reserves in proportion to population – generally one square mile per family of five – small annuities, the continued exercise of hunting, fishing and trapping rights, ammunition, fishing twine, farm implements and other goods and services.

From the time preceding the Royal Proclamation to the present day, the issue of Aboriginal land claims has never gone away. In addition to the fundamental question of Aboriginal title, First Nations lodged regular complaints about Crown management of their lands and assets and infringements of their Treaty rights. However, Aboriginal title was tenuous. Knowing that roughly half of Canada was not within any Treaty area, the courts were loath to acknowledge Aboriginal title, unless, as part of the decision, there was also a finding that it had been extinguished. It might be said that the courts favour the view that Aboriginal title is a political issue more than a legal one. Today, this view of political versus legal or political versus social, perpetuates itself where Aboriginal people are concerned.

Complicating every aspect of legislation was the Indian Act, which contradicted previous pieces of legislation and created imaginary boundaries and jurisdictions. Treaties and reserves and the confinement of Indian people was the beginning of the paternalistic view of the government towards Indian people that would lead to the dependence on government which continues to exist today for many communities. Today there are some 633 First Nations across Canada represented by the Assembly of First Nations.

Government Intervention

The results of legislative processes began to affect Aboriginal people and communities in terms of their livelihood and world view. The most significant and devastating government intervention was the development of the residential school system. Indian children were taken from their families and communities and put into schools run by ministers, priests and nuns. Forbidden to speak their language, they were forced to learn the teachings of these foreign churches while enduring the abuses imposed by the priests and nuns that should have been at least physically protecting them if not protecting their rights. In residential schools the boys and girls were segregated from each other. Having missed the adolescent opportunities of role modeling between the sexes, this generation lost the opportunity of relationship

development skills and this is linked to the inability of some Aboriginal women to negotiate safer sex today. The Catholic Church takes stances that promote homophobia and support the idea of sexually subservient women. The high incidence of sexual violence experienced by Aboriginal women and children is an additional indicator of the general social and health conditions that exist in some Aboriginal communities today. The role of government through the implementation of residential schools can be directly linked with the increase of sexual violence in our communities and the origins of generations of victims of physical and sexual abuse. Every Aboriginal person alive today has been impacted by the residential school system.

The injustices towards Aboriginal people continued over the years. Aboriginal men were drafted to fight in both the 1st and 2nd World War and many Aboriginal lives were lost. Those who survived returned only to be treated as second class citizens. Indeed, women were granted the right to vote in federal elections before Aboriginal people were, and it took bringing a legal battle to the Supreme Court of Canada to eliminate the discriminatory sections of the Indian Act. That historical landmark case dates back to 1850 with the first statute to define Indian status, at the time the intent of the statute was to determine who could use and occupy reserve lands. Until 1985, all versions of the Indian Act provided that, upon marriage, an Indian man conferred status on his non-Indian wife, while the Indian bride of a non-Indian man lost her status. This provision was challenged as discriminatory under the Canadian Bill of Rights, a federal statute enacted in the 1960's and since largely eclipsed by the 1982 Canadian Charter of Rights and Freedoms. In April 1985 Bill C-31 came into effect and not only ended any status consequences of marriage (no gain, no loss) but also restored status to those who had previously lost it and their children. The number of individuals entitled to Indian status and Band membership was greatly underestimated. The result was a major change in the demographics of some Indian communities, in some cases more than doubling the membership rolls. This is significant as prior to Bill C-31, about 40% of Band members lived off-reserve; after Bill C-31 increased the membership, the figure became 60%. As status Indians are deemed the responsibility of the federal government and health dollar transfers from the government are based on the number of registered Band members, this has created an inequity of resources based simply on jurisdiction.

In Canada, a division of Health Canada is Medical Services Branch which provides resources for health services for those living on

reserve, however, with the majority of status Indians living off-reserve, inequity exists. In the case of HIV/AIDS this is particularly important as due to homophobia and AIDSphobia most Aboriginal people living with HIV/AIDS go to large urban centers where programs and services are located and the discriminatory attitudes of small reserves can be avoided. As the Executive Director of 2-Spirited People of the 1st Nations, the largest Aboriginal AIDS Service Organization in the country, I see this every day.

The question of Aboriginal and Treaty rights must be addressed differently for Inuit and Métis people. They have no historical treaties and there has not been any regulation of their entitlement to Aboriginal status. This is a constitutional, not a statutory, issue. Recently the government of Canada recognized the new territory of Nunavut.

The Epidemic

In recent years, the HIV/AIDS epidemic among Aboriginal people in Canada has been better described. For years, ethnicity was lacking in approximately 45% of the reported AIDS cases. The unknown ethnicity is now about 20 - 25%. As of December 31, 1998 a total of 321 AIDS cases reported were indicated as Aboriginal. Of these cases 263 were male and 58 were female. The Adult Aboriginal AIDS cases attributed to any IDU category has dramatically increased between 1989 to and during 1994-98. However, two-spirited (gay) men continue to represent the largest number of reported Aboriginal AIDS cases representing 57.4% of cases. To date 2-Spirited People of the 1st Nations have seen the loss of approximately 40% of its membership to AIDS. These people include members who were gifted in the performing arts and notable contributions to the AIDS movement.

Aboriginal AIDS Service Organizations began to mobilize during the late 1980's, and as a result many organizations and programs missed out on opportunities for operational funding. There is only one stand alone or prominent Aboriginal AIDS Organization in each of the regions or provinces that works specifically on HIV/AIDS with Aboriginal people and communities.

Issues in the Community

The issues specific to the Aboriginal community in Canada are in

many ways related to the demographics. Approximately 50% of the Aboriginal population is under the age of 25 with the status Indian population expected to grow at a rate of 2.3% on reserves and 2.4% off reserves over the next five years. Aboriginal people and communities are particularly vulnerable to the many issues which the HIV/AIDS epidemic challenges us with. Statistically, the rate of teenage pregnancies and sexually transmitted diseases among Aboriginal people is larger than that of the national average as a whole.

Substance abuse is linked to the spread of HIV by impairing judgement, leaving an individual more vulnerable to engage in unsafe practices. If we are to succeed in our attempts to stop or hinder the spread of HIV/AIDS in our communities, our programs and services must adopt a harm reduction approach. Access to clean needles, alcohol swabs, bleach kits, condoms, health care, support and treatment are necessities not privileges. We have the right to have accessible to us the means to protect our lives and our health as any other citizen of this country.

There are a number of issues which pertain to the Aboriginal community and these issues require specific attention. For example, Aboriginal people are vastly over represented within the prison system in our country. In the prairie region Aboriginal people account for approximately 2% of the population, however they represent approximately 35% of the incarcerated population. The prison system in its own uniqueness, is an institution which promotes the spread of HIV/AIDS through drug use, consensual and non-consensual sex, as well as tattooing and body piercing. The spread of HIV/AIDS is further promoted by the passive views of Corrections Canada to make available to the prison population the means to engage in these activities in ways that will reduce the spread on the virus.

The overall health of Aboriginal people is generally poor by comparison to the mainstream population. Poor sanitation, contaminated water, poor nutrition, and multi-generations of families in one sub-standard dwelling are factors which influence the health status of Aboriginal people. We need to re-examine and participate actively in anti-poverty work to promote conditions which improve our overall quality of life.

One of the largest barriers which must be overcome in addressing the issue of HIV/AIDS in our communities is the dinosaur of jurisdiction.

HIV/AIDS knows no boundaries, therefore we need to strategize to work around these false boundaries that are imposed on us by government which has only lead to divisions and negative feelings. We need to work together and overcome the divide and conquer tactics which have been perpetuated by policy and government legislation. Legislation of provincial, federal and municipal governments must be addressed if we are to effectively combat this epidemic. We must feel free to move between our reserves and urban settings and still maintain the right to adequate education, information, care and treatment in our respective communities. We must come together as, on reserve, rural and urban representatives, to collectively develop a National Aboriginal HIV/AIDS Strategy for all Aboriginal people. The Canadian Aboriginal AIDS Network is committed to taking the lead role in its development.

The Canadian Aboriginal AIDS Network

Speaking of the Canadian Aboriginal AIDS Network I would like to take this opportunity to give a brief overview of our existence. In 1991 a group Aboriginal people living with HIV/AIDS convened in Vancouver to discuss issues and concerns relevant to them. The result of the day meeting was a list of some 80 recommendations. The following year a group convened again and began what was initially called the National Aboriginal People Living with HIV/AIDS Network known then as NAPHAN. With no funds or infrastructure the Network was only a loosely organized group of individuals. Through lobbying efforts with their local Aboriginal AIDS Service Organizations proposals for gatherings, meetings and conferences began. In 1996 the group renamed itself the Canadian Aboriginal AIDS Network known as CAAN which incorporated in March 1997. In 1998/99 CAAN was recognized by Health Canada as a national organization and we received our first year of operational funding under the new Canadian Strategy on HIV/AIDS.

Forums and similar projects that have national or international impacts on our communities are only part of CAAN's work. This is our second international forum, the first was a Satellite that coincided with the International AIDS Conference in Vancouver, Canada in July 1996. Although our initial contact with the International AIDS Conference to take place in the 2000 was turned down we are hoping that we may convene some kind of forum in hopes of having an opportunity for the Indigenous delegates to meet and share experiences and information.

United States of America

PREPARED AND PRESENTED BY
RONALD ROWELL, EXECUTIVE DIRECTOR
NATIONAL NATIVE AMERICAN AIDS PREVENTION CENTRE

Greetings, I am from the Choctaw Nation from the area that is now Mississippi, my people were removed from their homelands and relocated to what is now known as the State of Oklahoma. We have survived all of that into the 21st century and I am proud to come here today as a Choctaw.

History of HIV/AIDS

In the United States there are over 500 federally recognized tribes. We have our own federal bureaucracy as you do in Canada for our tribes. States have their own sovereignty so there are agreements with them individually as well. There are now just over 2 million people who self-report as American Indian or Alaskan Native. Of that about 22% live on reservations or trust lands. Over 60% of the population is now urban. This has happened over the last 30 or 40 years and Indian health policy has yet to catch up with that and this has a big impact on how we deal with the AIDS epidemic. Half of the population lives west of the Mississippi River, 39% are under the age of 20 (vs 20% of over all population), this is because of higher fertility rates. Our median income is 38% lower than the national average, 31% of American Indian/Alaskan Native people live in poverty (compare to 13% in rest of the country). The other fact is that Native American health status is lower on every other health indicator measured for the rest of the country. Of the top 10 causes of deaths 4 can directly and 6 indirectly (arguably) can be related to substance abuse.

As of the 31st December 1998 there was 1,940 case of AIDS in the American Indian/Alaskan Native population, that was a growth from the previous year of 8.8%. Of these cases males made up 83.4%, and females 16.6%. We also have begun tracking HIV infection in the states. This is done differently in each state. In the 29 states that do report, males make up 73% of new infections.

AIDS cases show us how things were 10 years ago. HIV infection gives us a more current picture of where things are going and we are seeing that more women are becoming infected by HIV. The

epidemic is spreading. Every single age group in the native community have been reported with AIDS.

The Indian Health Service prints annual reports using records of death and other information taken from populations living on or near reservations. AIDS is now the 8th leading cause of death for all American Indian/Alaskan Native people age 15 to 24 living on or near a reserve. It is now the 7th leading cause of death for those age 25 to 34 in American Indian/Alaskan Native population living on or near a reserve. If this is the case on reserve you can probably imagine what it is like in the urban areas.

Two Epidemics

We have two epidemics that are going on. We have an epidemic among gay men (MSMs) and another epidemic among intravenous drug users (IDU), which is how women are primarily getting infected. MSM who also are IDUs make up 3/4 of the AIDS cases in the Indian community. They only make up 63.6% of HIV infections, so the number of gay men is going down in the newer data, heterosexual men are taking their place in the statistics. For women it is not quite so dramatic. Women who use drugs make up 47% of women's AIDS cases and women who have sex with IDUs bring the numbers up to 65%. The HIV data has shown a decrease, but there are still a large number of cases that do not indicate how the woman got infected. The way that we approach dealing with these epidemics has to be different for MSMs and IDUs.

There are limits to the data that I am giving you. First off all AIDS case data is not very useful to us anymore. Since they have come up with new drugs, people who are HIV infected are not going on to be reported as AIDS cases as people with access to these drugs are living longer with HIV. Since only 29 states report HIV rates the data is not complete. It is going to be a few more years before we have access to the information that will give us an idea of what is going on with our people in relation to HIV/AIDS.

Other Problems

We have other problems as well. Recently a survey of tribal health services revealed that most of the tribes are not doing any disease reporting at the federal or state level, which means that there is a great deal of under-reporting of HIV infections and AIDS cases in the

communities.

Information beyond the AIDS data leads us to have concerns as well. Data on sexually transmitted diseases shows that American Indian/Alaskan Native people are the only group where occurrences of gonorrhoea and chlamydia have not gone down in recent years. It leads you to ask why is that, and what is being done to stop that. We also have old data (most recently from 1988) from the Centre for Disease Control.

The AIDS epidemic has uncovered an area that we have not previously recognized as a problem area: Intravenous Drug Use. South of the border you will not find people who will talk about IDU in their communities. Even most of the literature comes from Canada, particularly the work that has been done in Vancouver. Vancouver data showed that 80% of native people were infected from shared needles, and that native people are over-represented in the IDU HIV infected groups. Reports from Washington show that native HIV drug users are more likely to be HIV positive when they come into treatment programs. Drug mortality rates among the American Indian/Alaskan Native population on-reservations is 6 in 100,000 versus 5.1 in 100,000 in national statistics.

For several years we have had a care program at the National Native American AIDS Prevention Centre that has handled case management services for native people dealing with HIV infection in different parts of the country. We kept a database of what kinds of issues these people were facing and 1 in 5 had a history of homelessness. A little over half had a history of drug use, even more with alcohol abuse. These people were having to find their care in public institutions and emergency rooms. A lot of people did not have access to primary care when they got sick.

Information and Understanding

What do we know about American Indian/Alaskan Native people living with HIV/AIDS? Not enough. Searches of published materials on HIV/AIDS revealed very few publications that dealt directly with American Indian/Alaskan Native experiences. We need to understand better what is involved in people taking the risks that they do. We need to get a better handle on the issues of sexual behaviour in this community that we don't have. We need researchers to take off the lab coats and get into a study with regular people and try and apply the

limited resources we have where they are most needed.

We need native researchers in United States and the ability to share with researchers in other places with similar problems, like Canada. We don't have any evaluations of any of the prevention efforts that have gone on before now. We've all been working on this problem for years and we don't have any real evaluation of what works. And that is the first question that needs answering: What works?

There has also been a lack of investment in HIV prevention in the American Indian/Alaskan Native populations on part of the American Government. This has impacted greatly the American Indian/Alaskan Native population, but it is not limited to our people. AIDS spending in the United States is 0.5% of the overall US budget. 71% of that budget is spent on care.

The picture is this:

- We have unreliable AIDS case data,
- We have spotty HIV data,
- We have old STD data,
- We have a surveillance system that has pretty much broken down for the American Indian/Alaskan Native population.

If you want to do any research/programs in the United States you need these numbers. We need a better surveillance system.

Community Response

In terms of the community response there is denial, fear, and true concern. We have a total absence of involvement of Indian substance abuse programs in the United States. Even after this many years it is amazing to see how few people in the substance abuse community are interested and this needs to change.

We have some work that is being done in the Bureau of Indian Affairs Schools (boarding schools). One of things we found out was that average age of first sexual intercourse among children in those schools is 11 or 12, so programs have been developed to address HIV/AIDS with children of this age.

We also have a reluctance to deal with gay men, still. It is frustrating, it may not be different from other populations, but we need to get to the point where we can talk openly about the reality of human sexuality. Without that, I don't think we will ever be at a point where

we can gain a mastery of this disease or others effecting this group.

The Main Issues

We have four issues of public policy that we are working on at the National Native American AIDS Prevention Centre right now.

Fix the surveillance system because it is fundamental to everything else; first in understanding the truth of what is going on as well as getting resources for projects. Community based epidemiology is our goal.

- 1 Through private funding the National Tribal Leaders Education Program has been undertaken to try to convince tribal leaders to start speaking out about this issue.
- 2 We are trying to ensure that American Indian/Alaskan Native people have access to the new HIV drugs for treatment. Access is not guaranteed and the cost is very high (12-13,000 US Dollars per year) and Indian pharmacies cannot afford the cost of providing these drugs. Efforts at the national government level are made to ensure access to these drugs.
- 3 Access to funding for care for people living with AIDS provided through a federal act does not allow specifically for American Indian/Alaskan Native people to receive funding. Federal funding under this act is limited to a research clause that includes American Indian/Alaskan Native peoples and access to further national funding is not being lobbied for by the Indian Health Services itself because the Indian Health Services does not see AIDS as a priority.

Conclusion

How we go about doing this work is just as important as what it is that we do. Self-determination is as applicable to health as it is to anything else. If we don't do it ourselves and include our culture in what we do then we won't be successful. The connections between HIV/AIDS and other health problems must be recognized. One of the paths to our success will be to make people realize that the problem does not exist alone and that behaviour is a part of the problem and the solution.

Mexico

PREPARED AND PRESENTED BY
AMARANTA GOMEZ,
FRENTE COMÚN CONTRA EL SIDA (COMMON FRONT
AGAINST AIDS)

Diuxi squixe latu.
Saca nutu rari, guira xixe bini laanú.
Raguica ti diuxi sti bini ná.
Bini gulaza, bini zaa.

Que Diós les pague por estar aquí.
A todos ustedes, gente nuestra.
Reciban un cordial saludo de mi gente.
Gente que dispersó la danza, mi gente zapoteca.

Good afternoon.

My name is Amaranta Gomez and I am here with all of you from the country of Mexico, a country rich in culture with a deep pride in its 56 different Indigenous groups, each with its own language, traditions and view of life. Like Indigenous communities throughout Latin America, we live amidst the colours and aromas of nature, with mysticism, magic and the songs of our grandfathers.

In the forests of the southern part of Mexico, lies the state of Oaxaca, one of the largest, most populous, poorest and most ethnically diverse in the country. Amongst the coastal plains of the Pacific Ocean, the mountain of the Sierras, the deserts of the Mixteca and the exuberent vegetation of the Isthmus, are spread the state's seven regions: la Costa, la Sierra, el Papaloapan, la Mixteca, la Cañada, los Valles Centrales and, my land, el Istmo de Tehuantepec.

I am Zapotec of the Isthmus and I live in the cultural capital of the Isthmus, a city of 80,000 inhabitants called Juchitán de Zaragoza. It is a culture with an ancient history, the language is Zapotec of the Isthmus and it is rich in its customs, its fiesta, its prehispanic cuisine, its flowers, but most for the impressive presence of its women. In addition, it is a society of acceptance and sexual tolerance.

In my home, my mother of 48 years of age, is the female creator of the family. Too, there is my father, a professor of 57 years of age. I have

three sisters, Briseida, Mirna and Rosita, and two brothers, Alejandro and Ulises. All of whom are carried in my heart always and we have a strong bond typical of the Latin American family.

I am the “Muxe” of my family, that is: the feminine son, who will live as a woman, not marry, and stay always with my mother. I have a defined role in my family and my community. And I have the respect of my family and my community. I live with dignity and responsibility within the Zapotec culture.

The Role of the Mother and of the Muxe

I would like to explain briefly a little more about this particular dynamic in this Indigenous society, which I believe has a certain interest for this forum.

Although our society is not strictly classified as ‘matriarchal’ the role of the woman is profoundly important; the mother is the head of the family, in charge of the work, the economic and domestic administrator and the protector of her daughters and sons.

With her daughters, the mother is preparing them to become women. The daughters are separated from male family members and taught the traditions and customs of our culture. The physical virginity of the daughters before marriage is profoundly important in our culture and is guarded jealously by the mother.

With her sons, also, the mother is caretaker, she protects them and teaches them the values of being men and respect for the customs and traditions in respect to the woman.

The Muxe finds herself in a special place within the family and the community, she has the ability to be with both the women and men in the family. With the women, because of her way of life and way of being, and with the men, because she is, biologically, a man, and for her sexual preference.

The Muxe plays an essential role in my culture, actively participating in the traditional fiestas, in the family economy and in all activities of daily life: the Church mass, the parties, funerals, the work, the politics and certainly, the sexuality of the community.

The mother does not permit her daughters to be with the boys, but the

Muxe is allowed to be and to play with the boys. As you can all imagine, the Muxes offer the great majority of young males their first sexual experience.

This dynamic which exists in the family is part of our culture, accepted and respected as part of the general sexual tolerance in our community. Throughout the centuries, the Muxe has played a fundamental role in protecting the virginity of young girls before marriage and in preventing unwanted pregnancies. Till now, this dynamic has functioned to the benefit of society, a reflection of the general harmony in my land.

Today there is a new situation.

I refer to the presence of a virus; a virus which knows nothing about the dynamics of my community, nothing about gender, nothing about sexual tolerance, and even less about the Muxe.

The New Situation

The course of the HIV/AIDS epidemic in my Indigenous community has been profoundly affected by the dynamics of our culture. That is, in Juchitán, the way of life and sexual practices has contributed to the dramatic increase in cases of HIV/AIDS.

What are we to do in facing this situation?

The presence of HIV/AIDS in our Indigenous communities threatens to tear apart our customs and traditions, destroying the beauty and tranquillity of our way of life.

But, I want to say, today, we can change the course of the disease, not changing our culture but changing our hearts. The first step in facing this phenomenon is to begin with a positive attitude.

Respect for our brothers and sisters, the right to be different, tolerance and acceptance should be a part of all our Indigenous cultures. It is not our aim to destroy the customs and traditions that are so important in our societies. On the contrary, we would destroy prejudice, homophobia, intolerance and the stigmatization of HIV/AIDS, which should have NO part in any culture!

There are no Obstacles

This week we have been talking a lot about the obstacles which we face as Indigenous peoples: the marginalization, the poverty, the lack of social and health services and the indifference which the authorities have shown to our situation. And it is true; as always, the Indigenous community receives less funding, suffers more the effects of poverty and feels the very real racism which exists in all parts of the world.

But I prefer to say today, there are no obstacles in the fights against AIDS in our lives. Each one of us can change, we can make a difference in the course of this disease. The change takes place in each of our hearts.

We can, each one of us, respect the rights of others, we can destroy the homophobia in our lives, the intolerance and the stigmatization of HIV/AIDS in our minds. And we can make these changes in our own hearts, in our families, in our Indigenous communities.

Gunaxhii Guendanabani

In my city of Juchitán de Zaragoza, we have formed a group called “Gunaxhii Guendanabani” which means Love of Life in the Zapotec language. We are trying to open the debate about HIV/AIDS within the different elements which make up our community: women, men, young people, children, and, certainly, the Muxes.

Last year we produced a didactic drag show about AIDS and AIDS prevention entitled “Those Intrepid Against AIDS” and we toured to 11 cities in the state of Oaxaca. The aim was to change attitudes through theatre sketches in the Zapotec language. The show reflected inclusion, not exclusion, tolerance, not intolerance. Within the work that we presented, we displayed self-esteem, dignity, the right to be different and live as we are, to build a culture of AIDS prevention.

It was a message of love, respect, tolerance and reciprocity, emphasizing the participation of all sectors of society. Not once, in any of the cities, did we encounter homophobia or rejection by the people. In each city we performed in the principle auditorium, introduced by the wives of the mayors of the cities and with the support of the municipal governments. It was, for our group, very moving to see acceptance of our work and of our message which could actually be saving the lives of our youthful audience.

The tour ended in 1999 in the city of Ixtaltepec, through the generous help of the Pan-American Health Organization of the UN and its representative in Mexico, Jose Romero, and with a grand success in the South of Mexico. It gives me great pleasure to announce that the people of Oaxaca are anxiously awaiting “Those Intrepid Against AIDS - II.”

Additionally, there are in the state of Oaxaca some six other groups in various cities working in their own projects and collaborating with each other. We are currently seeking community leaders in those cities which have not yet begun movement in AIDS work to begin actions with them which, we believe, are extremely important.

AIDS Strategies in Oaxaca are diverse; for example, we recently opened the first condom store in the South of Mexico.

I would like to take this opportunity to invite each of you to visit our beautiful state, with her white beaches, soaring mountains and ancient cities. To know her villages, her people and to see and understand the work that we are doing. Our state is not exactly Paradise, and our work is not done. For it is a continuing process of changing attitudes about AIDS prevention.

We are conscious that Juchitán is not you cities, and none of the Indigenous cultures are exactly alike, but in the fight against AIDS we are bothers and sisters on this planet. In the respect for different sexual orientations, we are equals. In dignity and acceptance, we are equals. In the sexual tolerance, we must be equals.

What Do We Want?

Why is it so important for our Indigenous communities to si change our attitudes? I believe the answer can be found in these other questions.

What type of world do we wish to make for our communities? What kind of society do we wish for our children?

A society of fear? . . . Of lies, of myths, without information, of death?
. . . A society that rejects the desires and emotions of our young people?
. . . A society closed to scientific information, to the future, a society without compassion?

Or do we wish for our children to grow in love? . . . In protection, in dignity, with intelligence, with security in their own Indigenous community?

We want and we envision an Indigenous society which says “Welcome to life, young persons. Feel good, young people, in yourselves, in your sexual preference, in your protection against this deadly virus.”

We envision a society which says “Feel proud, young man, that your Indigenous community has responded to the AIDS epidemic with vision, with openness, with responsibility, with love and with the full respect for our own customs and traditions.”

This is the message that I bring today from Juchitán, City of Flowers in the South of Mexico. this is the universal message which the Muxes of Juchitán offer today.

We are all human beings; we all have the potential to make these changes in our own hearts, in our own families and in our own communities. We all hold in our hands the power to save lives and change the course of the disease in the Indigenous society, . . . and in the World.

Thank-you.

Projects in the fight Against AIDS in Oaxaca

The state of Oaxaca in the South of Mexico is one of the largest, most populated, poorest and most ethnically diverse in the country. The land of the Oaxaqueños is made up of ocean beaches, mountains of the Sierra, deserts of the Mixteca and the jungles of the Isthmus of Tehuantepec. In addition, the Human Immunodeficiency Virus has come to the state and groups have formed to combat it. The fight against AIDS, after seven years, is positive, intelligent, strong and can provide a model for other areas in Latin America.

The Non Governmental Organizations (NGOs) which comprise the backbone of this fight are Gunaxhii Guendanabani (Love for Life) in the city of Juchitán, TEVOSIDA (Tehuano Against AIDS) in Tehuantepec, Costa Unida el Sida (Coast United Against AIDS) in Puerto Escondido, and the Frente Común Contra el SIDA (Common Front Against AIDS) in the capital city of Oaxaca. the following projects (in Canadian dollars) are among the most important in the area and are urgently seeking funding.

1. Promotion of “Safe Sex Imagery of the Isthmus”

This project is a collaboration between Gunaxhii Guendanabani, its sister organization, the gay collective Binni Laanu (Our People) and the nearby group, TEVOSIDA. Using images such as the red ribbon, the condom, the heart and the famous flowers of the Isthmus on billboards, posters, and T-shirts with a message of love with protection. It is actually a simple project which has the broad support of young people, families and the general population. The modest budget will cover paint, rental of billboards and other materials so that the volunteers can execute this fine project.

\$7,000.00

2. AIDS Clinic on the Coast

The group Costa Unida Contra el Sida is located in the middle of the long Southern Pacific Coast and offers the only patient attention over a large area. The offices of the group and the small clinic are located some distance from the port city of Puerto Escondido and are quite inadequate for the growing number of persons seeking attention.

It is urgent that a new, centrally located space be found, that the work of Dr. Alejandra Santaella, head of the organization, be strengthened. This budget is designed to cover one year of that clinic.

\$15,000.00

3. **“Las Intrepidas Contra el SIDA”**

In 1997, a didactic drag show by the group Gunaxhii Guendanabani, entitled “Those Intrepid Against AIDS” toured 11 cities in the state of Oaxaca, with a strong and positive message about AIDS, prevention, safe sex and the sexual tolerance which is a key factor in the daily life of the Isthmus of Tehuantepec. Through an hilarious and absurd plot line filled with popular music and “can-can” dances, the young audiences which attended in great numbers were informed how to live and love in this, the second decade of AIDS and, ultimately, gained a higher respect for persons of different sexual orientation.

This year the Oaxacan population is anxiously awaiting “Those Intrepid Against AIDS – II.” The mounting of this show is labourious and costly; however, judging by the enormous success of the previous version, it will be time and money well spent. This group continues to save lives in its state.

\$25,000.00

4. **AIDS Education in the Schools**

Each of the groups of the state with work in HIV/AIDS has a priority to educate and inform its young people in the protection and prevention against AIDS. They are offering AIDS talks in the schools directed at the final year of elementary school and up. These talks cover what is HIV/AIDS, modes of transmission, prevention methods and the myths and falsehoods of AIDS. The State Public Education Department has approved of the talk and has opened its classrooms with much enthusiasm to the various groups in the state. It costs around \$15.00 to send a talk into the schools and the groups are hoping to send between 1,000 (\$15,000) and 3,000 (\$45,000) talks this year. This work is considered of the utmost importance and vital for our youthful population.

\$15,000 to \$45,000

5. **“Búsqueda de Líderes – a Search for Leaders”**

The current largest project in Oaxaca is a collaboration among all the

groups of the state entitled “A Search for Leaders”, which attempts to identify those largest cities in the state which do not yet have a movement against HIV/AIDS in their communities, use the many state-wide contact of the groups to solicit invitations and go to those communities. There, meetings will be held and experience will be shared in the hope of starting up new groups in the fight against AIDS. Concrete help will be given to new groups and to the community leaders wishing to join this important movement. The budget covers the first 18 months of the project.

\$60,000.00

The fight against AIDS in Oaxaca is in progress and there is no question it will continue with strength, resources, and the energy of these Non-Governmental Organizations who are truly working to save lives in Southern Mexico.

Evaluation

All participants of the Indigenous Peoples Forum were invited to fill out an evaluation survey. The data collected in these surveys allows the organizers to get a feeling for what went well and where improvements can be made at future gatherings. *Please note: demographic information drawn from these surveys and from registration forms may be found in Appendix A.*

There was a complete consensus on the fact that there is a need for these types of forums where sharing among international Indigenous groups is made possible. This was reflected in the resolution presented to the International AIDS Society and the chair of the XIII International Conference on HIV/AIDS. Delegates of the Indigenous Peoples Forum and other interested parties petitioned these groups to ensure the ongoing inclusion of Indigenous representation on planning committees of international gatherings. With that in mind they specifically requested that provisions be made to ensure that an Indigenous peoples satellite be included in plans for the International AIDS Conference to be held in Durban, South Africa.

What did you like best about the Indigenous Peoples Forum?

- The fact that Indigenous People can come together and shared ideas, processes, successes and pains.
- Diversity!
- It addressed global Indigenous issues and fostered networking.

Many of the participants of the forum were pleased at the opportunity to hear about projects being done in other countries to educate Indigenous populations and to bring communities together in the fight against HIV/AIDS. Others were pleased with the opportunity to network and discuss projects with other groups. Delegates were struck by the similarities of the struggles in different parts of the world and interested in hearing what types of projects work in different parts of the world.

Suggestions for improvement included requests that future forums be spread out over more days. Some of the participants were torn between attending the Indigenous Peoples Forum all day and certain

workshops that were taking place at the AIDS Impact Conference. A frequent request was for future forums to be held in advance of the conference so delegates would be able to take in more presentations at the main conference.

On the whole, participants seemed quite pleased with the Indigenous Peoples Forum. Rating of the forum organization (average= 8.64/10) and the meals/accommodations (average=9.12/10) was high. This level of success could never have been achieved without the efforts of our hard-working volunteers and staff, as many of the delegates noted in their words of thanks.

Attendance

There were several issues that arose in critical analysis of the event and its participation. One of these is the poor attendance at the Indigenous Peoples Forum of those who were brought to Ottawa on scholarship. Estimates show that as many as 30% of the delegates that received a scholarship, full or partial, were absent for part or all of the forum. Many participants were upset that some of those on scholarship came to Ottawa but chose not to attend the forum. In order to ensure that all those being sponsored by CAAN attend the events they have been brought to the conference to attend the forum, the following recommendations are made;

- 1 All scholarship participants sign in on each day the event is being held.
- 2 That per diem cheques for meals and ground transport be given on a daily basis over the course of the event, and require a sign-in by those who are participating.
- 3 That those being considered for scholarship provide reference by a sponsoring organization in their area.
- 4 That the attendance record of the scholarship applicant at events he/she is sponsored for be considered when reviewing the scholarship application.
- 5 That participation in an evaluation be required component for those attending events on scholarship.
6. That attendees brought on scholarship sign a contract that

states that if they do not attend the event or any part of the event they are being sponsored for, without sufficient reason for their absence, that they may be financially responsible for expenses associated with their attendance at the event.

Preparation

Another common concern in the evaluation was that participants were not given enough time to prepare for the event. This is partially due to the nature of the event, which was conceived of and organized only three months prior to the actual event. Participants requested that CAAN give more notice when they organize events of this kind, and that word of the upcoming conferences and forums be circulated in the media at least three (3) months prior to the event.

Language

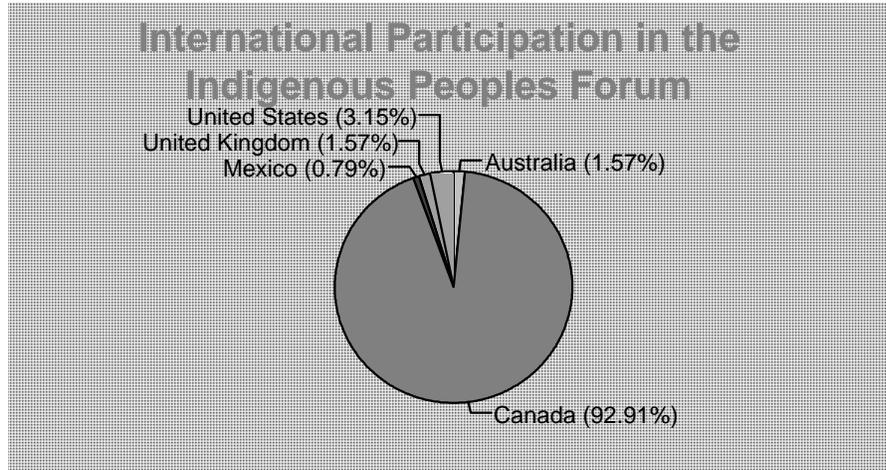
Because the official language of the AIDS Impact Conference was English, it was decided that the Indigenous Peoples Forum would be held in English also, with simultaneous Spanish/English interpretation for Amaranta Gomez who presented in Spanish. Although there were no comments on the evaluation forms about French representation and translation, this may have been because few Francophones attended the forum. In future, because the Canadian Aboriginal AIDS Network serves both English and French Native communities, translation and bi-lingual events must be ensured.

Representation

CAAN was pleased to offer materials of interest to all Canadian Aboriginal groups on their information tables at the AIDS Impact Conference and at the Indigenous Peoples Forum, including a newly produced set of Inuit language AIDS education packages.

Inuit and Métis representation at the forum was low compared to First Nations (See Appendix A). CAAN must provide more linkage with the Inuit and Métis communities to ensure these participation levels rise at future events.

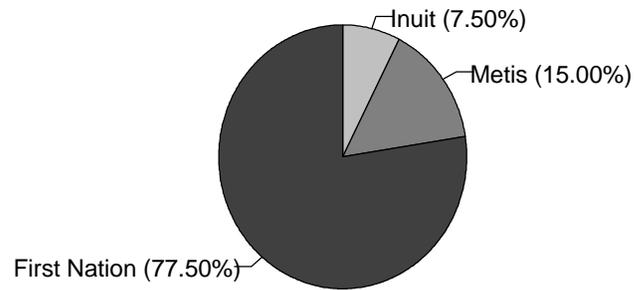
Appendix A: Demographics



Regional Representation of Canadian Delegates at Indigenous Peoples Forum

Province	Percentage
British Columbia	24.58
Alberta	3.39
Saskatchewan	8.47
Manitoba	9.32
Ontario	27.97
Quebec	4.24
New Brunswick	1.69
Nova Scotia	4.24
Newfoundland	4.24
Yukon	2.54
Nunavut	1.69
Northwest Territory	7.64
TOTAL	100.00

First Peoples Representation at Indigenous Peoples Forum



Appendix B: Keywords, Concepts and Acronyms

Aboriginal	Term used to describe all of the Indigenous Peoples of Canada. This include Métis, Inuit and First Nations People.
AIDS	Acquired Immune Deficiency Syndrome
AIDS Impact	International Conference held every two years to discuss the biological, psychological and social aspects of HIV and AIDS.
CAAN	Canadian Aboriginal AIDS Network.
CPA	Canadian Psychological Association
First Nations	First Nations are Indigenous peoples who are recognized and registered under Canada's Indian Act. They are also registered with an Indian Band and include individuals recognized under Bill C-31.
HPPB	Health Promotions and Programs Branch
HIV	Human Immunodeficiency Virus
Indian Act	Legislation of the Canada Federal Government governing the treatment and rights of First Nations in Canada
Indigenous	People considered native to or belonging naturally to a place.
Inuit	Indigenous peoples living in the North West Territories, Nunavut, Northern Quebec and Labrador who are recognized as a distinct Aboriginal group by the Canadian Government.

IDU	Intravenous Drug User
LCDC	Laboratory Centre for Disease Control
Métis	The descendants of inter-married Indigenous people and non-Aboriginal people. They are recognized by the Canadian government as a distinct Aboriginal group.
MSB	Medical Services Branch of Health Canada.
MSM	Men having sex with men.
NGO	Non-Government Organization
NHRDP	National Health Research and Development Program
Off-Reserve/Urban	First Nations People living in non-Reserve settings either by choice or necessity of circumstance.
On-Reserve	First Nations People living on Reserves.
Reserve	Land which is federally recognized as being in First Nations jurisdiction and which the Department of Indian Affairs and Northern Development (DIAND) and Medical Services Branch (MSB) are responsible for providing with education, housing, health and social services.
World AIDS Conference	International Conference held every two year, last one was held in Geneva, Switzerland in 1998. The next World AIDS Conference is to be held in Durban, South Africa. 867-872-2643

Appendix C: Participants

Gary Adkins	Alex Adrien
Darcy Albert	Fred Andersen
Obed Anoe	Alex Archie
Judy Auerbach	Dolan Badger
Maribeth Baxter	Elizabeth Benson
Mary Pia Benuen	Sheila Berry
Wendy Blackmon	Roxanne Boekelder
Bobbie Boland	Lyse Bolanos
Lucille Bruce	Ian Campeau
Gary Carbonnell	Dina Cardinal
Walter Cavalieri	Guy Chenard
Barbara Clifton	Linda Collins
Laura Commanda	Douglas Connors
Tobin Copley	Landi Cunningham
Les Davy	Linda Day
Sue Deranger	Katherine Dinner
Violet Doolittle	Brenda Elias
Duane Etienne	Reepa Evic-Carleton
Arlo Yuzicapi Fayant	Virginia Forsythe
Lynda Francis	Chantil Frank
Joanne Fraser	Winston Gabriel
Paul Gaist	Gail Gavdon
Amaranta Gomez	Douglas Graydon
Sandra Greene	Roda Grey
Kate Griew	Loralie Hamel
May Henderson	Tomson Highway
Brenda Hilliar	Margaret Horn
Alain Houde	Judy Howard
Tamara Hunt	Marty Iqqaqsaq
Larry Johnny	Linda Johnny
Garry Johnson	Helen Johnson
Steve Keewatin	Sandra Ladoucer
Wendy Lameman	Bertha Lennie
Lynne Leonard	Alfred L'Hirondelle
William Lowe	Maurice Malin
Roger Mannilaq	Namaste Marsden
Renée Masching	Marie Mason
Alex McClelland	Elizabeth McDougall
Dorland McKay	Albert McLeod
Connie Merasty	Laverne Monette

Melwyn Morning Bull
Helen B. Murphy
Joanne Mussell-Oppenheim
Anita Nadjiwon
Mai Nguyen
Kevin Paul
Denis Peter
Alana Dawn Phillips
Russel Keith Prince
Debra Ann Reid
Bernard Robinson
Lisa Sappier
David Schneider
Barby Skaling
Jacqueline Smith
Vernon Smith
Clarence Spence
Patty Tait
Alan Tremayne
Cindy Vanderheyden
Schuyler Webster
Sarah Wood
Art Zoccole

Duane Morriseau
Patricia Murphy
Ted Myers
Melvin Nash
Earl Nowgesic
Geraldine Pearce
Irene Peters
Gil Poitras
Alison Rader
Melanie Rivers
Ronald Rowell
Gabe Saulnier
Dorinda Shirey
Paul Skanks
Quinn Smith
Ellen Smith
Earl Sunshine
Laurie Touesnard
Louisa Ukalianuk
Karina Walters
Brenda Wells
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