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GOOD PRACTICES APPROACH

FOR ABORIGINAL ORGANIZATIONS IN CANADA:

INTEGRATION OF STI PREVENTION EDUCATION WITH HIV/AIDS AND ADDICTIONS PROGRAMS

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CANADIAN ABORIGINAL AIDS NETWORK

Overview of the Canadian Aboriginal AIDS Network (CAAN)

- CAAN is a National and not-for-profit organization, established in 1997.
- CAAN represents over 160 member organizations and individuals.
- CAAN provides a National forum for members to express needs and concerns.
- CAAN provides relevant, accurate and up-to-date information on issues facing Aboriginal people living with and affected by HIV/AIDS in Canada.
- CAAN is governed by a twelve member National Board of Directors and operated by a four member Executive.

MISSION STATEMENT

The mission of the Canadian Aboriginal AIDS Network is to provide leadership, support and advocacy for Aboriginal people living with and affected by HIV/AIDS regardless of where they reside.

ACKNOWLEDGEMENTS

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CONTENTS

1. EXECUTIVE SUMMARY

The Canadian Aboriginal AIDS Network (CAAN) has identified a need to address the links between addictions, sexually transmitted infections (STIs), and HIV/AIDS within Canada's Aboriginal population. In *Strengthening Ties – Strengthening Communities: An Aboriginal Strategy on HIV/AIDS in Canada for First Nations, Inuit and Métis People* (2003), CAAN clearly outlines the problem of addictions – including alcohol, injection drug use (IDU) and other substance abuse – that lead to high-risk behaviour for STIs, HIV and Hepatitis C. Personal histories that increase chances that an Aboriginal person will turn to alcohol and/or drugs include: growing up in a violent home, sexual abuse, poverty, loss of loved ones to suicide or violent death. At the root of these personal histories is the history shared by Aboriginal societies in Canada, including for example: loss of culture, the residential school legacy, underdeveloped economies and unemployment, and systemic discrimination and racism.

This present project is a first step toward exploring and addressing the connection between addiction, STIs and HIV/AIDS within the Canadian Aboriginal community. The objective of this project is to provide a framework on which to build a "Best Practice Model" for integrating the prevention and treatment of sexually transmitted infections, into existing HIV/AIDS and Addictions programs and services related to Aboriginal communities in Canada. This is one of seven projects funded under Health Canada's HIV/AIDS Strategy to promote community development in the area of "Best Practice Models for the Integration of HIV Prevention, Care Treatment and Support" (Health Canada 2003).

This report is partly the result of a search and review of the literature, including reports and manuals produced by Aboriginal organizations in Canada. More importantly, this report reflects the opinions and insights of representatives of Aboriginal HIV/AIDS and Addictions service providers. Fifteen representatives attended a weekend focus group seminar at the Odawa Native Friendship Centre (Ottawa) in December 2003. These Addiction and HIV/AIDS front-line workers immediately took ownership of the "best practice model" project, re-moulding it into a "Good Practices Approach" that better reflects their Aboriginal perspectives on cultural and community uniqueness and the need for flexibility in program design.

The scope of this project allows for the "first steps" to be taken toward developing a "Good Practices Approach" appropriate to Aboriginal Addictions and HIV/AIDS organizations in Canada. This report does not provide a comprehensive and complete guide for the integration of STI prevention and treatment into existing programs. Rather, it lays the foundation for future integrated programming, outlining the basic approach and eight principles of practice as advocated by Aboriginal organizations who participated in the project. The eight principles of "good practice" are:

Principle 1. Community-Based Approaches
Principle 2. Holistic Care, Treatment and Support
Principle 3. Community Awareness
Principle 4. High-Risk Group Education and Counselling
Principle 5. STI Screening as HIV Prevention
Principle 6. Harm Reduction for Addictions
Principle 7. Healthy Sexuality
Principle 8. Sustainable Funding, Resources and Advocacy

It is on these foundational principles that CAAN will build its "Good Practices Approach" toward the integration of STI prevention education into HIV/AIDS and Addiction programming for Aboriginal communities in Canada.

This present project is a first step toward exploring and addressing the connection between addiction, STIs and HIV/AIDS within the Canadian Aboriginal community.

2. BACKGROUND: CAAN'S "BEST PRACTICE MODEL" PROJECT

CAAN approached this "best practice model" project by drawing on two main sources of information:

1) A review of literature, reports and programs that aim to integrate STI prevention and treatment with HIV/AIDS and/or addiction care, support and services. A preliminary annotated bibliography was completed in September 2003.
2) Focus group sessions with representatives of Aboriginal organizations in Canada involved in the care and treatment of HIV/AIDS and Addictions (hereafter referred to as the "CAAN Focus Group"). Focus groups were held on December 6-7, 2003 at the Odawa Native Friendship Centre in Ottawa. A summary report of the focus group sessions and a brief "draft framework" report on the "Good Practices Approach" were distributed to all participants in January 2004. Feedback from the CAAN Focus Group on these reports was solicited by teleconference and e-mail, and is incorporated into this report.[1]

The literature and program review was conducted from the following sources:

- Manual and reports produced by Aboriginal AIDS and Addictions organizations;
- Reports on HIV/AIDS by government agencies (eg., Health Canada);
- A review of the mainstream literature (published books, journals, etc.)
- Internet sources such as Aboriginal web-sites, government online sources (eg., Health Canada), online academic databases, etc.

The search was limited mainly to recent material (the past three years or so), to focus on "leading-edge" concepts and practice. An annotated bibliography of relevant references collected during the literature and program review, and cited within the text of this report, is attached as Appendix A.

The academic literature contains little information that is directly relevant to the project's objectives. Few mainstream HIV/AIDS publications document the experience of Aboriginal people in Canada or elsewhere, although there are recurring "best practice" themes in the literature that relate to Aboriginal issues regarding STI and HIV/AIDS prevention and treatment. In contrast, reports and manuals by Canadian Aboriginal organizations offer relevant and supportive documentation for much of what was discussed and concluded by the CAAN Focus Group.

The "best practice" themes identified in the literature review served as general ideas and directions to guide the CAAN Focus Group discussions.

The CAAN Focus Group seminar involved fifteen participants representing thirteen Aboriginal HIV/AIDS and Addictions organizations (listed in Appendix B). The "best practice" themes identified in the literature review served as general ideas and directions to guide the CAAN Focus Group discussions. The approach to the CAAN Focus Group was to refine these themes into principles that applied to specific types of practices appropriate to the integration of STI, HIV/AIDS and Addiction programming in Aboriginal communities in Canada. In the course of the sessions, these principles were prioritized, expanded, and reinterpreted into a "Good Practices Approach."

[1]Quotations which appear in this report are paraphrased from notes taken during the CAAN Focus Group sessions, and from follow-up consultations via e-mail and teleconference.

3. A "GOOD PRACTICES APPROACH"

The CAAN Focus Group rejected the "Best Practice Model" concept, arguing that the "cookie cutter" approach implied by such a model is inappropriate to programming in the variety of unique cultural and situational environments that characterize Aboriginal communities. Instead, participants recommended what came to be called a "Good Practices Approach." In order to give context to participants' objections to the notion of "Best Practice Model," a description of this model is provided below. The rationale for an alternative "Good Practices Approach" follows.

3.1 Objections to "Best Practice Model"

A "Best Practice Model" (BPM) is defined as an ideal but practical approach in which evidence shows that certain ways of doing things achieve desired results. Simply put, it is a model of what works best, based on experience. For the purposes of this project, Health Canada defines a "Best Practice Model" as follows:

> *Best Practice Model is a targeted, sustainable, evidence-based initiative where information about the design, development, implementation, outcomes and experience of the initiative are well documented and made available in enough detail that its effectiveness can be assessed and the initiative can be adapted for implementation in other locations.* (Health Canada 2003)

Targeted: Aimed at Aboriginal people whose actions put them at risk of acquiring or transmitting HIV. Aimed at reducing risk and maintaining or improving health by changing at-risk behaviour.

Sustainable: On-going, consistent and affordable initiatives that reach a significant number of at-risk Aboriginal people. Interventions must be powerful enough to motivate people to change their at-risk behaviour.

Evidence-based: Reliable information (data) from a variety of sources that show which practices have worked. For this project, "evidence" includes a literature and program review, focus group sessions, and follow-up analysis by the coordinators and focus group participants.

In general, the CAAN Focus Group is not convinced that the concept of "Best Practice Model" is appropriate to programming in Aboriginal communities in Canada. Two main objections to the concept of "Best Practice Model" are:

Objection 1:
There is no "best" practice: While there are many "good practices" that can be documented, participants objected to judging any one practice as "best". What is a best practice for one community may not be best for another. The concept of "best practices" was rejected on the grounds that it is a hierarchical non-Aboriginal construct that does not acknowledge Aboriginal perspectives.

Objection 2:
One "model" does not fit all: The needs of many communities cannot be met by one model. No single "model" can be applied to the myriad of unique programming situations Aboriginal communities represent. A "cookie-cutter" approach is not acceptable for meeting needs within the contexts of Reserve, urban, remote, First Nation, Métis, Inuit and Innu communities.

These objections were voiced in various ways by the CAAN Focus Group, as follows:

> *There is a need for culture-specific approaches to BPMs. We can recognise when we do good things. However, a good thing in one community is not a good thing in another community.*

A "Best Practice Model" (BPM) is defined as an ideal but practical approach in which evidence shows that certain ways of doing things achieve desired results.

The concept of a Best Practice Model is to replicate experience and apply it elsewhere. BPMs don't work!

The key to "good practices" – a term which is acceptable and non-competitive [compared to] the concept of 'best' – is good people who are supported. We also need advocacy, but we must recognise different experiences, situations. We should suggest a different way of communicating the business that we need to. Our experience is that if framed in a BPM... [Aboriginal] communities won't use it. If you want to know what's necessary, then talk to people who do the work...

...We have to recognise that we need to identify our own processes for developing best practices. The process so far is flawed because the information is not in books but in the minds of those here.

It's best to develop an open model, using traditional knowledge, keeping things living and open, so that it can grow and evolve rather than being like a closed box.

The notion that Best Practice Models are "evidence-based" was also challenged. Participants questioned what constituted "evidence," stating that what Aboriginal front-line workers consider evidence is likely not the same as what academic or professional researchers consider evidence:

Also problematic is the [non-Aboriginal] definition of "evidence." Evidence needs to be culturally appropriate... We need to find a different way of communicating what we want to do.

[At Aboriginal Health Centres] facilitators work for us, so it is important to understand that we are the experts and they must listen to us. The way we talk is important... we can deliver the message.

In view of these objections, it is important to note that other Canadian Aboriginal health organizations have embraced the idea of "best practices." For example, the Atlantic First Nations AIDS Network (AFNAN) developed a *Best Practice Model on Child Sexual Abuse and HIV/AIDS* (1997). Consistent with the CAAN Focus Group perspective, the AFNAN report advocates the documentation and sharing of information among Aboriginal organizations, in order to assist each other in dealing with a variety of situations related to HIV/AIDS.

Another notable example is the National Aboriginal Health Organization (NAHO) report, *A Path to a Better Future: A Preliminary Framework for a Best Practices Program for Aboriginal Health and Health Care* (2001). The NAHO report reflects the consensus voiced by the CAAN Focus Group, but rather than rejecting the "best practice model", re-defines it as a "moving target" that is re-directed as ideas, problems, and methods change and emerge (NAHO 2001:21). NAHO does not promote a "cookie-cutter" model but rather views best practices as a program of ongoing capacity building through information, expertise and experience. NAHO's "Best Practices Program" is considered a process of transferring knowledge, including "cultural knowledge," defined as:

[T]he beliefs an organization holds to be true, the experience, observation, reflection about itself and its environments as well as the norms and criteria used to evaluate projects and performance. It includes 'shared assumptions and beliefs.' These same attributes could also be applied to 'communities' and organizations influenced by and responsive to particular cultural influences. (NAHO 2001:7)

When viewed as knowledge management and development, notions of "best practice" are considered diverse and constantly evolving, consistent with and reflecting the complex and dynamic elements of Aboriginal health and health care. Similar to the Health Canada criteria of "targeted, sustainable and evidence based," the criteria of best practices adopted by NAHO are:

Best Practices are thoroughly documented, well-measured, and effectively managed based on fact gathering and analysis. They yield better outcomes, higher quality at lower costs and more positive impact than comparable procedures. (NAHO 2001:21)

3.2 CAAN Focus Group Alternative: A "Good Practices Approach"

The general consensus of the CAAN Focus Group is that the "Best Practice Model" is an idealized and artificial approach constructed by outsiders. A more acceptable concept is that a variety of good practices currently exist across Aboriginal communities in Canada. Indeed, "best practices" are sometimes applied to refer to "preferred practices" or "good practices" (Barlow 2003:13). Consistent with NAHO's approach advocating knowledge transfer, the CAAN Focus Group agreed that what is needed is to document and compile preferred or good practices. Such a resource would allow any Aboriginal community to adapt proven principles and practices to suit their situation:

> *Standardisation – make sure that information is consistent and reflects what is happening at the community level. What is happening in one part of the country might be helpful for another part of the country. Culturally appropriate messaging is important. Common experiences can be shared – consistent and repetitive messaging.*

As one participant recommended, a "Good Practices Approach" must address two practical questions:

> *The project at hand must: 1) find out what is out there, and; 2) find out what is possible. How do these two agendas interface? How do these streams connect?*

Another participant concluded:

> *I believe that if good information is distributed to the communities, the communities themselves will formulate their own approach.*

One participant echoed NAHO's definition by offering the following opinion on "best practices":

> *[Best Practices] are normative and ranked... Calling it "good" vs. "best" does nothing to take away that normative ranking of one optional practice over another... Practices are "best" because it is a practice that "beats all others... so far."*
>
> *They are remedial... They are embodied in human action, and can be worked at. They point out a problem to which the best practice is a solution. So a best practice is a best response to a given problem. Fire fighters (and the people they help) do not just want "good" practices – they want/need the best practices in that given area. Best practices are specific to a particular knowledge area.*

The consensus among the CAAN Focus Group is that the name "Good Practices Approach" is preferable because it implies a more open, inclusive, and flexible perspective than "Best Practice Model." For the purposes of this report, the title "Good Practices Approach" is used to most accurately reflect the perspectives of the Aboriginal HIV/AIDS and Addictions organizations represented during the CAAN Focus Group and subsequent follow-up consultations.

4. AN "INNOVATION CYCLE" TOWARD SELF-DETERMINATION

One component of the CAAN Focus Group seminar was a presentation of current Best Practice Models on the international scene. In particular, the several different ways in which BPMs are used, depending on the context and goal of the model, were reviewed:

Self-Determination in Health: A BPM of health consists of practices that are chosen and controlled by Aboriginal communities. "Best practices" are those which achieve "the right to health" among First Nations peoples (Ah Chee 1997).

Guide for New Programs: BPMs are useful documents, particularly for inexperienced program developers and front-line workers, because it strives to define and reflect what is considered "good practice" in the field (Lamont 2000).

Principles of Front-line Practice: BPMs provide practical guidelines or steps that care staff can follow in various circumstances to deal with specific situations; i.e. "if this is the situation, then do the following..." (New South Wales Health Department 2000).

Decision-Making Strategy: BPMs outline a strategy of best practice decision-making in identifying the problem, deciding if treatment is necessary, and then managing the appropriate treatment (New South Wales Health Department 2000).

Self-Assessment Tool: "Best practices" can be used as a standard by which existing programs can "test" their performance and identify areas where they can make changes to be more effective (Indian Health Services BPM for Diabetes Care and Education 2003).

Accountability Standards: BPMs promote accountability by providing clear and consistent frameworks that outline what is considered good practice principles. BPMs should be linked to contractual requirements of funding agreements to better ensure standards of quality service by the program provider to those in need of the service (Lamont 2000).

Program and Project Resources: Examples of "best practice" projects and programs by Aboriginal organizations that have achieved desired results in a variety of areas of HIV/AIDS care, treatment and support including harm reduction, interventions, prevention education, etc. (Barlow 2003).

The CAAN Focus Group observed that these different applications and goals form an "innovation cycle" that can generate ideas and action toward sustainable program administration and funding. A Good Practices Approach can be a means of defining and advancing from one goal to the next in order to ensure that STI prevention education is effectively integrated into HIV/AIDS and Addictions programs.

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GOOD PRACTICES APPROACH

Figure 1 below illustrates how a Good Practices Approach, self-determined by Aboriginal HIV/AIDS and Addictions service organizations, can be the foundation for: new program guidelines; principles of good practice and decision-making strategies for front-line workers in the area of STI prevention education; self-assessment tools to measure progress and to ensure continued integration of STI prevention education into existing programs, and; standards of accountability that allow Aboriginal organizations to justify and advocate for long-term sustainable funding and resources (which in turn empowers greater self-determination in program development and community health in general).

The CAAN Focus Group used this "innovation cycle" as a reminder that any approach toward integrating STI prevention into Aboriginal HIV/AIDS and Addictions programs must...

> *...defer to people who actually do the work and can tell you what works and what does not.*

The CAAN Focus Group affirmed that any approach to the integration of STIs prevention education, must fit in with broader self-determination aspirations of Aboriginal people. In this sense, the Good Practices Approach outlined in this report is also an affirmation of the research principles of "OCAP" (Ownership, Control, Access and Possession) adopted by CAAN (2004b), as well as by NAHO (2004). Self-determination by Aboriginal people in the area of HIV/AIDS is also supported by the recent Standing Committee on Health report, *Strengthening the Canadian Strategy on HIV/AIDS* (2003), which recommends that Health Canada and its federal partners ensure that awareness and prevention programs are increasingly administered by affected communities including people living with HIV/AIDS, youth, Aboriginal or ethnic communities and are more sensitive to culture, age and gender.

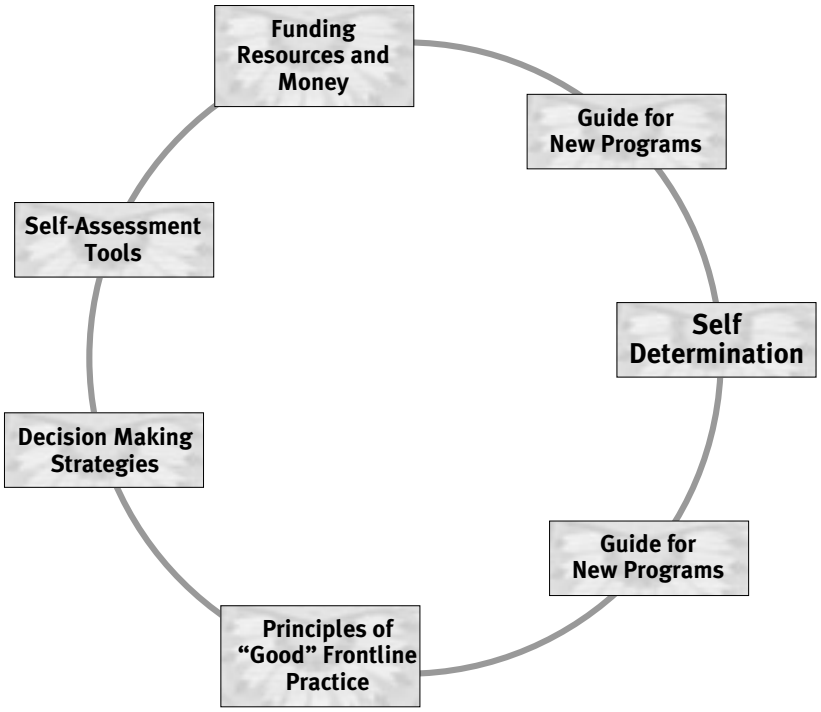

Figure 1. Good Practice Goals: An Innovation Cycle

5. PRINCIPLES OF A "GOOD PRACTICES APPROACH"

Eight good practice principles were identified as a result of both the literature review and the CAAN Focus Group sessions. Each of these good practice principles is discussed separately below.

Principle 1 – Community-Based Approaches
Each community is different and its needs unique. Effective STI and HIV prevention is the result of research and action from within each Aboriginal community. As well, approaches to addictions need to be based on the principle that "most communities likely support reducing harm, yet require the autonomy to develop approaches that fit their needs and circumstances" (CAAN 2003:20). Good practices consist of consultation with and research by community members as the means to correctly identify problems, the key players, and the appropriate medium of prevention, care, treatment and support. It also means working with outside researchers to ensure "respectful research":

> *Doing respectful research in Aboriginal communities takes more time, more money, and arguable, moral fibre. Imagine having to get permission from Chief and Council, attend joint advisory committee meetings and solicit input from the Elders, in addition to your regular supervisor in order to do your job.* (Schnarch 2004:84)

However, many communities are distrustful and resentful of researchers and program coordinators who are outsiders. This is particularly the case in areas of health and when research and programs are aimed at such sensitive topics as STIs, HIV/AIDS and addictions.

Several members of the CAAN Focus Group expressed that an Aboriginal Good Practices Approach must be open-ended and adaptable, allowing for both culture-specific (eg., Inuit, Innu, Metis and First Nation) and community-specific (eg., urban, reserve, remote) programming:

> *We must learn that every community is unique and has its own belief system. We have to be respectful, no matter what their belief system.*

> *In BC not many Aboriginal people are doing HIV work... The dominant culture must step away and let Aboriginal people do the work... We can't have one [token Aboriginal] person in a large health organisation when Aboriginal people are the majority of the clients. We talk about equity and equality – if we make up the majority of health care problems – [we should be the majority of workers]. [Instead] we get service from the dominant culture. How we're treated – that's why we don't use the services – why HIV people don't get help.*

> *In Saskatchewan about 70% of people don't live in [Aboriginal or Reserve] communities and never will. So for a BPM, traditions are different on-reserve and off-reserve. We have to look at what is happening in cities. Cities are filled with Aboriginal people and they have their own culture.*

These sentiments have also been voiced by Pauktuutit, the Inuit Women's Association of Canada (Armstrong 2000). Because the distinct nature of Inuit culture, traditions and beliefs has rarely been reflected in HIV/AIDS educational materials developed for Aboriginal people, Inuit have been allowed to ignore and even deny the likelihood that they are at risk of HIV/AIDS. It has been viewed as a southern white male (homosexual) disease, rather than one related to STIs and heterosexual relations that also affect the north. Pauktuutit's response has been to develop HIV/AIDS prevention material for Inuit communities through comprehensive community consultation. In evaluating the process, Pauktuutit identified "best practices" to include: 1) broad community representation and meaningful community consultation ("One Inuk cannot adequately represent the needs of all Inuit..."), and; 2) representation must be not only cultural, but also about gender, age, regional difference and life experience, and also involving the balance between modern life and traditional life.

Similarly, a review of the HIV/AIDS Education Program in Wikwemikong (Ontario) recommends close collaboration between community-based HIV/AIDS prevention programs and the existing community health network for On-Reserve programs (Maar et al 2000). In British Columbia, Healing Our Spirit BC First Nations AIDS Society also recognizes

that prevention workshops need to be custom designed for a cross-section of communities and institutions according to gender, age, and venue, ensuring that workshops are delivered in collaboration with the communities and organizations to tailor training and education to specific needs (Marsden et al. 2000). Likewise, Native American HIV/AIDS organizations in the USA have advocated for full involvement of Native people and their leaders in the development and implementation of prevention programs, so that the cultural and social context is "shown to be true" for the communities' individual experiences (Vernon 2001). General population studies also show that when STI and HIV interventions are delivered by health professionals, but without a community base, they are usually unsuccessful (Ross and Williams 2002b).

Principle 2 – Holistic Care, Treatment and Support
A holistic approach that takes into account physical, mental, spiritual, and emotional wellness is a good practice in both prevention, as well as care, treatment and support of Aboriginal people who struggle with addictions and those who are HIV positive. Holistic approaches that have been adopted by various Aboriginal HIV/AIDS and Addictions organizations are relevant also to the integration of STI prevention education into existing programs (see for example, Nechi Institute, and; Manitoba Aboriginal AIDS Taskforce – McLeod 2001). Experience has proven that to be effective, integrated STI prevention education must be culturally relevant and meaningful to the individual.

In particular, HIV/AIDS and Addictions programs must have the capacity to identify and address the root causes of high-risk behaviour. Depending on the individual, their family and their home community, these root causes may include, for example, the history of colonization and the Residential School legacy:

> *We need to be proactive, we don't want more people infected. What are core issues? We need to address these root causes in order to heal. When my mother told her story of survival of Residential School I understood why she can't talk about sex. My mother was taught that they can't talk about sex because they would be punished by God. So there are inter-generational issues. I want to be proactive [in talking about sex] because I do not want to see my children or grand-children infected.*
>
> *Some Aboriginal people don't know their own history – people living with addictions [do not know] why they're living the way they are – personal stories – why didn't my mom talk to me about sexual health? In communities, sexual health is not talked about – in committees we talk about it after the fact – when it HAS to be talked about.*

A workshop on the risks of HIV/AIDS and STIs in relation to alcohol consumption in Inuit communities, addressed behavioural issues that are usually deeper and more complex than simply substance abuse. Often behavioural issues include the attitudes of disempowerment, low self-esteem, and other problems such as childhood sexual abuse (Pauktuutit 1995).

Documented studies in non-Aboriginal communities also indicate that traumatic personal histories may lead to high-risk behaviour. O'Leary et al (2003) found that men who had a history of childhood sexual abuse

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were significantly associated with recent unprotected sex with partners of HIV-negative or unknown HIV status. Results such as this highlight the importance of mental health services for individuals who have been sexually abused, both for personal and for public health benefit.

Addictions counsellors participating in the CAAN Focus Group emphasized the need for a holistic approach toward individuals at various stages of treatment and the healing process:

> *When we're talking about addictions treatment, it depends where in the addictions continuum we're talking – health prevention, care, in-patient treatment, out-patient – it depends on where person is on the continuum. It would be helpful for the AIDS group to know there's a continuum out there.*

> *There are issues of the individual – poly-drug use, behavioural problems associated with process addictions that rarely get recognised or treated. Treatment organisations working in a holistic capacity – treating the whole person, not just the addiction – are seeing a lack of support for this approach. The reality of diminishing dollars, and problems holding on to qualified staff. All of these issues colour the treatment an individual is going to get. We need to prioritize what is core and what is optional. For treatment centres, what constitutes "best" treatments? Many people are getting pieces of what they need instead of a one-shot deal. The situation is getting more difficult, more complex.*

> *Chronic illness has stages and so do addictions. We must consider these in addressing a [Good Practices Approach].*

CAAN Focus Group comments were consistent with the holistic approaches outlined in the recent Aboriginal strategy on HIV/AIDS, *Strengthening Ties – Strengthening Communities* (CAAN 2003), as well as with strategies, manuals and reports produced by other Aboriginal HIV/AIDS organizations in Canada. For example, the BC Aboriginal HIV/AIDS Task Force strategy, *The Red Road: Pathways to Wholeness* (1999), recommends that healthy communities must be built by targeting the underlying causes of high risk behaviour for HIV such as poor parenting skills, alcohol and drug use, emotional, physical and sexual abuse, and historical abuse such as the residential school system.

Quebec First Nations and Inuit HIV & AIDS Working Group's strategy, *The Circle of Hope* (1999), is based on the principle of "**H**olistic **O**pportunity for **P**revention and **E**quality in Treatment (HOPE). *The Circle of Hope* addresses the high rate of STIs as an indicator of high-risk behaviour, linking this rate to multi-generational trauma, cultural oppression, and the legacy of the residential school experience, all of which have deeply impacted upon self esteem and the capacity for intimacy and sexual expression. The Quebec report also links the presence of alcohol, IDU and solvent use to high risk behaviours.

The Aboriginal Nurses Association's *Finding Our Way* (2002) identifies several factors and situations relevant to the increased risk of STIs in Aboriginal communities, including: high mobility between reserves and urban communities leading to many sexual partners living in different places; residential school experiences; sexual abuse and sexual violence in communities, resulting in low self-esteem and alcohol abuse and their negative effects on sexual decision making, and; breakdown of the family and stress on relationships. Negative experiences of sexuality lead to problems making healthy sexual decisions, a lack of knowledge about safer sex practices and the risk of sexually transmitted infections, and contracting sexually transmitted infections in prison and spreading them in the community.

The Métis National Council's strategy, *Following the Red Cart – Métis and HIV/AIDS* (2003), deals specifically with STIs and HIV/AIDS, linking the higher rates of STIs in the Aboriginal (including Métis) population to factors which increase the rate of high-risk behaviour to even the most remote communities. Such factors include poor self-esteem, an inability to demand safer-sex practices or to decline sex, increased alcohol and drug use, and high mobility between inner cities and rural communities.

The CAAN Focus Group emphasized the historical and systemic causes behind high-risk behaviour among Aboriginal people:

> *When talking about root causes, we are really talking about the healing journey of people, of individuals, and of nations. The whole nation is taking power back and the more this occurs, the more healing comes with that. We must look at root causes of addiction and take the Red Road. Only recently have we got out rights back, so it is important to remember how far we've come... remember our successes... It's important to understand we're colonised people and our history... Teach being on the Red Road [the black road is the road to addictions; the Red Road is respecting the native way of living].*

Holistic practices must also promote individual self-acceptance, meaning that front-line workers must accept individuals who are Two-Spirit, HIV-positive, or addicts. Addiction treatment centres must also deal with the problem of discrimination against individuals who are gay, Two-Spirit, HIV-positive or APHAs:

> *The main issues for organizations are stigma and discrimination, and lack of funding. Stigma about Two Spirit, HIV, addictions etc. in organisations or within the community prevents full, outright awareness education. To me this is the main issue.*

> *There is a stigma in terms of HIV/AIDS – the funders within communities, within people themselves. In a treatment centre, someone self-identifying as gay is probably not wise, but then to tell them that you're HIV positive? [That is risky] because of the stigma associated with [homosexual] behaviours.*

> *My role as a counsellor is not to judge but to identify issues and help the person make decisions and help to heal. That person can't learn self-acceptance if I don't show them acceptance... I have a Two Spirit client – his addiction is self-hate, self-destruction. I'd like to work on this person to like himself. This person hurts from being criticised about being Two Spirit. What do you say to these people that criticise you? I encourage them to stand up for themselves, that's my goal. They realise that. They talk a lot more after that. That's where recovery is at – it's helping people with self-acceptance.*

The AIDS Coalition of Nova Scotia (1998) has studied what motivates gay and bisexual men to choose to use alcohol, and what alcohol represents in their lives. Designed to develop HIV prevention strategies which address the link between alcohol use and risk for men who have sex with men, the study found that few specific services existed for gay and bisexual men who wanted help with alcohol addiction. Partnerships between health care providers and addictions workers that will help gay and bisexual men to access necessary services were recommended. In Toronto, Monette and Albert (2001) documented the need among Aboriginal Two Spirit men for prevention service providers to not only hand out condoms and needles, but to understand their needs for love, respect, support and some sense of community. Increased sensitivity training regarding Two Spirit people with Addiction treatment programs is also recommended in a report by the Alberta Two-Spirit Working Group and Nechi Institute (2003).

There is a stigma in terms of HIV/AIDS – the funders within communities, within people themselves. In a treatment centre, someone self-identifying as gay is probably not wise, but then to tell them that you're HIV positive?

Principle 3 – Community Awareness
A Good Practices Approach must incorporate community-wide awareness and education about the connection of STIs, HIV, intravenous drug use and high-risk behaviour associated with addictions. *The Red Road* report recommends strategies to coordinate HIV and STI health services and increase community education regarding their linkages (B.C. Aboriginal HIV/AIDS Task Force 1999).

Homophobia, the stigma of AIDS, denial that it exists in their community, and reluctance to speak about related issues prevents communities from taking preventive action:

> *Are HIV positive, Two Spirit people still stigmatised in our communities? Part of the process is to educate communities. They MUST talk about this or we will lose children.*

> *I did some research on Two Spirit people... I asked my asked aunt, "What happened before?" She said, "People moved away from the community because of the shame." Later, we had one of the seers in the community who was Two Spirit. I didn't think our community would accept him, but our community welcomed him with open arms. In his community he has to tell people he has cancer – he has HIV – no one in his community is looking at the problem of stigma, HIV, etc.*

> *We need to be proactive, we don't want more people infected.... Education is key. The [Good Practices] "Model" must be inclusive of everybody, regardless of where they are at mentally, physically, sexually, spiritually, etc.*

In *Voices of Two-Spirited Men*, Monette and Albert (2001) conclude that the core issue of homophobia must be addressed in order to reduce risk-taking behaviour among Two-Spirited men. More than any other factor, it is the sense of alienation that contributes to engaging in high-risk activities which makes Two Spirit men vulnerable to HIV/AIDS. In Nunavut, a lack of Inuit-specific educational materials has allowed Inuit to ignore and even deny the likelihood that they are at risk of HIV/AIDS. Community awareness is essential in a context where AIDS has been viewed as a southern white male (homosexual) disease, rather than one related to STIs and heterosexual relations that might also affect the north (Armstrong 2000).

A Good Practices Approach must be inclusive of everybody, and messages need to target children, youth, parents, elders and local leaders in ways that will be meaningful to each.

> *In many communities, sex becomes part of reality, it is an expectation... Did my grandmother really choose to be pregnant at 12 years old? ... When I asked her if she was happy being a mother at that age, and she said "yes" and was offended [that I had asked]. I think it was because she didn't want to admit she had no control over her self. No power.*

> *Where did she learn that? Older women 'leak' their ideas. Girls think they can have power through sex. It comes from residential school thinking. Who I am as a being – triggered by touch, sight, smells – I'm a walking time bomb for sex addiction.*

A community-based approach that customizes community awareness and education programming to suit different ages and venues is documented at Wikwemikong (Maar et al. 2000). The HIV/AIDS Education Program in Wikwemikong has developed programs for elementary, junior-high and high schools in order to reach adolescent and teenage youth, and elsewhere within the community such as at sporting events to reach young to middle-age adults. Within a more urban context, Perez and Dabis (2003) describe and evaluate a school-based program on HIV primary prevention to promote risk awareness and safe sexual behaviours among urban youth populations (Columbia). This study found that interpersonal peer intervention, classroom education sessions, and community actions effective primary prevention strategies for HIV sexual transmission. Among Native American in the USA, community awareness was also documented as a characteristic of effective HIV/AIDS strategies (Vernon 2001).

Principle 4 – High-Risk Group Education and Counselling

Education and peer counselling among high risk groups is identified as a key to preventing HIV infection via sexual transmission and drug use. The CAAN Focus Group stated that among HIV/AIDS service providers, STI prevention education is common practice. However, there is a need for Addiction treatment centres to become proactive educators in order to prevent more STI and HIV infections among this high-risk group. This education must be suitable to the stage of life in which a person is living:

> *AIDS service organizations have always done STI education. STIs are predictors for HIV. Teenage pregnancy is also a predictor. So they are all a part of prevention.... Integrating those things into addictions is the most important... Don't reinvent wheel. Look at what is being done about STI prevention education in HIV organizations and adapt it... Older people are now getting HIV because of Viagra, sexually enhancing drugs, so HIV education is now necessary for older population.*

There is increasing acknowledgement among Aboriginal Addiction organizations that HIV/AIDS and associated STIs must be dealt with among their clientele:

> *We must look at whole picture. We are challenged with emerging issues, such as in urban centres. In prevention and awareness and counselling for First Nation, Inuit, Métis, the primary focus is addictions. We can do much more than provide advice. We should look at the potential of existing systems – building on things as we go along. HIV/AIDS is not much of a focus now. How do we make it more of a focus?*

One participant pointed out that "good practices" already exist in many communities that have developed programs to build life-skills toward creating productive members of society, and to provide support in addressing addictions. However, in many cases, the addiction population is slipping through the cracks of STI and HIV/AIDS counselling. For example, injection drug users might regularly access needle-exchange programs, but will not access any HIV/AIDS programs or services:

> *Existing programs and services in place do not meet the needs of the populations struggling with addiction, STI's, and HIV/AIDS issues. Grassroots initiatives are effective and efficient at addressing many of these needs and reaching this population.*

There is evidence that some Addiction treatment centres are implementing STI and HIV/AIDS education programs, and it is practices such as these that should be documented as part of a "Good Practices Approach":

> *We have a whole morning dedicated to HIV awareness at our addictions treatment program. If clients feel the need to take care of themselves, counsellors will provide the information. It is up to the client to go to the next level – testing, etc. We show them another alternative to maintain themselves, [to decide] "I don't want to put myself in a risky situation with risky behaviours."*

> *In Addictions, there are core education workshops, core elements of the treatment program that must be always present. STIs are a core element in our organisation, but not everywhere.*

A good practice frequently identified in both the literature and the CAAN Focus Group are programs which teach positive sexual behaviour skills that are culturally relevant, as an effective way to prevent STI and HIV infection. Indeed, neglecting the cultural context in which sexual behaviour occurs is linked to high-risk behaviour, because prevention messages may be either misunderstood or ignored. This was the case in a study of eleven Aboriginal On-Reserve communities in Ontario (Myers et al. 1999). This study revealed that learning about sex from partners and having familiarity of Aboriginal language and traditions led to more risk-taking behaviour than did learning about sex from Family and Health Services. It is important to understand the conflicting paradigms of Aboriginal tradition, modern medicine and public health service, and an awareness of the complexity of culture and differences within and between Aboriginal

communities is critical. A review of HIV prevention literature by Wilson and Miller (2003) concluded that there is a need to recognize the unique contribution of cultural elements to HIV prevention and to the design of programs that reduce the risk of HIV.

The CAAN Focus Group identified both individual counselling and sharing circles as culturally relevant environments in which to teach positive sexual behaviour skills:

> *Use positive language, especially with youth.*
>
> *The whole thing is based on sharing. I would like to see the day we can normalise STIs. It's up to the service providers to normalise it, to not sensationalise. We're dealing with people that have sensationalised everything they've done. I don't know about women, but for men it's sex, drugs, rock and roll. If the group [sharing circle] attacks any of these three – they're not going to want to share. We need gender specific information to share – we have to find a safe way to share.*

Peer counselling and education is key to effective high-risk group prevention and support:

> *Peer education is important: addicts helping addicts.*
>
> *STI education has to be gender-specific when dealing with behaviours. [For example] men can best understand sexual attitudes of male youth.*
>
> *Sometimes females are not able to talk to men. Some men couldn't talk to men, because they were abused by men.*

Peer counselling and education for STIs and HIV/AIDS among high-risk groups is a fairly well-documented phenomenon (eg., Perez and Dabis 2003 cited above). A study among youth in Ghana (West Africa) demonstrated that peer educators who were highly similar to their contacts were more likely to induce less risk behaviours in their contacts (Cameron and Bond 2002). Furthermore, as Elford et al. (2003) point out, peer education programs may require substantial input from professional health promoters in order to be maintained in the long term, meaning that peer education should not necessarily be viewed as a low-cost approach to prevention.

However, it should not be assumed that peer counselling necessarily refers to "known" peers, particularly in small communities where confidentiality may be compromised. For example, in the cultural context of rural Uganda, participants expressed a strong need for HIV counselling and testing services, but stressed that those who provided these services should not come from the same community (Kipp et al. 2002). This issue was raised also in the context of Inuit communities – most of which are small – where there is difficulty for health workers to remain objective because everyone knows everyone else (Pauktuutit 1995).

Principle 5 – STI Screening as HIV Prevention
Screening for STIs among high risk groups is an important good practice in HIV prevention. For example, a study of men who have sex with men in a prison setting identified an urgent need to integrate HIV prevention into STI screening as a component of both primary and secondary prevention services within the jail including case management, early treatment, and referral services (Chen et al. 2003). A study of sexual behaviour among drug abuse treatment populations suggests that drug users generally, and crack-using populations in particular, should be routinely screened for STIs as an integral part of all drug treatment programs (Ross et al. 2002a).

Peer counselling and education for STIs and HIV/AIDS among high-risk groups is a fairly well-documented phenomenon

According to the CAAN Focus Group, STI screening and HIV testing is standard practice for many HIV/AIDS service organizations, and is a good practice recommended for Addiction treatment centres as well:

> *The problem is that people are dying before they are diagnosed [with STIs or HIV]. Addiction programs are not effectively dealing with this problem, especially among IDUs.*

> *Intake diagnostic tools... have a section on sexual [questions]: self-identification of homosexual, heterosexual, etc. This part is short – I did not realise that I didn't get to finish it [and ask about STIs]. We end up moving on to the next section. It asks number of partners, preference, AIDS testing, abortion, pregnancies, etc. Then it gets into child-sexual abuse. It doesn't get into the STI part. There is more than just AIDS [to deal with]. If this section were expanded, I know there are some individuals who would benefit from an expanded list, [for example]: "Would you like an HIV/AIDS or STI test?" They do TB tests and physical tests and exams, but the HIV test is not there. Should it be on admission requirements for treatment centres?*

> *In our Addictions treatment facility, people live there for several weeks to long-term. If a person has a virus or STI, and lives with other people, there is a risk [of transmission]. Mandatory testing would make them aware of STIs and HIV. It doesn't mean you're not welcome, but you have to be aware of it. Right now, the HIV test is not performed or results are not handed in to the treatment centre.*

The B.C. Aboriginal HIV/AIDS Task Force (1999) adds that there is a need to increase the availability of STI prevention, screening and treatment services in rural, remote and reserve communities.

Aboriginal Addiction organizations point out that the issue of screening must strike a balance between: 1) an individual's rights of choice (whether or not to be screened/tested) and of privacy (whether or not to reveal HIV status), and; 2) the obligation to protect others from infection:

> *What happens is it is the client's choice to share information. We have to respect that. But [there should be] information [about STIs and HIV] that you can't get the disease from a spoon or cup.*

> *If precautions are in place, HIV status should not be an issue if education is for everybody, and nobody is singled out. I have talked to clients about disclosing their status, but it is their choice. One valid reason to disclose is to get support. But, we also have the rest of population to protect. Most [Addiction] treatment centres don't encourage sexual relations. [But they're out there doing it – in the bushes.]*

If STI and HIV testing is available, participants agreed that treatment must also be available for those who test positive:

> *There are not enough resources for people who test positive. We need to try to get community groups to be effective with clients who test positive. Right now we're not set up at that level in the Aboriginal population to deal adequately with HIV and other issues. That is why there are suicides and deaths. The [Good Practices Approach] should acknowledge, "How do we care for people who test positive?"*

Principle 6 – Harm Reduction for Addictions
Needle exchange programs, safe injection sites, and methadone treatment provide evidence-based good practices for preventing HIV. Statistics show Aboriginal people are among the groups that have the highest

[2]Phase II of "Joining the Circle" is in its final stages of completion. It focuses on the successful ways that Aboriginal communities use harm reduction in order to create an Aboriginal Harm Reduction Policy. The information about harm reduction in Aboriginal communities is documented in a guide for community use (see CAAN 2004a).

rate of new infections and, in the case of women, intravenous drug use is the most marked route of HIV transmission (eg., Weber 2001; Spittal 2003). CAAN's study, *Joining the Circle: An Aboriginal Harm Reduction Mode* (Phase I) emphasizes a harm reduction approach as a pragmatic, non-judgmental way of dealing with HIV infection through intravenous drug use, and aims to address the issue of transmission rather than focus on the use of drugs which, in some instances, are inevitable (CAAN 1998).[2] The changing roles of support staff in community-based AIDS organizations and the promotion of harm reduction practices among persons living with HIV/AIDS who are also drug users is addressed also in the Canadian AIDS Society report, *Under the Influence: Making the Connection between HIV/AIDS and Substance Use* (CAS 1997).

Addiction treatment centres are just beginning to address issues of high-risk behaviour, such as injection drug use, leading to STIs and HIV/AIDS. Aboriginal HIV/AIDS organizations recommend the prevention of HIV transmission through harm reduction programs such as needle exchange and disposal programs, and methadone treatment (B.C. Aboriginal HIV/AIDS Task Force 1999). Likewise, the CAAN Focus Group representing HIV/AIDS organizations argue that harm reduction programs (as opposed to abstinence programs) are a more culturally appropriate method of addiction treatment because it allows individuals to deal with social and personal issues rather than the "symptom" of addiction:

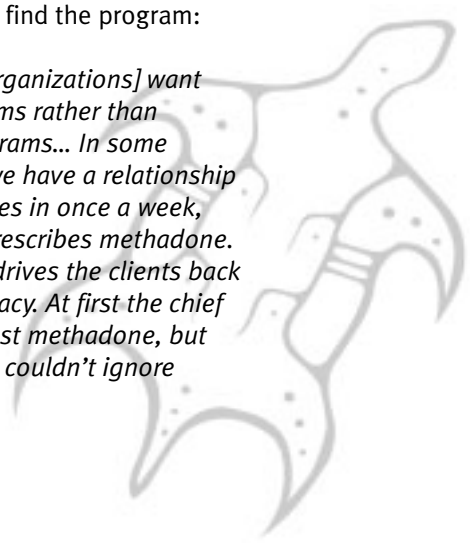
> *The twelve-step program puts social problems on the back burner. We need a culturally appropriate method that deals with social and personal issues rather than the symptom of addictions. Do we know how successful Addictions treatment programs are for Aboriginal people? I suggest that they are not effective, so why does the government keep putting the money into them? Maybe we need to look at different programs if Aboriginal people are using the system and not receiving benefit. The 12 step model keeps people sick – an addict for life – and should not be a model for Aboriginal communities.*
>
> *Addicts have given power over to dominant culture by saying "my name is [Jane or Joe] and I'm an addict." Elders suggest that we return to rites of passage and holism. Dealing with root causes, rather than symptoms.*

The Vancouver Injection Drug Users Study noted that one of five predictors of HIV infection was Aboriginal ethnicity (Tyndall et al. 2003). This study concluded that injection drug users remain particularly vulnerable to HIV infection and treatment options for drug dependency remain woefully inadequate.

The challenge remains that many of Aboriginal Addiction treatment centres are using abstinence-based models and are not prepared to deal with injection drug use. The Aboriginal strategy on HIV/AIDS, *Strengthening Ties – Strengthening Communities*, supports broad-based harm reduction approaches aimed at better defining harm reduction so that greater efforts are placed to overcome how addictions or substance use relate to HIV/AIDS (CAAN 2003:20). The CAAN strategy recognizes that many Aboriginal customs and traditions require abstinence or freedom from mind and mood altering drugs. However, harm reductions and abstinence based philosophies need not be in conflict with each other. Ultimately they both support the common goal of "no harm" for the individual while using different ways to reach that goal. If no harm (abstinence) is not possible, ways of reducing harm need to be offered and supported.

A Good Practices principle advocated by the CAAN Focus Group representatives of HIV/AIDS organizations is that Addiction treatment centres should offer a choice between abstinence and harm reduction programs. One participant shared a "best practice" where a methadone and needle-disposal program was brought to those who needed it, rather than expecting those in need to find the program:

> *[Aboriginal HIV/AIDS organizations] want harm reduction programs rather than abstinence based programs… In some Atlantic communities we have a relationship with a doctor who comes in once a week, does urine tests and prescribes methadone. One worker-volunteer drives the clients back and forth to the pharmacy. At first the chief and council were against methadone, but then they realised they couldn't ignore*



the problem. Now the volunteer is being reimbursed. The doctor interrupts her own family practice to come [to the treatment centre] one day a week. This eliminates having to take people to appointments off reserve. When the doctor is there, a day-care opens up to let people drop their kids off for the hour they need. The [safety of the] community is more important – [it is better that] more people are going on methadone, instead of finding needles all over the place. Now this volunteers provides needle disposal to all the houses, to prevent them from being scattered around. She's the ideal "best practice model."

The CAAN Focus Group representing HIV/AIDS organizations questioned the Addiction workers about current practices to treat injection drug users, suggesting that this type of high-risk behaviour for HIV transmission is neglected in Addiction programming. Below is a synthesis of exchanges between HIV/AIDS and Addictions participants:

[HIV/AIDS Question]: In cities we're seeing a lot of injection drug use. How are addiction counsellors dealing with this change?

[Addictions Response]: We're trained primarily for alcohol and drugs. Also, courses at college level. I don't know what we're training with regard to IDUs. It's a huge issue and Hepatitis C is a huge issue – a high risk transmission.

[HIV/AIDS Question]: There is a harm reduction approach throughout our district. But when it gets down to the [Addiction] counsellors they don't support methadone maintenance. So where does it leave the client when centres are mandated to do it, but it still doesn't happen?

[Addictions Response]: Ours is a cultural and abstinence-based program – a tertiary program. Methadone, IDU... I'm thankful I'm here – I'll take these ideas back to the centre.

[HIV/AIDS Comment]: There are no centres that will take someone on methadone in Saskatchewan... It's discrimination. If a person was sick with cancer, they would be treated.

[HIV/AIDS Comment]: That doesn't make sense that there are no Addiction treatment programs around intravenous drugs... Specialized training [is needed]. From what I understand, Addiction treatment isn't long enough to deal with triggers. They just start then they have to leave. They're very vulnerable. Some have after-care... but some people go many, many times.

[Addictions Response]: After-care is lacking. This raises a new set of challenges. There is a lack of co-ordination between treatment centres and HIV programming.

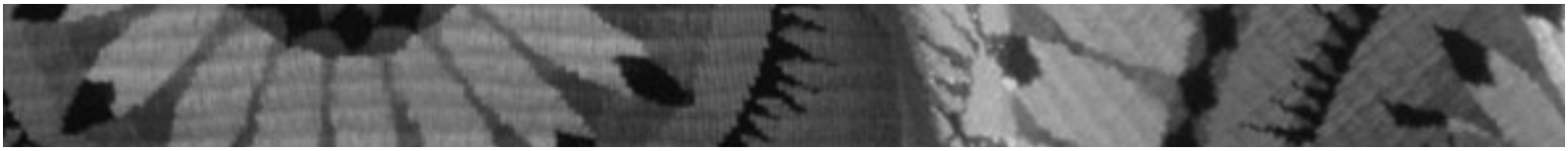
Principle 7 – Healthy Sexuality

The importance of promoting healthy sexuality – especially among Aboriginal youth – is documented in several publications. Wikwemikong's HIV/AIDS Education Program recommended that a primary way to reduce the transmission of HIV/AIDS and STIs in the community was to establish a "healthy sexuality program" in the elementary and secondary schools. The high school program focuses on HIV/AIDS and STDs including sessions to increase students' capabilities to talk about and to practice safer sex (Maar et al 2000).

The CAAN Focus Group also spoke about problems of unhealthy and dangerous attitudes towards sexuality within Aboriginal communities:

I've seen young men brag about having STDs. If you've had gonorrhoea several times, it's like a badge of honour. This needs to be addressed. Is it part of a negative stigma, or positive stigma?

It's almost a rite of passage to manhood...: Our cultural rites of passage have been bastardised. Other rites of passage have replaced these and they're frightening. It's part of the residential school legacy, we did not learn these rites from our parents. There is a whole generation that did not have children around.



Sex trade work is going on in bedrooms and homes, not necessarily on the street. It is an economic reality. In a community in Alberta, there are families from the community near a military base pimping their daughters to the base because they were making money. Children being victimised by their own parents. When an intervention was tried, the parents got angry, saying: "You are from off reserve. What are you doing here?" We have to look at economic conditions that create conditions for sex work.

Participants agreed that a Good Practices Approach must balance negative issues (eg., "sexual abuse") with a positive approach to teaching "healthy sexuality," tied to Aboriginal traditions (such as rites of passage):

In addictions counselling organisations, sex abuse is talked about, but healthy sexuality is not... We should encourage institutions that train counsellors to improve that. Many do, but not all.

Healthy sexuality education must begin at a young age, and be appropriate to each age and stage and of a person's life, in order to effectively reduce STIs and HIV:

Interventions need to happen earlier.

We should be finding culturally appropriate rites and ceremony. Our communities are not experiencing these things at these appropriate ages. There's a lot of things I needed to know by age 13. Appropriateness – cultural rites of passage.

Rites of passage are important because they acknowledge positive changes, growth, etc. and connect to teachings and to the community. We shouldn't be scared of natural processes, sex, etc. It is important to talk about these things. This used to be the case in traditional practice and we need to bring this back. Have pride in natural processes. Children should know their history, rites of passage, and return to traditional teachings.

The Aboriginal Nurses Association of Canada has produced an extensive resource using Aboriginal holistic models and history to explain sexuality to people of all backgrounds and age groups (*Finding Our Way*, ANAC 2002). As well, the Wabano Centre for Aboriginal Health in Ottawa has developed an HIV train the trainer program based on an interactive training circle rooted in Aboriginal culture (*Keep the Circle Strong*, 2000).

Finally, minimizing risk in sexual behaviour, for example condom use, is identified as a main line of defence against acquiring and transmitting HIV and some STIs (i.e. discharge diseases). The Métis National Council (2003) identifies low rates of condom use and one factor which brings the risk of contact with STDs to even the most remote Métis communities, and suggests sexual abstinence, choosing a sex partner who you know and trust, learning to use latex condoms, and talking with your partner about past relationships and the risk of STIs and HIV/AIDS. A study across USA and African cultures found that condom distribution, as a community-level HIV prevention intervention, could reach large segments of the general population, thereby saving significant numbers of HIV infections and associated medical costs (Bedima et al. 2002). This study also suggests that condom intervention is easy to scale up to large populations or down to small populations. Similar results were reported among youth in Hungary (Gyramanthy et al. 2002). However, as Myers et al. (1999) point out, simply making condoms available in Aboriginal communities is not enough. Their study of eleven Indian Reserves in Ontario revealed that important challenges exist for the integration of traditional learning methods with knowledge of HIV/AIDS, and the role that condom use can play in preventing HIV and some STIs.

Principle 8 – Sustainable Funding, Resources and Advocacy

Funding for sustainable programming is an essential good practice. Advocacy by Aboriginal organizations for long-term, sustainable program funding and resources must be accompanied by cooperation among funding agencies in order to better channel funds to community-based organizations:

Aboriginal communities and individuals are good at integrating [programming] but governments are not. Politics get in the way of Aboriginal people dealing with issues.

It is a double edged sword because we need politicians and advocacy to get funding.

There should be a connection of issues... What are the community-based resources, family-based resources, and others? You need a MAP to see who does what, when. Resources – who funds what? Who pays to whom? Provincial, federal, etc? We need to know who [is being funded] so we don't step on [each others'] toes, and don't fight [among ourselves] for money and resources. We need a better [cooperative] strategy for funding and resources.

The call for sustainable and integrated funding is not new. In 1999, for example, the B.C. Aboriginal HIV/AIDS Task Force (1999) recommended secure funding for Aboriginal HIV/AIDS services by developing clearer procedures and better liaisons between funding agencies and independent service providers, by promoting available funding sources for HIV/AIDS services and providing proposal development support. Indeed, the CAAN Focus Group identified current proposal requirements demanded by government funding agencies, as a main obstacle to many "good practice" community-based ideas from ever being developed. For example, the move towards a logic model framework without appropriate capacity-building and training may prevent some ideas from ever getting off the ground.

More recently, the report by the Standing Committee on Health – *Strengthening the Canadian Strategy on HIV/AIDS* (2003) – has recommended that the federal government at least double the total funding for the renewed federal Canadian Strategy on HIV/AIDS. Funding has remained at $42.2 million since 1998, without increases to match the rise of AIDS cases or even annual rates of inflation. Furthermore, the Committee found that Aboriginal peoples accounted for more than one-quarter of all new AIDS cases, and further recommends that increased federal funding specifically designate $5 million annually to the at-risk sub-population of First Nations and Inuit. The Aboriginal strategy on HIV/AIDS in Canada, *Strengthening Ties – Strengthening Communities* supports the Committee's recommendation, adding that an avenue of support for coordinated funding efforts is necessary, particularly in those communities and regions where territorial and provincial funding is not available (CAAN 2003).

Of great importance is the Standing Committee's recommendation that stable and long-term funding be provided for regional Aboriginal AIDS service organizations to develop culturally appropriate practices to fight HIV in the community and to help implement specific programs to deal with the HIV/AIDS-related needs of the disproportionately large Aboriginal population in prisons. This latter recommendation responds to a fundamental problem highlighted by the CAAN Focus Group: the lack of core funding to organizations and an over-emphasis on project-based (short-term) funding. Weak or non-existent operational funds for Aboriginal organizations – in particular regional organizations located off Reserves – prevents sustainable programming. As such, the lack of core funding contradicts a main goal of "Best Practice Models" as defined by Health Canada (2003), for on-going, consistent and affordable initiatives that reach a significant number of at-risk Aboriginal people" (see Section 3.1 above). Finally, although they acknowledged the need for accountability of public funds, the CAAN Focus Group was critical of the complexity and frequency of reporting requirements which often "get in the way" of doing the actual work they are mandated to perform.

Equally important to funding are resources produced by and appropriate to Aboriginal organizations involved in HIV/AIDS and Addictions. A successful Good Practices Approach will rely on input from many Aboriginal sources, through oral tradition and an ongoing sharing of knowledge. Experiences and examples of successful ways of integrating STI prevention education into HIV/AIDS and Addictions programs need to be documented and accessible.

6. RECOMMENDATIONS TOWARD A "GOOD PRACTICES APPROACH"

Several key points that emerged from the CAAN Focus Group sessions are offered here as a set of nineteen "good practice" recommendations toward an overall approach to the integration of STI prevention education with HIV/AIDS and Addiction services in Aboriginal communities.

Recommendations toward Community-Based Approaches:

1. Any Good Practices Approach must be based on the principle of self-determination. STI prevention cannot succeed without the community's involvement, and it is up to Aboriginal organizations to identify issues, inform and engage their communities, according to their unique needs and character.

2. Aboriginal people are best suited to educate, treat and support their own people, including those at risk of STIs and HIV, those suffering from addictions, and those living with and affected by HIV/AIDS. The focus should be on developing community-based Aboriginal research and service delivery capacity, at many levels and in the many urban and rural communities across Canada.

Recommendations toward Holistic Care, Treatment and Support:

3. Any effective Good Practices Approach toward education and treatment cannot ignore underlying issues common to the Aboriginal experience – such as colonisation and the residential school legacy – which may be at the root of addictive and high risk sexual behaviour. The "Red Road" and "Red Cart" models are examples of such an holistic approach.

4. Front-line workers in Aboriginal Addiction organizations must fully accept individuals who are Two-Spirit, homosexual, etc., as an important first step towards self-acceptance and healing among these individuals. APHAs with addictions must be able to get addiction treatment without being stigmatized.

5. Front-line workers in Aboriginal HIV/AIDS organizations must fully accept individuals who are addicts and substance abusers, and be aware that such individuals require help depending on where they are on the continuum of healing.

Recommendations toward Community Awareness:

6. Aboriginal communities create obstacles to prevention education by the stigma placed on homosexuality, Two-Spirit, and HIV/AIDS. Awareness and openness within the community as a whole, particularly among leaders, is necessary for prevention education to be possible, and effective.

7. Communities must be educated about the sexual realities associated with STIs and HIV, and potential risks to children who are placed in situations of high-risk sexual behaviour. Educational efforts are best when targeted to suit different age-groups, gender groups, and events and venues.

Recommendations toward High Risk Group Counselling:

8. Addiction treatment centres need to be more proactive in order to prevent STI and HIV infections among this high-risk group. To this end, STI prevention and education practices which currently exist in Aboriginal HIV/AIDS and some Addiction programs, need to be documented as part of a "Good Practices Approach."

9. Peer counselling is necessary for effective STI prevention. Aboriginal people are best suited to deliver these messages to their own people, and situations may require that peers are grouped according to gender and age. Culturally relevant programs need to encourage the development of positive sexual behaviour skills as an effective way to prevent STI and HIV infection.

Recommendations toward STI Screening:

10. STI screening could be integrated into Addictions programs. It should not be mandatory, but information about and access to testing for both STIs and HIV should become a core element in Addiction intake procedures and programs.

11. For both Addictions and HIV/AIDS programs where individuals are encouraged to be tested for STIs and/or HIV, there must be complementary treatment and counselling programs for individuals who test positive.

Recommendations toward Harm Reduction:

12. Aboriginal organizations must work together to reinforce STI and HIV prevention among the high-risk groups they serve. In the cities particularly where IDU rates are high, cooperation between Addictions and HIV workers is essential.

13. There is lack of coordination between harm reduction and abstinence programs. For instance, people on methadone often cannot get addiction treatment and fall between the cracks. Aboriginal organizations must address the fundamental divide between HIV-based organizations (harm reduction) and Addictions centres (abstinence).

14. Both harm reduction and abstinence approaches strongly rely on traditional healing and medicines from different traditions. This commonality may be a bridge between the two streams. It is at least a place where they can begin to come together to better define the goal of "no harm" or "reduced harm" for Aboriginal people at risk.

Recommendations toward Healthy Sexuality:

15. Sexualization of communities and youth, and sex trade in communities, is a root cause for spread of STIs. Education in healthy sexuality, and a return to traditional ways (eg., rites of passage), is part of the solution.

16. Prevention measures such as condom availability and distribution are a good practice in promoting healthy sexuality, but such interventions must be culturally and community appropriate to be effective.

Recommendations toward Sustainable Funding, Resources and Advocacy:

17. In order to be sustainable, a Good Practices Approach must be supported by stable and long-term funding to Aboriginal HIV/AIDS and Addictions organizations. Core funding to organizations is essential to the goal of on-going, consistent and affordable initiatives that reach significant numbers of at-risk Aboriginal people.

18. Integration of addictions and HIV/AIDS agendas will become more critical, as the situation in Aboriginal communities is increasingly more difficult and complex with the combination of alcohol and IDU addictions, Hepatitis C, HIV and AIDS.

19. A successful Good Practices Approach will rely on input from many Aboriginal sources, through oral tradition and ongoing sharing of knowledge. Seminars such as the CAAN Focus Group which bring together specialists from both Addictions and HIV/AIDS organizations must continue as part of a long-term strategy for STI prevention education.

7. CONCLUDING REMARKS

Together, the literature review and the CAAN Focus Group seminar were an effective means of exploring the foundations of what will work – and what will not work – towards the education and prevention of STIs in Aboriginal communities. The CAAN Focus Group clearly stated that answers cannot be found in the literature, but rather in the experiences of Aboriginal front-line workers in addictions and HIV/AIDS organizations:

> *We have an addictions treatment matrix, HIV and STI – 3 matrices – and layers and layers of pieces that fit together in terms of STIs and awareness. Our processes for having an indigenous – First Nation, Métis, Inuit approach – is to take some time to step back so we're not just doing literature reviews – taking some time to develop our own tools for developing assessments. If we put all of our best minds together we can come up with some good stuff. All of our [best] practices are walking around in the communities. Our communities are oral tradition. When it comes to our own best practices – it's more oral, so this focus group process is better for us than a literature review.*

The CAAN Focus Group demonstrated the need to share experiences and to understand each other...

However, as shown throughout this report, published literature, reports and manuals provide both background to and support for much of what was voiced during the CAAN Focus Group discussions. From an "oral tradition" perspective, the CAAN Focus Group seminar was in itself a "good practice." Knowledge was shared among individuals with complimentary, and sometimes contradictory, viewpoints. The challenge comes with the integration of these differences:

> *There are so many different views represented here... we won't have a pancake made out of the same dough.*

Rather than a "Best Practice Model," the CAAN Focus Group has advocated and assembled a preliminary list of principles toward a "Good Practice Approach" that can be communicated among Aboriginal organizations of all types. The approach must be flexible and expandable in order to apply to the various types and levels of Aboriginal organizations and communities. This is consistent with the "moving target" approach advocated by NAHO's (2001) "Best Practices Program" for knowledge transfer. Notions of flexibility, expansion and movement are echoed also in the "innovation cycle" developed during the CAAN Focus Group seminar, emphasizing the current need for integrated and sustained funding and resources in the area of awareness and education regarding STIs, HIV/AIDS and Addictions.

Aboriginal front-line workers in both HIV/AIDS and Addictions organizations are dealing with an unprecedented combination of new factors, such as the rise of STI and HIV infection among intravenous drug users and other addiction-related high-risk behaviours. The CAAN Focus Group demonstrated the need to share experiences and to understand each other, and indicated a willingness among Aboriginal HIV/AIDS and Addictions organizations to work together to integrate approaches and messages regarding common issues, including sexually transmitted infections.

APPENDIX A: ANNOTATED BIBLIOGRAPHY OF SOURCES CITED

Aboriginal Nurses Association of Canada
2002 *Finding Our Way: A Sexual and Reproductive Health Sourcebook for Aboriginal Communities*. Aboriginal Nurses Association of Canada and Planned Parenthood Federation of Canada: Ottawa. (URL: http://www.anac.on.ca/)

This is an extensive resource using Aboriginal holistic models and history to explain sexuality to people of all backgrounds and age groups. It features sections on Two Spirit people and HIV prevention, based on a Harm Reduction model. It also includes sections on Community Planning for education and Harm Reduction. It also contains much information on the incidence of AIDS among Aboriginal people. For example, several factors and situations are identified as relevant to the increased risk of STIs in Aboriginal communities: 1) more travel, especially of Aboriginal youth and young adults, between reserves and urban communities leading to people having many sexual partners living in different places; 2) residential school experiences, sexual abuse and sexual violence in our communities, resulting in low self-esteem and alcohol abuse and their negative effects on sexual decision making; 3) breakdown of the family and stress on relationships; negative experiences of sexuality lead to problems making healthy sexual decisions ; 4) poor access to health services; 5) loss of parental guidance and support; 6) poverty, which makes it hard to stay healthy and resist infection, to buy condoms and to travel to sexual health clinics; 7) a lack of knowledge about safer sex practices and the risk of sexually transmitted infections; 8) intravenous drug use; 9) contracting sexually transmitted infections in prison and spreading them in the community.

Ah Chee, Donna
1997 *Good Practice Means Self-Determination. A Case Study from Central Australia*. Paper presented by the Director of the Institute for Aboriginal Development (Alice Springs) to ANTA's ATSIPTAC Network Exchange, Canberra, August 25th, 1997. (URL: www.koori.usyd.edu.au/fiaep/atsiptac.html)

This paper advocates that "good practices" begin with the fundamental principal of Aboriginal self-determination. Aimed at Aboriginal political and cultural achievement, Ah Chee argues that good health practices are those chosen and controlled by Aboriginal communities. She concludes that "good practices" are those which achieve "the right to health" among First Nations peoples.

AIDS Coalition of Nova Scotia
1998 *Gay Men and Alcohol Project: boys just wanna have fun*. Halifax.

A study that goes beyond the risks associated with the connections between alcohol use and unsafe sexual behaviour, to examine what motivates gay and bisexual men to choose to use alcohol, or what alcohol represents in their lives. The project is designed to develop and evaluate HIV prevention strategies which address the link between alcohol use and risk for men who have sex with men. One of the findings was that few specific services existed for gay and bisexual men who wanted help with alcohol addiction. Recommendations targeted to Addictions Workers include: 1) community-based research through addiction agencies to identify social factors that influence alcohol use leading to high-risk behaviour; 2) partnerships between health care providers and addictions workers that will help gay and bisexual men to access necessary services, etc.

Alberta Two Spirit Working Group and Nechi Institute
2003 *Two Spirits in Motion, 1st Canadian Forum on Two Spirit Peoples, HIV/AIDS and Health*. Alberta Two Spirit Working Group and the Nechi Training, Research and Health Promotions Institute.

Working groups were held with 82 people from all regions of Canada. Workshop solutions included: Education and awareness training for Correctional staff, Justice workers, Probation Officers, also staff at Healing Lodges and Correctional Elders; Harm Reduction through decriminalization of sexual relations in Institutions and availability of Harm Reduction training; increased sensitivity training regarding Two Spirit people with addiction treatment programs, parents, Chiefs and Councils etc.; educate mainstream society about homophobia and addictions; further research into Two Spirit people, historically and cross-culturally; more use of Two Spirit people in decolonization (i.e. Residential School issues) and traditional ceremonies; formation of a national Two Spirit organization.

Atlantic First Nations AIDS Network (AFNAN)

1997 *Best Practices Model on Child Sexual Abuse and HIV/AIDS*. Halifax.

One of the few reports directly relevant to both "best practice models" and to Aboriginal HIV/AIDS. The model was developed as AFNAN's response to instances where, as the only ASO for HIV/AIDS in the Atlantic, staff was compelled to intervene in an HIV/AIDS crisis connected to child sexual abuse. Unable to find any guide to help deal with this type of crisis, AFNAN decided to document the information they gathered and what they learned from experience in dealing with this issue. The report advocates the importance of documenting and sharing information among ASOs, in order to assist each other in dealing with a variety of situations related to HIV/AIDS.

Armstrong, Todd (Pauktuutit – Inuit Women's Association of Canada)

2000 Celebrating Community Knowledge: Encouraging Involvement, Achieving Ownership and Building Confidence Through Comprehensive Community Consultation. *Native Social Work Journal* (Special Edition – HIV/AIDS: Issues Within Aboriginal Populations) 3(1): 107-118.

The distinct nature of Inuit culture, traditions and beliefs has rarely been reflected in HIV/AIDS educational materials developed for Aboriginal people. A lack of Inuit-specific educational materials has allowed Inuit to ignore and even deny the likelihood that they are at risk of HIV/AIDS. It has been viewed as a southern white male (homosexual) disease, rather than one related to STDS and heterosexual relations that might also affect the north. In response, Pauktuutit began developing HIV/AIDS prevention material for Inuit communities in 1998. The value of comprehensive community consultation in the development of educational materials cannot be overstated. The project was facilitated by Pauktuutit, but community-driven. The goal was to broaden the scope of understandable, relevant, accessible HIV/AIDS prevention, treatment and care information for Inuit communities. Several best practices are identified: 1) broad community representation and meaningful community consultation ("One Inuk cannot adequately represent the needs of all Inuit..."); 2) representation must be not only cultural, but also about gender, age, regional difference and life experience, and also involving the balance between modern life and traditional life.

Barlow, J. Kevin

2003 *Examining HIV/AIDS among the Aboriginal Population in Canada in the Post-Residential Schools Era*. (URL: www.ahf.ca/english/index.shtml)

This article explores "best practices" regarding HIV/AIDS as these may relate to the link between a legacy of emotional difficulties as a result of residential schools, and negative coping patterns such as sexual compulsions and addictions that increase risk for STIs and HIV infection. Children of residential school survivors who grow up in an environment of alcoholism, physical, mental and sexual abuse may be predisposed to addictions (eg., IDU) and at higher risk for STI and HIV. Examples are presented of "best practice" projects and programs by Aboriginal organizations that have achieved desired results in a variety of areas of HIV/AIDS care, treatment and support including harm reduction, interventions, prevention education, etc.

Bedima, A.L. with S.D. Pinkerton, D. Cohen, B. Gray and T. Farley

2002 Condom Distribution: A Cost-Utility Analysis. *International Journal of STD & AIDS* 13/6: 384-392.

The study conducted a cost-utility analysis of a social marketing campaign in which over 33 million condoms were made freely available throughout Louisiana over three years, at a cost of $3 million. Surveys among 275,000 African Americans reveal that condom use increased 30%. The report estimates that 170 HIV infections were thereby prevented, saving an estimated $33 million in medical costs. The study also found that condom increases as low as 2.7% were still cost-saving. Condom distribution is a community-level HIV prevention intervention that has the potential to reach large segments of the general population, thereby averting significant numbers of HIV infections and associated medical costs. The intervention is easy to scale up to large populations or down to small populations (Aboriginal, reserves). The financial and health benefits of condom social marketing support making it a routine component of HIV prevention services nationally.

British Columbia (BC) Aboriginal HIV/AIDS Task Force
1999 *The Red Road: Pathways to Wholeness*. (Nadine Caplette and Alex Archie, Co-Chairs)

An Aboriginal Strategy for HIV and AIDS in BC. Recommendations include: 1) Build healthy communities by targeting the underlying causes of high risk behaviour for HIV such as poor parenting skills, alcohol and drug use, emotional, physical and sexual abuse, and historical abuse, eg., residential school system; 2) increase STD prevention and treatment services available to rural, remote and reserve communities; 3) coordinate HIV, STD, and TB health services and increase community education regarding their linkages; 4) prevent HIV transmission through harm reduction programs such as needle exchange and disposal programs, and methadone treatment; 5) secure funding for Aboriginal HIV/AIDS services by developing clearer procedures and better liaisons between funding agencies and independent service providers, by promoting available funding sources for HIV/AIDS services and providing proposal development support.

Cameron Wolf and K. C. Bond
2002 Exploring Similarity Between Peer Educators and Their Contacts and AIDS-protective Behaviours in Reproductive Health Programmes for Adolescents and Young Adults in Ghana. *AIDS CARE* 14/3: 361-373.

The study of 106 peer counsellors and 526 of their contacts found that peer educators tend to teach people who are much like themselves (53% within two years of age, 59% same sex, 70% same ethnicity, and 65% same school status). The study also shows that peer educators"who are highly similar to their contacts are more likely to induce less risk behaviours in their contacts.

Canadian Aboriginal AIDS Network (CAAN)
1998 *Joining the Circle: An Aboriginal Harm Reduction Model, A Guide for Developing a Harm Reduction Program in Your Community, Phase I*. Ottawa: CAAN.

Phase I focused on the social and economic profile of Aboriginal Injection Drug Users across Canada. CAAN notes a lack of Aboriginal specific programs and aims to improve services offered to this segment of the population. Statistics show Aboriginal people are among the groups that have the highest rate of new infections and, in the case of women, IDU is the most marked route of HIV transmission. CAAN emphasizes the Harm Reduction approach as a pragmatic, non-judgmental way of dealing with HIV infection through injection drug use, and aims to address the issue of transmission rather than focus on the use of drugs which, in some instances, are inevitable (for Phase II, see CAAN 2004a).

2003 *Strengthening Ties – Strengthening Communities: An Aboriginal Strategy on HIV/AIDS in Canada for First Nations, Inuit and Métis People*. Ottawa: CAAN.

This is CAAN's most recent broad-based strategy in response to HIV/AIDS within the Inuit, Métis and First Nations (status and non-status; on- and off-reserve) population in Canada. The strategy outlines key issues and nine strategic areas for programs and services specific to Aboriginal People living with and affected by HIV/AIDS. Chapter 6, titled "Diverse Groups, Many Needs" addresses the issue of addictions, including injection drug use (IDU) and other substance abuse that leads to high-risk behaviour for STIs, HIV and Hepatitis C. The challenge remains that many of Aboriginal Addiction Treatment centres are using abstinence-based models and are not prepared to deal with injection drug use. One of the nine strategic areas is "Supporting Broad-Based Harm Reduction Approaches," aimed at better defining harm reduction so that greater efforts are placed to overcome how addictions or substance use relate to HIV/AIDS. Harm reductions and abstinence based philosophies are not in conflict with each – rather, they both support the common goal of "no harm" for the individual while using different ways to reach that goal. If no harm (abstinence) is not possible, ways of reducing harm need to be offered and supported. Personal histories that increase chances that an Aboriginal person will turn to alcohol and/or drugs include: growing up in a violent home, sexual abuse, poverty, loss of loved ones to suicide or other violent deaths. Underlying causes of these personal histories may include: residential school legacy, seemingly hopeless economic conditions in isolated communities, and systematic discrimination and racism.

2004a *Joining the Circle: An Aboriginal Harm Reduction Model, A Guide for Developing a Harm Reduction Program in Your Community, Phase II*. [Draft Report]. Ottawa: CAAN.

This Phase II guide is the result of further research following the 1998 Phase I report. It provides a step-by-step approach to developing programs. It focuses on the successful ways that Aboriginal communities use harm reduction in order to create an Aboriginal Harm Reduction Policy. The information about harm reduction in Aboriginal communities is documented in a guide for community use.

2004b *The Community Based HIV/AIDS Research Environmental Scan* (Final Report). Ottawa: CAAN.

This report documents the findings of the Community Based HIV/AIDS Research environmental scan conducted by CAAN. The scan explores the research capacity building needs of Aboriginal HIV/AIDS service organizations, in part to fulfil CAAN's commitment to the self-determining principles of Aboriginal community based research, encompassed in the acronym "OCAP": Ownership, Control, Access, Possession.

Canadian AIDS Society (CAS)

1997 *Under the Influence: Making the Connection between HIV/AIDS and Substance Use*. Ottawa.

A manual that builds on the findings and recommendations of a previous project, "The HIV, Alcohol, and Other Drug Use Project" (CAS 1994). The manual provides support to the changing roles of support staff in community-based AIDS organizations (CBAOs), and the promotion of harm reduction practices among persons living with HIV/AIDS who are also drug users. The manual provides guidelines on the best way for each CBAO to develop appropriate policies and procedures in such areas as: 1) confidentiality and privacy for clients; 2) attitudes, values and beliefs of the organization; 3) boundaries and ethics that define the relationship between staff and clients; 4) a code of conduct ("house rules") for both staff and clients; 5) self-care strategies; 6) harm reduction practices and treatment options for substance users, and others.

Chen, James L. et. al.

2003 Sexually Transmitted Diseases Surveillance Among Incarcerated MSM and Opportunity for HIV Prevention. *AIDS Education and Prevention* 15, Supplement A: 117-126.

STD screening and a survey was used to determine the rate of HIV among a segregated unit of men who have sex with men (MSM) in Los Angeles. The HIV rate was 12.4%, and the high prevalence found in this population indicates the opportunity for HIV prevention within STD screening of incarcerated MSM. Bridging HIV prevention into STD screening will require the integration of primary and secondary prevention services within the jail including case management, early treatment, and referral services.

Elford, J. et. al.

2003 Peer-Led HIV Prevention among Gay Men in London: A Process Evaluation. *AIDS CARE* 14/3: 351-360.

A peer-led prevention initiative was developed among men visiting gyms in central London. The study found no significant impact on the risk behaviours of gay men using the gym, largely because peer counsellors did not follow through with the programme for the most part – only 20% remained in the study. The study concludes that peer education programs require a substantial input from the health promotion team, meaning that peer education should not necessarily be viewed as a low-cost approach to prevention.

Gyramanthy, VA, RP Thomas, J Mikl, LA Mcnutt, DL Morse, J DeHovitz, E Ujhelyi, S Szamado

2002 Sexual Activity and Condom Use among Eastern European Adolescents: Study of Hungarian Adolescent Risk Behaviours. *International Journal of STD & AIDS* 13/6: 399-405.

A questionnaire was given to 3,486 secondary school students in Hungary to measure sexual activity and attitudes toward condom use. Condom use by those having sex in the past three weeks was reported as consistent/every time (40%), irregular (25.6%) and none (34.3%). More frequent condom use was predicted in youth who had positive opinions about condoms, who had a fear of AIDS,

and where condom use was initiated by both partners. The report calls for targeted AIDS/STD education and prevention among adolescents.

Health Canada, Canadian Strategy on HIV/AIDS / Community Development
2003 *Best Practice Models fo the Integration of HIV Prevention, Care, Treatment and Support* Request for Proposals (seven projects approved for funding). (URL: www.hc-sc.gc.ca/hppb/hiv_aids/can_strat/community/models.html)

Indian Health Services BPM for Diabetes Care and Education (USA)
2003 *The Indian Health Service (IHS) Integrated Best Practice Model. Basic Diabetes Care and Education: A Systems Approach*. (URL: www.betterdiabetescare.org/NEEDSbestpracticemodel.htm)

A self-assessment tool that defines important components of a diabetes care system for American Indian / Alaska Native communities. "Best practices" are used as a standard by which existing programs can "test" their performance and identify areas where they can make changes to be more effective.

Kipp, W. et. al.
2002 HIV Counselling and Testing in Rural Uganda: Communities' Attitudes and Perceptions Towards an HIV Counselling and Testing Programme. *AIDS CARE* 14/5: 699-706.

The aim of this qualitative study was to elucidate whether HIV counselling and testing was acceptable to a rural community and whether they expressed a need for it. In focus groups, participants expressed a strong need for HIV counselling and testing services. Community health workers were the preferred provider of services. However, participants stressed that they should not come from the same community. Also, single intervention programs for HIV were thought to be ineffective in reducing risk behaviour; the participants requested counselling services that could be continually offered. The study results also showed that there is a demand for HIV counselling services without being HIV tested.

Lamont, Louise
2000 *A Best Practice Model for Victim Services: A Reflection on the Process that Developed the Model*. Paper presented at the Conference, Reducing Criminality... Perth, Western Australia, 31 July and 1 August 2000. (URL: www.aic.gov.au/conferences/criminality/lamont.pdf)

A Best Practice Model (BPM) for victim services, aimed at promoting victim safety. The model is applied as a set of accountability standards: BPMs promote accountability by providing clear and consistent frameworks that outline what is considered good practice principles; argues that BPMs should be linked to contractual requirements of funding agreements to better ensure standards of quality service by the program provider to those in need of the service. The BPM also serves as a guide for new programs: BPMs are useful documents, particularly for inexperienced program developers and front-line workers, because it strives to define and reflect what is considered "good practice" in the field.

Maar, Marion, S. Cooper and M.A. Peltier
2000 A Community-based Approach to Reducing HIV/AIDS Infection in the Wikwemikong Unceded Indian Reserve. *Native Social Work Journal* (Special Edition – HIV/AIDS: Issues Within Aboriginal Populations) 3(1): 119-126.

A review of the HIV/AIDS Education Program in Wikwemikong with recommendations to reduce the transmission of HIV/AIDS and STDs in the community. A "healthy sexuality program" implemented in the elementary and secondary schools educates children beginning in grade 5 about healthy sexual development (eg., "good touch / bad touch"). The high school program focuses on HIV/AIDS and STDs including sessions to increase students' capabilities to talk about and to practice safer sex. Best practices include: close collaboration between community-based HIV/AIDS prevention programs and the existing community health network is required (for On-Reserve programs); inter-program collaboration is necessary within the local health care system; clinics delivered at schools reach youth; educational activities outside the health environment (eg., community sporting events) reach young to middle age adults.

Marsden, Namaste, K. Clement and D. Schneider
2000 Honouring and Caring for Aboriginal People and Communities in the Fight Against HIV/AIDS. *Native Social Work Journal* (Special Edition – HIV/AIDS: Issues Within Aboriginal Populations) 3(1): 127-142.

Healing Our Spirit BC First Nations AIDS Society introduces a holistic healing and Aboriginal specific service delivery model to address the HIV/AIDS epidemic. A holistic approach attempts to address the multiple and complex issues associated with HIV/AIDS, including sexual abuse, homophobia, shame, lack of housing, lack of education, alcohol and drug abuse and addiction. Good practices include: Prevention workshops custom designed for a cross-section of audiences; communities, schools, tradition houses, prisons, women's groups, youth groups, elders, colleges & universities, powwows, conferences; workshops are delivered to suit the audience working in collaboration with organizations and communities to tailor training and education to specific needs of the group.

McLeod, Albert
2001 *All My Relations: Aboriginal IDU Harm Reduction Training Peer Educators Manual*. Manitoba Aboriginal AIDS Taskforce (Produced for the Four Doorways Project – Phase II).

Four teaching modules based on the Medicine Wheel, part of an HIV prevention peer education training program, using a detailed training manual and videos. The manual takes into account the physical, emotional, mental and spiritual doorways towards HIV prevention and treatment. It is based on traditional teachings such as the Sharing Circle, the Four Directions, and use of medicines. Particularly suited to Ojibwe, Cree and other Anishnabek, also to urban Native populations. The approach also incorporates information and videos from the larger local AIDS community.

Métis National Council
2003 *Following the Red Cart – Métis and HIV/AIDS: The Basic Facts*. Ottawa.

Chapter 4 of this report deals specifically with Sexually Transmitted Diseases (STDs) and HIV/AIDS, linking the higher rates of STDs in the Aboriginal population to sexual risk behaviour. Factors which bring the risk of contact with STDs to even the most remote Métis communities include: low rates of condom use, poor self-esteem, an inability to demand safer-sex practices or to decline sex, increased alcohol and drug use, and high mobility between inner cities and rural communities. To reduce the risk of STI and/or HIV/AIDS, the manual suggests sexual abstinence, choosing a sex partner who you know and trust, learning to use latex condoms, and talking with your partner about past relationships and the risk of STIs and HIV/AIDS.

Monette, LaVerne and Darcy Albert
2001 *Voices of Two-Spirited Men: A Survey of Aboriginal Two Spirited Men Across Canada*. 2 – Spirited People of the 1st Nations. Toronto.

Two-Spirited men recommended the following prevention programs as most effective (in order of priority): promoting condom use; talking/ healing circles; needle exchange programs; Elder counselling; Medicine wheel. Peer education and community education are also important prevention strategies. The core issue of homophobia must be addressed in order to reduce risk-taking behaviour among Two-Spirited men. More than any other factor, it is the sense of alienation that contributes to engaging in high-risk activities which makes two-spirited men vulnerable to HIV/AIDS. As well, it is the responsibility of interveners to not only hand out condoms and needles, but to understand their needs for love, respect, support and some sense of community.

Myers, Ted, S.L. Bullock, L.M. Calzavara, R. Cockerill, V.W. Marshall, & C. George-Mandoka
1999 Culture and Sexual Practices in Response to HIV among Aboriginal People Living On-Reserve in Ontario. *Culture Health and Sexuality* 1(1): 19-37.

An extensive study of 658 status Indians on 11 reserves, the paper shows that learning about sex from partners and having familiarity of Aboriginal language and traditions led to more risk-taking behaviour than did learning about sex from Family and Health Services – which led to more condom use. Important challenges exist for the integration of traditional learning methods with knowledge of HIV/AIDS. It is important to understand the conflicting paradigms of Aboriginal tradition, modern medicine and public health service.

An awareness of the complexity of culture and differences within and between communities is critical to future research in this area.

National Aboriginal Health Organization (NAHO)
2001 *A Path to a Better Future: A Preliminary Framework for a Best Practices Program for Aboriginal Health and Health Care* (Produced for NAHO by John Marriott and Ann L. Mabel). Ottawa. (URL: www.naho.ca/english/pdf/research_path.pdf)

An examination of the "best practice" concept and how it relates to Aboriginal health and health care in Canada. This study is based on information found on-line and in the literature. Interviews with Canadian Aboriginal organizations and individuals were conducted in order to determine their perspectives on "best practices." The paper addresses the background context and foundational concepts of best practices, and presents a proposed preliminary framework for health care in the Canadian Aboriginal context. Adapting best practices is considered a process of transferring knowledge, including "cultural knowledge" defined as "the beliefs an organization holds to be true, the experience, observation, reflection about itself and its environments as well as the norms and criteria used to evaluate projects and performance. It includes 'shared assumptions and beliefs.' These same attributes could also be applied to 'communities' and organizations influenced by and responsive to particular cultural influences" (p.7). Defined as knowledge management and development, notions of "best practice" are considered diverse and constantly evolving, and elements of Aboriginal health and health care are similarly complex and dynamic. Best Practices are "thoroughly documented, well-measured, and effectively managed based on fact gathering and analysis. They yield better outcomes, higher quality at lower costs and more positive impact than comparable procedures" (p.21). It is important to note that this paper does not promote a "model" per se, but rather views best practices as a program of ongoing capacity building through information, expertise and experience. It defines a best practice as a "moving target" that is re-directed as ideas, problems, and methods change and emerge (p.21).

Nechi Institute (URL: http://www.nechi.com.)
Alberta's Nechi Institute is one of the primary Aboriginal holistic health organizations in Canada. Community based, it is based more on an Abstinence model, rather than Harm Reduction. "Nechi is an Aboriginal Movement committed to holistic healing and healthy, addiction-free lifestyles."

New South Wales Health Department (Australia)
2000 *Best Practice Model for the Use of Psychotropic Medication in Residential Care Facilities and Guidelines on the Management of Challenging Behaviour in Residential Aged Care Facilities in New South Wales*. (URL: www.health.nsw.gov.au)

"Best practices" for dealing with difficult behaviour among the elderly in Residential Care, focusing on when to use physical restraint and/or drugs. It applies the "best practice model" in two ways: 1) Decision Strategy– 3 step strategy of best practice decision-making in identifying the problem (cause of difficult behaviour), deciding if restraint is necessary, and then managing the appropriate restraint (physical or chemical); 2) Principles of Practice – 5 practical guidelines or steps that care staff can follow in various circumstances around difficult behaviour; i.e. "if this is the situation, then do the following..."

O'Leary, A. et. al.
2003 Childhood Sexual Abuse and Sexual Transmission Risk Behaviour among HIV-positive Men Who Have Sex with Men. *AIDS CARE* 15/1: 17-26.

Previous studies have indicated an association between childhood sexual abuse (CSA) and adult sexual risk behaviour among women and among men who have sex with men (MSM). However, no studies to date have tested the hypothesis that a history of childhood sexual abuse predicts sexual behaviour carrying risk of transmission of HIV to others, ie. in a known HIV-positive cohort. This study tests this hypothesis among a sample of 456 HIV-positive MSM recruited from community venues in New York and San Francisco. "CSA history was found to be significantly associated with recent unprotected sex with partners of HIV-negative or

unknown HIV status. These results highlight the importance of mental health services for individuals who have been sexually abused, both for personal and for public health benefit, and also indicate a need for further research into mediators of CSA effects on transmission-related behaviour.

Pauktuutit: Inuit Women's Association of Canada
1995 *National Inuit HIV/AIDS and STDs Training Workshop, May 3-5, 1995: Final Report*. Iqaluit.

Addresses the risks of HIV/AIDS and STDs in relation to alcohol consumption, and explores behaviours rather than attitudes that put people at risk. Behavioural issues are usually deeper and more complex than simply substance abuse and often include the attitudes of dis-empowerment, low self-esteem, and other problems such as childhood sexual abuse. In Inuit communities – most of which are small – there is difficulty for health workers to remain objective because everyone knows everyone else. It is also difficult to organize groups of Inuit and non-Inuit, due to the "history of oppression."

Perez, F and F. Dabis
2003 HIV Prevention in Latin America: Reaching Youth in Colombia. *AIDS CARE* 15/1: 77-87.

The paper describes and evaluates a school-based peer education programme on HIV primary prevention implemented in urban marginal districts of three cities of Colombia from 1997 to 1999. Its main objective was to promote risk awareness and safe sexual behaviours among urban youth populations. Methodology included the collection of baseline information through qualitative methods (focus groups and in-depth interviews), a knowledge, attitudes and practices (KAP) survey, a health education intervention, and post-intervention data collection. Direct beneficiaries were adolescents 10 to 19 years of age, and secondary school teachers of 6th to 9th grades. Main strategies used were peer education and classroom sessions. The interventions had a positive effect. Mass education by a combination of interventions and events at school level, backed up by effective interpersonal communication such as peer education, classroom teaching and community actions are effective primary prevention strategies for HIV sexual transmission and should be more extensively considered.

Quebec First Nations & Inuit HIV & AIDS Working Group
1999 *The Circle of Hope: The First Nations & Inuit of Quebec HIV & AIDS Strategy*. Prepared by Juanita Cree, Consultant, First Nations of Quebec & Labrador Health and Social Services Commission.

HIV/AIDS strategy based on the principle of "Holistic Opportunity for Prevention and Equality in Treatment (HOPE). Addresses the high rate of sexually-transmitted disease as an indicator of high-risk behaviour, linking this rate to "multigenerational trauma, cultural oppression, the legacy of the residential school experience (which) have all deeply impacted upon self esteem and the capacity for intimacy and sexual expression." As well, "the presence of alcohol, Injection Drug Use (IDU) and solvent use is also linked to high risk behaviours." Recommendations include: 1) Determine the knowledge and attitudes on risk environment of sex. alcohol, drug and solvent use practices and IDU among First Nations and Inuit communities; 2) Ensure that ongoing surveillance and monitoring mechanisms are First Nation and Inuit specific in regards to STDs and HIV infection; 3) Ensure that First Nation and Inuit communities hae ownership, control, and access to research and studies that will assist communities and individuals with assessments, trends, behaviours and needs; 4) promote prevention programming that respects First Nation and Inuit holistic approaches, using culturally appropriate materials; 5) Create a network of resources to assist caregivers, individuals with STDs, HIV and AIDS, families and others affected by HIV/AIDS; 6) view the challenge of STD-HIV and AIDS as an opportunity for envisioning and developing healthy communities by promoting healthy attitudes through prevention.

Ross, Michael W., with L.Y. Hwang, C. Zack, L. Bull and M.L. Williams
2002a Sexual Risk Behaviours and STIs in Drug Abuse Treatment Populations Whose Drug of Choice Is Crack Cocaine. *International Journal of STD & AIDS* 13/11: 769-774.

This study investigated STI prevalence in drug users and associated demographics with sexual behaviours. Data analysis focused on differences between those for who crack cocaine was the drug of choice compared with other drugs, since

crack is associated with sexual arousal and a sex-for-drugs economy. Data indicates that having crack as a drug of choice is significantly associated with increased levels of previous STIs, previous drug treatment, African-American race, selling or buying sex for drugs or money, and increased infection markets for syphilis, chlamydia and herpes simplex-2. The data suggests that drug users generally, and crack-using populations in particular, should be routinely screened for STIs as an integral part of all drug treatment programs.

Ross, Michael W. and Mark L. Williams
2002b Effective Targeted and Community HIV/STD Prevention Programs. *Journal of Sex Research* 39/1: 58-62.

Community interventions and interventions targeting specific groups at risk of STDs/HIV have demonstrated significant impacts on sexual behaviour, particularly condom use and safer sex. Interventions delivered by health professionals, absent a community base, appear to be unsuccessful. Where cultures or subcultures are targeted, the close involvement of such groups in the design and delivery of messages is critical to their success. Diffusion of interventions through existing social networks further extends the intervention into the community and acts to reinforce and maintain changes in peer norms toward safer sexual behaviour. Targeting interventions to change sexual behaviours which cause sexually transmissible diseases (STDs) at individuals in large numbers usually involves community-level interventions. Community interventions frequently attempt to bring about changes in safer sex knowledge, attitudes, intentions, and peer norms among members of the entire target population.

Schnarch, Brian; First Nations Centre – National Aboriginal Health Organization
2004 *Ownership, Control, Access, and Possession (OCAP) or Self-Determination Applied to Research: A Critical Analysis of Contemporary First Nations Research and Some Options for First Nations Communities*. Journal of Aboriginal Health (January 2004: 80-95)

The principles of ownership, control, access and possession (OCAP) crystallize themes long advocated by First Nations in Canada. Coined by the Steering Committee of the First Nations Regional Longitudinal Health Survey, the principles are discussed as an expression of self-determination in research. The key notions outlined in this paper relate to the collective ownership of group information; First Nations control over research and information; First Nations' management of access to their data and physical possession of the data. Following a critical review of colonial research practices and recent institutional efforts to improve ethics in Aboriginal research, this paper highlights policies and strategies adopted by First Nations organizations – approaches which offer a way out of the muddle of contemporary Aboriginal research and the ethical dilemmas that characterize it. The benefits of OCAP are described including the rebuilding of trust, improved research quality and relevance, decreased bias, meaningful capacity development, and community empowerment to make change.

Spittal, Patricia M. et. al.
2003 Surviving the Sex Trade: a Comparison of HIV Risk Behaviours among Street-involved Women in Two Canadian Cities Who Inject Drugs. *AIDS CARE* 15/2: 187-195.

In Canada, very little is known about the factors and processes that cause drug-related harm among female intravenous drug users (IDUs). Women who inject drugs and participate in the survival sex trade are considered to be at increased risk for sexual and drug-related harms, including HIV infection. Between September 1999 and September 2000, women participating in the VIDUS cohort in Vancouver and the St. Luc Cohort in Montreal completed interviewer-administered questionnaires. Analyses were conducted to compare the demographic characteristics, sexual risk behaviours, risky injection practices and drug use patterns among women who self-identified as participating in the sex trade with those who did not identify as participating in the sex trade. While patterns of sexual risk were similar, the risky injection practice and drug use patterns between sex trade workers and non-sex trade workers were markedly different. Behaviours associated with the sex trade included greater than once per day use of heroin, smokable crack cocaine and borrowing used syringes. Also, sex

trade workers were less likely to be enrolled in methadone treatment. Of the sex trade workers, 24% were Aboriginal, and of the non-sex trade workers, 31% were Aboriginal.

Standing Committee on Health
2003 *Strengthening the Canadian Strategy on HIV/AIDS*. Report of the Standing Committee on Health. Bonnie Brown, M.P., Chair. Ottawa: House of Commons Canada (June 2003).

The report of the Standing Committee on Health of its study on the Canadian Strategy on HIV/AIDS. The Committee found that Aboriginal peoples accounted for more than one-quarter of all new AIDS cases. Relevant recommendations include: Recommendation 1a.) That the federal government increase the total funding for the renewed federal Canadian Strategy on HIV/AIDS to $100 million annually (funding has remained at $42.2 million since 1993); Recommendation 1b.) This increased federal funding specifically designate $5 million annually to the at-risk sub-population of First Nations and Inuit; Recommendation 3c.) That Health Canada and its federal partners ensure that awareness and prevention programs are increasingly administered by affected communities including people living with HIV/AIDS, youth, Aboriginal or ethnic communities and are more sensitive to culture, age and gender; Recommendation 4b.) That Health Canada and other federal partners provide stable, long-term funding for regional Aboriginal AIDS service organizations to develop culturally appropriate practices to fight HIV in the community and to help implement specific programs to deal with the HIV/AIDS-related needs of the disproportionately large Aboriginal population in prisons.

Tyndall, Mark W. et. al.
2003 Intensive Injection Cocaine Use as the Primary Risk Factor in the Vancouver HIV-1 Epidemic. *AIDS* 17/6: 887-893.

This study was conducted to determine how patterns of cocaine use influence the risk of HIV infection. The Vancouver Injection Drug Users Study is an open prospective cohort of injecting drug users that began in May 1996. During the six months prior to seroconversion, predictors of HIV infection were: 1) injecting cocaine use; 2) incarceration; 3) unstable housing; 4) methadone maintenance treatment, and; 5) Aboriginal ethnicity. Injection cocaine users remain particularly vulnerable to HIV infection and treatment options for cocaine dependency remain woefully inadequate.

Vernon, Irene S.
2001 *Killing Us Quietly: Native Americans and HIV/AIDS*. Lincoln: University of Nebraska Press.

Chapter 4, "Native American Prevention", deals with HIV/AIDS programs implemented in a variety of Aboriginal contexts in the USA. Pages 86-99 provide a list and summary of Native organizations in the USA who provide programs that work. Characteristics of HIV education and prevention that work, include: 1) a clearly defined target population (eg., age, gender, sexual orientation, race/ethnicity, neighbourhood, etc.); 2) clearly defined objectives (eg., what behaviour is being targeted for change; what new behaviours are to be achieved and by whom); 3) clearly defined interventions (eg., interventions explained in plain language); 4) targeting the highest-risk populations. This means that Native people and in many cases Native leaders are involved in the development and implementation and that the cultural and social context is shown to be true for the communities' individual experiences. Other characteristics of effective HIV/AIDS strategies include: 5) group support for individuals in the process of behaviour change; 6) enhance individual self-esteem through concrete and achievable incentives for behaviour change; 7) spiritual resources and cultural revitalization; 8) help to change the physical and social environment of the individual; 9) community awareness; 10) reaching people "where they live, where they work, and where they go." A critical aspect of native HIV prevention is the use of multiple strategies that link to other components such as treatment, care, and other disease prevention efforts (eg., STIs).

Wabano Centre for Aboriginal Health
2000 *Keep the Circle Strong*. Ottawa: Wabano.

An HIV/AIDS awareness tool in which a "train the trainer" program is based on an interactive training circle rooted in Aboriginal culture where Eagle, Mouse, Bear and Buffalo are invited to share their stories and wisdom to help us keep the circle strong.

Weber, Amy E.
2001 Risk Factors Associated With HIV Infection Among Young Gay and Bisexual Men in Canada. *Journal of Acquired Immune Deficiency Syndromes* 28: 81-88.

The Vanguard Project and the Omega Cohort are prospective cohort studies of gay and bisexual men ongoing in Vancouver and Montreal. Men who were HIV-positive were more likely to report living in unstable housing, to have had less than a high school education, and to have been unemployed than those who were HIV-negative. HIV-positive men were also more likely to report having engaged in sexual risk behaviour. With respect to substance use, HIV-positive men were more likely to report the use of crack, cocaine, heroin, and marijuana and to use injection drugs. Reports of cocaine use and injection drug use were also significantly higher for men who seroconverted compared with HIV-negative men. The data indicate that HIV-positive gay and bisexual men are more likely to be living in unstable conditions and to report more risky sexual and substance use behaviours than HIV-negative men. Although statistics are not provided for Aboriginal men in the study, the results indicate a direct link between social disadvantages and the likelihood of acquiring HIV, characteristics that apply to much of the Aboriginal population in Canada.

Wilson, Bianca D. M. and R.L. Miller
2003 Examining Strategies for Cultural Grounded HIV Prevention: A Review. *AIDS Education and Prevention* 15/2: 184-202.

A review of HIV prevention literature to 2001 to examine interventions that have explicitly sought to address cultural concepts. It notes that cultural roles are not accounted for in interventions that were designed for European Americans, and that there is a need to recognize the unique contribution of cultural elements to HIV prevention and to the design of programs that reduce the risk of HIV.

APPENDIX B: LIST OF PARTICIPATING ABORIGINAL HIV/AIDS AND ADDICTIONS ORGANIZATIONS

Akwesasne Wholistic Health & Wellness (Mohawk Council of Akwesasne ON)

All Nations Hope AIDS Network (Regina SK)

Canadian Aboriginal AIDS Network (Ottawa ON)

First Nations Quebec and Labrador Health and Social Services Commission (Wendake QC)

Healing Our Nations (Halifax NS)

Healing Our Spirit (Vancouver BC)

Health Secretariat / HIV and Diabetes, Assembly of First Nations (Ottawa ON)

Métis Addictions Council of Saskatchewan Provincial Métis Health Inc. (Regina SK)

National Native Addictions Partnership Foundation (Muskoday SK)

Nechi Institute (Edmonton AB)

Onen'to:kon Treatment Centre (Kahnesetake QC)

Wabano Centre for Aboriginal Health (Ottawa ON)

Wanaki Treatment Centre (Maniwaki / Kitigan Zibi, QC)

CANADIAN ABORIGINAL AIDS NETWORK (CAAN)

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