A COMPARATIVE ANALYSIS

Strengthening Ties – Strengthening Communities

An Aboriginal Strategy on HIV/AIDS in Canada for First Nations, Inuit and Métis People – CAAN July 2003

AND

Leading Together

Canada Takes Action on HIV/AIDS 2005-2010

January 2, 2007

PREFACE:

It is important that before any comparison is attempted between an Aboriginal Strategy to address HIV/AIDS and one adopted by the federal government that the context for the comparison be articulated.

The Aboriginal Reality

The National Aboriginal Council on HIV/AIDS (NACHA) uses the phrase *Aboriginal reality* to reflect the context within which the Council addresses the challenges faced by the Aboriginal community with respect to HIV/AIDS.

The results of colonization, the residential school era, the loss of language and land base, the lack of economic opportunities are well known in the Aboriginal community and are becoming known in Canada generally. The negative impacts of these losses are strongly felt in the transgendered, gay, lesbian, intersexed, bisexual and two spirited Aboriginal community due to the stigma attached to sexual orientation that was ingrained in Aboriginal people generally by colonizers. Before the arrival of newcomers to Canada, all Aboriginal people were embraced regardless of their sexual orientation and were valued for their gifts and talents alone. They were not judged by others but participated fully in an inclusive society.

Sadly the *Aboriginal reality* of today is far different and has resulted in:

- Lower educational attainment, compared to other Canadians
- Unemployment rates that mirror third world countries
- Living conditions that are below acceptable standards including the lack of housing, safe drinking water, appropriate sewage disposal, adequate sources of heat etc.
- Poor nutrition
- High rates of Fetal Alcohol Spectrum Disorder (FASD)
- High rates of suicide, substance abuse, homelessness, mental illness
- High rates of disease including, but not limited to, HIV/AIDS, Diabetes, TB etc.
- High rates of the Aboriginal population are housed in federally run institutions.(While Aboriginal people make up 2.8% of the Canadian population they represent 18% of the federally incarcerated population)
- Aboriginal people make up a large percentage of street workers and those involved in the sex trade
- Aboriginal women and children suffer from emotional, sexual and physical abuse at alarming rates
- Lower life expectancy of Aboriginal people compared to Canadians generally.
- Homophobia and internalized racism etc.

In addition to these realities, Aboriginal people experience disparities between the access that on-reserve and off-reserve populations have to resources such as, health care, post secondary education and housing.

Aboriginal people experience the *reality* of always being subservient and dependent on governments to "do the right thing". Experience has demonstrated that when Aboriginal people are in a position to make decisions for themselves and to design and implement their own solutions, they are more likely to succeed. This too is *the Aboriginal reality.*

It is important to understand that the Aboriginal population in Canada is very diverse in terms of political structures, social / cultural structures, language, geographical location and sexual orientation. One thing all have in common is the history of colonization, assimilation attempts and the general "disruption of the peace" Aboriginal people once enjoyed and treasured.

Aboriginal World View

When designing a Strategy to address HIV/AIDS in the Aboriginal community it is important to understand the Aboriginal world view and the fundamental differences between how mainstream Canadians and Aboriginal people perceive the affect/impact of the disease.

Aboriginal people value the interconnectedness of all life. The Commissioners of the Royal Commission on Aboriginal Peoples in 1996, came to understand the Aboriginal world view as follows:

"Culture we understand to be a whole way of life of a people…Aboriginal languages, relationship with the land, spirituality, and the ethics or rules of behaviour by which Aboriginal peoples maintained order in their families, clans, communities, nations and confederacies. Spirituality, in Aboriginal discourse, is not a system of beliefs that can be defined like a religion; it is a way in which people acknowledge that every element of the material world is in some sense infused with spirit, and all human behaviour is affected by, and in turn has an effect in, a non-material, spiritual realm. Ethics or rules guiding conduct of human beings toward one another and with other creatures and elements of the world, are more than rational codes that can be ignored. The rules are embedded in the way things are; they are enforced, inescapably, by the whole order of life, through movement and response in the physical world and the spiritual realm."[1]

HIV/AIDS cannot be viewed in isolation from everything else and treated in isolation from the Aboriginal reality. The disease has an impact or affect on everything within the Aboriginal family, community and world. If this world view is ignored in favour of mainstream thinking the result can be devastating. The Royal Commission on Aboriginal Peoples noted the following:

[1] James Dumont, Royal Commission on Aboriginal Peoples (RCAP) 1996, Chapter 15, Rekindling the Fire p.3

"If the circumstances in which Aboriginal people express their world view are controlled by persons with a different view of reality, and those in control are unwilling to acknowledge or accommodate Aboriginal ways, the scene is set for conflict or suppression of difference."[2]

Aboriginal AIDS Service Organizations and others have repeatedly said that they must develop their own methods to treat and prevent the spread of HIV/AIDS, methods that are respectful of the Aboriginal world view and the importance of a family-based or kinship focused approach. Some of these ideas are reflected in the ASHAC as well as regional Aboriginal HIV/AIDS Strategies, the Inuit Action Plan and First Nations Plans of Action and are beginning to emerge in Leading Together: Canada Takes Action on HIV/AIDS, particularly in its population specific yet holistic response to the epidemic.

Distinction between the Canadian Aboriginal AIDS Network (CAAN) and the National Aboriginal Council on HIV/AIDS (NACHA)

At the national level, there are two bodies that address HIV/AIDS in the Aboriginal community. NACHA is a body comprised of representatives from the Métis, First Nations, Inuit and "Aboriginal HIV Community" (AASOs, CAAN etc). NACHA's mandate is to provide policy advice to the Public Health Agency of Canada (and federal partners) on issues related to Aboriginal people and HIV/AIDS.

CAAN has a much broader mandate in that it develops policy, develops and delivers programs, undertakes research and advocacy, capacity building and communications and social marketing. Both groups play important roles in addressing the epidemic within the Aboriginal population.

[2] RCAP 1996, Chapter 15 p.11

INTRODUCTION:

In 2003, The Canadian Aboriginal AIDS Network (CAAN) developed a Strategy (ASHAC) Strengthening Ties – Strengthening Communities, to help to focus efforts aimed at responding to the HIV/AIDS epidemic specifically within the First Nations, Métis and Inuit population in Canada. The need to develop such a Strategy was based on existing epidemiological evidence that identified alarming increases of infection within the Aboriginal population and the need to develop and implement Aboriginal-specific approaches to address HIV/AIDS and those infected and affected by it, including holistic and integrated approaches. In fact, in 1997, CAAN provided projections on where the epidemic would be over five years within the Aboriginal population and these proved "right on the mark". There was also a realization that Aboriginal AIDS Services Organizations in various parts of the country and community-based health/social service providers would benefit from strategic approaches to confronting the epidemic from an Aboriginal viewpoint. The ASHAC was developed with 173 Aboriginal individuals and organizations across the country. It was intended to be a document that would guide the broader Aboriginal HIV/AIDS movement (without interfering with successful community-based approaches) and inform government officials of what was needed to help curb the Aboriginal HIV/AIDS epidemic.

At the same time, it should be noted that because no substantial prevention investment was made into the Aboriginal population under the former National AIDS Strategy I & II (later the Canadian Strategy on HIV/AIDS and now the Federal Initiative), that this has resulted in the epidemic taking a firm foothold in a population which already experienced poorer health and distressed social conditions.

In 2004, the federal government released, The Federal Initiative to Address HIV/AIDS in Canada (Strengthening Federal Action in the Canadian Response to HIV/AIDS) also known as the "FI". The document indicates that the "epidemic has gained a foothold in vulnerable populations including Aboriginal people, inmates [where Aboriginal people are over-represented], injection drug users [the leading factor in HIV infections amongst the Aboriginal population], at risk youth and women, and people from countries where HIV is endemic."

In October 2005, the Canadian Public Health Agency (PHAC) released, Leading Together (Canada Takes Action on HIV/AIDS), a five year blueprint that outlines a coordinated response to the disease and sets a benchmark of 2010 when Canada hopes to see, "the end of the epidemic in sight." Leading Together notes the unique differences and challenges faced by the Aboriginal community in the face of HIV/AIDS:

"Strengthening Ties – Strengthening Communities: An Aboriginal Strategy on HIV/AIDS in Canada, along with strategies for Aboriginal people in British Columbia, Quebec , Alberta and

Ontario) is on HIV as part of the larger challenge of building healthy communities. Within Aboriginal communities, HIV prevention initiatives must target women and two-spirit men as well as the underlying issues of poverty, lack of employment, stigma within the Aboriginal community, substance use and low self-esteem. Effective approaches will be led by Aboriginal people and grounded in Aboriginal culture, healing and the intertwining of body, mind and spirit. They will also be integrated with other urgent Aboriginal health issues, such as diabetes and the use of tobacco and alcohol, and encourage people to value and take care of themselves. Leadership, innovation and a long-term commitment will be vital."[3]

Over the more than 20 years since HIV/AIDS has been recognized as a threat to the health of Aboriginal people and their communities, Aboriginal organizations, agencies and groups have struggled to keep on top of the ever evolving needs of APHAs and those affected by HIV/AIDS.

"The absence of an Aboriginal HIV/AIDS Strategy has been felt for sometime. In its place the federal strategy guided actions, but several factors complicated efforts to effectively reach Aboriginal populations. Some were systematic weaknesses found in the federal funding, as many Aboriginal AIDS Service organizations were quite late in getting started. In the first and second phases of the federal strategy, the main source of funds that could be accessed by Aboriginal groups were known as "special projects", which meant they were time-limited. Medical Services Branch (now called First Nations & Inuit Health Branch) also offered funding for On-reserve and Inuit communities, but again, these funds did not support organizational structures. Other factors experienced, included the fact that, as with main-stream populations, HIV/AIDS first began affecting Two-Spirited (gay) males, and also occurred mostly in larger urban centers. Thus, many Aboriginal political leaders, and even health portfolios did not heed the warnings being raised. Today, we know that HIV/AIDS is being spread through unprotected sex and injection drug use among all people, irregardless if they are heterosexual, homosexual, bisexual, women, babies develop HIV from HIV+ mothers, youth, or older individuals. [4]

Both the Federal Initiative and Leading Together recognize the need to support Aboriginal organizations to develop and deliver programs and services within Aboriginal populations. The *purpose* of this document is to closely examine the degree to which strategies are aligned and where there may be gaps. It is important to lay out the similarities and differences so that when progress is measured, the unique circumstances of Aboriginal people with respect to HIV/AIDS, is clearly understood by all stakeholders.

1.0 VISIONS and MISSIONS:

Leading Together has as its' Vision:

The end of the HIV/AIDS epidemic is in sight.

The Mission:

- *To champion the needs and rights of people living with HIV/AIDS and people at risk*

[3] Leading Together, PHAC 2005 p.33
[4] Strengthening Ties – Strengthening Communities CAAN, 2003 p.4

- *To work collaboratively to build effective responses and lead the fight against HIV/AIDS at home and abroad*
- *To act boldly and strategically to stop the HIV/AIDS epidemic*

ASHAC has as its' Vision:

Aboriginal People in Canada will achieve and maintain strong, healthy, and fulfilling lives, free of HIV/AIDS and related issues.

The Mission:

To support meaningful, lasting efforts for Aboriginal communities to address HIV/AIDS and related issues in a culturally relevant manner.

The Vision and Mission of the ASHAC are more comprehensive than that described by Leading Together. This is due to the addition of the words, "related issues" which reflects the family-based reality and the world view of the Aboriginal community. It will not be enough to see an end to the epidemic in sight but rather to repair the damage to the family and thus, the community left in its wake. The Aboriginal population has experienced a legacy of similar assaults and is aware of the need for a process to allow for healing so that the people are not only free from the epidemic but are also, *strong, healthy and fulfilled.* As a result, the benchmark of 2010 may not be realistic within the Aboriginal population.

In addition, the lack of long term, sustained funding for Aboriginal AIDS Service Organizations and Aboriginal communities under CSHA I and II has put the Aboriginal response to HIV/AIDS ten years behind other ASOs.

Leading Together however, recognizes the need to support the long term efforts of Aboriginal people in the fight against HIV/AIDS and supports an integrated/holistic approach that is reflective and respectful of Aboriginal cultures.

2.0 Goals:

The goals identified in Leading Together have been strengthened from the direction set by the FI.

To the year 2010, we will pursue four main goals. All four are intricately linked. The second and third goals are a continuum:

1. *Reduce the social inequities, stigma and discrimination that threaten people's health and well-being.*
2. *Prevent the spread of HIV.*
3. *Provide timely, safe and effective diagnosis, care, treatment and support for all people living in Canada with HIV/AIDS.*

4. *Contribute to global efforts to fight the epidemic and find a cure.*[5]

The goals identified in ASHAC are as follows:

Two broad goals will be supported by the ASHAC, which are:

- *Ensure the best possible efforts, in all areas, are placed to meet the needs of Aboriginal people living with HIV/AIDS; and*
- *Prevent the further spread of HIV/AIDS among Aboriginal populations, through education, awareness and whatever means available and necessary.*

Underlying these broad goals, is the recognition that because Aboriginal people are family-based, support is also needed for those affected by this disease such as family members, partners, and HIV/AIDS workers to name a few.[6]

The goals identified by both Strategies are complimentary with the possible exception of goal #4 identified by Leading Together. However, it is important to note again that the ASHAC goes further with the incorporation of the needs of those affected by the disease.

3.0 STRATEGIES:

Leading Together has identified nine strategic areas and while the ASHAC may not use the same language many of the nine strategies identified in Strengthening Ties - Strengthening Communities are a good fit.

Leading Together Strategy #1 *Commitment to Social Justice and Human Rights:* This strategy recognizes individual and cultural differences as well as diversity. It speaks to fairness in terms of access to services and health outcomes. It supports programs that meets everyone's basic life needs, self esteem and seeks to reduce inequities in wealth, income and life chances. It encourages participation by all even the most disadvantaged.

The Strategy supports responses to HIV that "recognize[s] and address[es] the broad determinants of health that make people vulnerable to HIV and to disease progression"

While ASHAC does not identify a specific Strategy to address "determinants of health" and social justice, Strengthening Ties – Strengthening Communities was developed within this context as follows:

Determinants of health which are factors known to affect or influence a person's health, can be either negative or positive. Negative determinants can be such

[5] Leading Together, PHAC 2005 p.5
[6] ASHAC, CAAN, 2003 p.3

things as living in poverty, having inadequate or no housing, as well as childhood traumas that remain unresolved. Positive determinants can be getting higher education, having stable home environments, or strong cultural connections. Generally, the main factor affecting the health of Aboriginal people is socio-economic status, in addition to environmental factors. Many Aboriginal people experience higher rates of disease and extensive health issues, mainly because these social determinants of health are much lower for far too many Aboriginal people. When there are too many negative determinants in a person's life, the risks for HIV/AIDS and other diseases increase. Aboriginal communities have experienced major negative forces, like the Residential School Legacy. While Aboriginal peoples' experiences are not all the same, there are some common issues, such as: a loss of language, culture, and traditional use of land. As well, systemic discrimination; gender inequality and displaced roles; are just some of the other forces that have shook the foundations that Aboriginal cultures once thrived upon. It is easy to see how many of these underlying issues can complicate intervention strategies. For many Aboriginal people, achieving holistic health after generations of trauma and losses, is necessary to re-building our societies and in order for our health conditions to improve, including removing much of the risk for HIV and AIDS. Holistic health is about finding balance emotionally, physically, spiritually, and mentally. Northern and isolated communities face challenges brought on simply by their geographic location, such as access to adequate resources and health systems. Language can also be a factor.[7]

Leading Together Strategy #2 *Leadership and Innovation*

This Strategy speaks to the need for *"leadership at all levels…in local communities…and within Aboriginal, provincial/territorial and federal governments. We need committed people who are willing to speak out to convince the public and policy makers that HIV deserves focused, discrete attention."*[8]

The ASHAC does not designate a Strategy to Aboriginal Leadership but prefaces the Strategic Plan with "a message to Aboriginal leadership".

"*There is a critical role that Aboriginal Leaders can play in each of these strategic areas and in the overall struggle to overcome all the challenges that come with HIV/AIDS. Aboriginal Leaders need to speak publicly about HIV/AIDS so that Aboriginal communities hear their Leaders talking about these issues and begin to take it more seriously."* [9]

Leading Together Strategy #3 *Meaningful Participation of People Living With HIV/Communities at Risk*

[7] ASHAC, CAAN 2003 p.4-5
[8] Leading Together, PHAC 2005 p.15
[9] ASHAC, CAAN 2003 p.11

This strategy highlights the value of engaging people living with HIV and communities at risk to reduce the stigma associated with the disease, prevent the spread of the virus, improve care, living conditions and end the epidemic. It recognizes that people living with HIV/AIDS have a right to participate in the decisions that affect them. It also educates care givers and others and it provides a social support network.

The ASHAC identifies a Strategy "Engaging Aboriginal Groups with Specific Needs" and also devotes an entire chapter to "Diverse Groups Many Needs."

This Strategy states the following:

"The purpose here is when working with specific groups, it is best to meaningfully engage members of these groups in all aspects of how a program or service can best meet their needs. Cross-cultural training, increasing awareness among service providers, and respecting individual choices are some examples of where work is needed. As well, increasing Aboriginal participation in HIV/AIDS program planning, implementation and evaluation is another area."[10]

Leading Together Strategy #4 *Early Intervention*

Early intervention includes needle exchange programs, testing for pregnant women and early diagnosis.

The ASHAC addresses *early intervention* under the Strategic direction, Supporting Broad-Based Harm Reduction Approaches. The area speaks to substance use including alcohol, injection drug use and other substances and the potential for risk behaviours as a result of substance use and addiction. In terms of *testing for women during pregnancy,* the issue is raised in the document under Diverse Groups, Many Needs, under Aboriginal women[11] but it does not specifically address testing. Under ASHAC's Strategic area, Prevention and Education, one of the objectives refers to "*to examine and develop appropriate initiatives to address mother-to-child transmission."*[12] This could be an area where "testing and even early diagnosis" could be addressed, however there appears to be a gap on the part of ASHAC to address this issue in a targeted manner.

Leading Together Strategy #5 *Research/Evidence*

[10] IBID p.18
[11] ASHAC, CAAN 2003 p.26
[12] IBID p.14

This strategy seeks to get ahead of the HIV/AIDS epidemic through basic scientific research, evaluation and epidemiological, clinical, psychosocial, community-based and health services research. The research and evidence will:

- Help to track and monitor the spread of HIV
- Contribute to worldwide efforts
- Help us understand the needs of people with HIV and communities at risk
- Lead to stronger care and treatment programs
- Inform policy
- Help us make better use of limited resources

The ASHAC addresses the Research/Evidence Strategy under the Research and Evaluation Strategic direction. Strengthening Ties – Strengthening Communities focuses attention on the need for accurate epidemiological evidence across Canada with respect to Aboriginal people and HIV. The Strategy also addresses intellectual property, the OCAP philosophy (Ownership, Control, Access and Possession), the need to build research capacity within the Aboriginal community and the need to establish Aboriginal ethics review processes. The outcomes largely reflect the outcomes identified in Leading Together however, this may be an area within the ASHAC that requires a renewed approach especially given the continuing disparity in accurate epidemiological evidence with respect to the Aboriginal population from one province to the next.

Leading Together Strategy #6 *A Sustained Response*

The Strategy highlights the need to ensure a response to HIV prevention and treatment that is long-term and comprehensive. The focus is on changing and adapting prevention messages as new knowledge is gained, messages that are developed by PHAs and treatment of PHAs that are now living with the disease for longer periods of time.

The ASHAC addresses sustainability under the Strategic Area, "Sustainability, Partnerships and Collaboration" The section notes the following:

"Sustainability is about designing comprehensive efforts that can ensure HIV/AIDS work gets incorporated into all relevant services and agencies…Sustainability rests on how well efforts can influence and create positive outcomes."[13]

In terms of Prevention, ASHAC devotes a Strategic direction to the subject under Prevention and Education and indicates the following outcomes:

- *enhanced prevention and education messages/approaches*
- *expanded, working knowledge of broad and targeted deliveries*

[13] ASHAC, CAAN 2003 p.15

- *increased and updated resources*
- *formalized appropriate and current education messages*
- *increased awareness of issues facing hard-to-reach groups*
- *increased collaboration with shared expertise*
- *shared knowledge of current trends and emerging issues*
- *enhanced awareness campaigns*
- *mobilized regions and communities*
- *broadened support through more knowledgeable communities*
- *effective delivery and refined approaches*
- *appropriately developed and maintained programs*
- *broadened awareness and support*
- *cross-jurisdictional approaches*
- *better informed children and youth*
- *healthier life approaches to sex and sexuality, alcohol and drug use, and other related issues*
- *enhanced and relevant educational delivery*
- *up-to-date information delivery*
- *enhanced and relevant educational delivery*
- *informed and appropriate treatment choices*[14]

Leading Together Strategy #7 Culture, *Gender and Age- Appropriate Programs and Services*

This strategy deals specifically with the Aboriginal population as follows:

"*Programs and services for First Nations, Métis and Inuit people must 'first and foremost, show respect and honour for all Aboriginal beliefs, practices and customs' and reflect the 'pride and dignity that Aboriginal heritage demands"*[15]

The Strategy also addresses the specific needs of:

- Youth
- Gay men
- Women and
- People from different ethnocultural and ethnoracial groups

The entire ASHAC is, of course, directed to the Aboriginal population but there are specific areas that address issues such as "respect and honour" for example:

- Under the Strategy that addresses *Sustainability, Partnerships and Collaboration* two of the objectives are complimentary to the intent of Leading Together; *"to support and utilize where appropriate, cross-cultural*

[14] IBID p. 14
[15] Leading Together, PHAC 2005 p.17

sensitivity training for non-Aboriginal workers/agencies who work with Aboriginal people." And "to insist government departments engage Aboriginal input regarding decisions affecting policy and programs related to HIV/AIDS and the determinants of health".[16]

- Under the Strategy that addresses *Legal, Ethical, and Human Rights Issues* this section deals with the need for both Aboriginal service providers and decision makers and non-Aboriginal service providers to become more aware of individual rights and respect and protect these rights.
- Under the Strategy that addresses *Engaging Aboriginal Groups with Specific Needs* this area addresses the diversity within the Aboriginal population and supports the notion that "one size does not fit all". Not only is the Aboriginal population comprised of First Nations, Métis and Inuit people, it is comprised of people who speak different languages, practice different customs and live in a variety of settings.

Objectives under this Strategy address "population-specific approaches" as follows:

- *to encourage and support development of appropriate programs and activities*
- *to ensure Aboriginal women are provided access to current and accurate information and support regarding testing, prevention, sexual assault issues, choices and treatment options around pregnancy and HIV/AIDS to address perinatal HIV and HCV transmission, as well as female-specific research on care and treatment issues, which is both culture and gender specific*
- *to continue to examine and respond to specific issues related to the role of unprotected sex in the spread of HIV/AIDS within all groups*
- *to ensure an increase in youth-specific efforts are designed to provide access to current and accurate information and support regarding testing and prevention, as well as care and treatment needs*
- *to increase knowledge and education on Inter-sexed and transgendered issues/needs regarding HIV/AIDS and related issues*
- *to expand efforts that respond to issues facing Aboriginal men in regards to HIV/AIDS and related issues*
- *to continue and expand efforts that respond to issues facing Two-Spirited people in regards to HIV/AIDS and related issues*
- *to recognize, design and implement efforts that address needs and issues, within a "family-based" cultural context, and in consideration of impacts on Support and Prevention Workers in the HIV/AIDS field*

[16] ASHAC, CAAN 2003 p.14

- *to recognize unique and special needs and challenges in terms of mental health issues, and developmental learning issues, including Fetal Alcohol Spectrum Disorder, Attention Deficit Disorder, among others.* [17]

Leading Together Strategy #8 *A Commitment to Monitoring, Evaluation and Quality Improvement*

Leading Together states the following:

"To stop the epidemic, our programs must be better than they are today. We must:

- *Monitor and evaluate the impact of what we do*
- *Learn from our experiences*
- *Continually refine and monitor our services"*[18]

The ASHAC makes reference to monitoring throughout the Strategic Plan and speaks to evaluation under *Research and Evaluation.* The ASHAC notes:

"It has been often said that Aboriginal people have been researched to death and the time is here to research us back to life. The time is long overdue for Aboriginal people themselves to use research as a tool for designing efforts that can support greater opportunities to collect and analyze data, so as to respond appropriately and effectively. There remains a need to train and increase the number of Aboriginal researchers."[19]

Leading Together Strategy #9 *Shared Responsibility*

Leading Together recognizes the need to undertake an *holistic* approach to addressing issues and factors that impact HIV/AIDS and this is an approach that has long been recommended by Aboriginal people. It is not enough to target the disease alone but the social determinants of health and economic circumstances must also be addressed. This will require a concerted effort across jurisdictions to impact services and systems such as:

- *Income programs*
- *Social and housing services*
- *The justice system*
- *The education system*
- *Correctional services*
- *The private sector (e.g. employment)*

[17] ASHAC, CAAN 2003 p.19
[18] Leading Together, PHAC 2005 p.17
[19] ASHAC, CAAN 2003 p.23

The ASHAC addresses the above as an overriding principle but also is more specific in two Strategic areas namely, Holistic Care, Treatment and Support and Coordination and Technical Support. Both areas speak to the need to address interjurisdictional issues at the national/provincial/territorial and local levels. They also speak to mental health issues, co-infections etc.

It is important to note that before Aboriginal groups can fully "share responsibility" there is a need for additional *Community Development, Capacity Building and Training.* ASHAC devotes a Strategic area to this effort and notes the following:

"Community development, capacity building and training are key to the success of the ASHAC, as well as the Aboriginal HIV/AIDS movement in Canada. Capacity building can include informal learning, whereas training generally (not always) involves more formal learning environments. In large part, Aboriginal communities are doubly burdened, both with the challenge of playing catch up to the rest of Canada in regard to HIV/AIDS, but also because significant social, economic and other health issues continue to exhaust resources. Greater efforts are required to plan, design, create and support implementation and/or adoption of preferred practices to ensure the best possible use of both human and financial resources. It is also critical to understand that Aboriginal communities have generations of negative impacts from failed government policy such as Residential Schools and assimilation in general. These have contributed directly and indirectly, to the multitude of underlying issues that Aboriginal people experience."[20]

4.0 CONCLUSIONS:

1. Because the purpose of this document is to examine the degree to which the Federal Initiative on HIV/AIDS and the blueprint for action, Leading Together are aligned with Strengthening Ties – Strengthening Communities, the ASHAC, one can conclude from an analysis of the Strategies that the documents ***are closely aligned in all respects***. While there are differences in the way strategies and objectives are defined, the ASHAC closely mirrors the objectives of both federal documents.

2. It is important to note that the ASHAC was not intended to be prescriptive in terms of the Aboriginal community but rather a guide to strategic thinking and planning for decision makers and service providers. As a result the language may not be as strong as the language used in Leading Together. In addition, no specific target dates or milestones are articulated in the ASHAC and this is largely due to the diversity within the Aboriginal population and the fact that most Aboriginal communities started to

[20] ASHAC, CAAN 2003 p.13

address HIV/AIDS later than others. Leading Together envisions seeing ***an end in sight to the epidemic by 2010 but this may be unrealistic for the Aboriginal community*** who continue to play "catch up" in terms of sustained funding, access to sensitive and skilled human resources and the lack of comprehensive and accurate data to track the epidemic.

3. Another important difference between the federal response to HIV/AIDS and that of the ASHAC are ***the socio-economic disparities felt by the Aboriginal community*** compared to the rest of Canada. Leading Together acknowledges the need to address the social determinants of health under Strategy #9, *Shared Responsibility* but when the "Aboriginal reality" is considered ***the work needed is considerable and will take policy and legislative change to address the jurisdictional issues*** that continue to place barriers between Aboriginal people and well-being. The 2010 Vision becomes more unrealistic when these issues are considered.

4. Another difference between the Aboriginal response and that of Leading Together and the FI is the "family-centered" approach which is the basis for the ASHAC. In other words, the importance placed on the individual living with HIV/AIDS is equal to that placed on those who are affected by HIV/AIDS. ***The whole family (broadly defined) is impacted by the disease and needs healing just as the whole family suffered from residential school abuses experienced by one or two family members***. This continues over generations. The loss of one results in weakening of the family and thus, the community.

5. Strengthening Ties – Strengthening Communities identifies a strategy to address *Aboriginal groups with special needs*. The document also provides narrative on *Diverse Groups, Many Needs*, however given the fact that it is now known that there are ***"mini-epidemics" within the Aboriginal community*** this section of ASHAC ***deserves to be revisited***. In 2003 when the ASHAC was released, HIV/AIDS crises within certain segments of the Aboriginal population were suspected but not well documented. It is well known now that heterosexual Aboriginal women and especially those who inject drugs are most at risk of becoming infected. Leading Together ***opens the door for a more focused approach to Aboriginal populations at risk***.

6. The FI speaks to *Global Engagement* as one of the Areas of Action. The ASHAC does not address global engagement even though more and more the world indigenous community is looking to Aboriginal AIDS Service Organizations (AASOs) and Non-governmental Organizations (NGOs) to assist them with planning and implementing HIV/AIDS related programs and services in their countries. ***Sharing indigenous knowledge around the world should be more clearly and strategically thought out in the ASHAC and articulated in a renewed ASHAC***. (CAAN formed an International Indigenous HIV/AIDS Secretariat after the

hugely successful Indigenous Satellite at IAC 2006. This is an example of how current efforts are naturally filling areas not prominently stated in the ASHAC and is also involved in a 5-year research collaboration with Australia and New Zealand).

7. One of the critical areas that all Strategic Plans agree on is the need for *long- term sustained responses to HIV/AIDS*. The piece-meal and time limited approach to funding HIV/AIDS has not facilitated the comprehensive planning and implementation of needed programs and services in the Aboriginal community. The ASHAC should be renewed with long-term, sustained funding in mind. Answers to the Question: ***'What could be achieved if Aboriginal ASOs were not always looking for funding to keep their doors open?' should be articulated in a strategic and realistic manner.*** Perhaps then, targets and milestones could be set.

8. Another area where the Federal Initiative and the ASHAC agree is the need to *integrate* the efforts of all of the key stakeholders. HIV/AIDS cannot be isolated from contributing factors such as poverty, homelessness, unemployment and mental health issues. To address these issues, which plague the Aboriginal community, a long term vision is required along with the establishment and maintenance of meaningful partnerships. This will not happen over night and therefore, the Aboriginal population will not realistically meet the 2010 target. Concern has been expressed by Aboriginal groups including CAAN that policy and decision makers may penalize the Aboriginal AIDS movement for failing to meet the targets set for the mainstream Canadian population. ***A renewed ASHAC ought to be developed that attempts to set out realistic measures and targets for the Aboriginal population and what is needed to meet***. A renewed ASHAC ***should also provide an analysis of how funding opportunities under the new Federal Initiative may or may not support the unique and substantial issues*** within the Aboriginal population.

Summary:

COMPARATIVE ANALYSIS – Strengthening Ties – Strengthening Communities (CAAN) and Leading Together (CANADA)

Theme/Strategy	Strengthening Ties	Leading Together
Vision:	• Achieve and maintain healthy and fulfilling lives free of HIV/AIDS	• The end of the epidemic is in sight by 2010.Rights respected and promoted; PHAs partners in policies; effective services re health and well-being; the racism, discrimination, poverty and homelessness that fuel the epidemic are reduced or eliminated.
Mission:	• Support lasting and meaningful efforts for Aboriginal. Communities to address HIV/AIDS and related issues/culturally relevant	• Champion the needs of PHAs and those at risk • Collaborate on effective responses here and abroad • Act boldly and strategically to stop the epidemic
Guiding Principles	• Respect and honour Aboriginal beliefs • Remember who we are, FN, Métis, Inuit and keep a community-based approach • Recognize the importance and contributions of APHAs • Best possible access to improved and equitable quality health ,life and wellness • Unity amongst all Aboriginal people • Uphold principles of OCAP (Ownership, Control, Access and Possession) of info and programs • Honour and respect the commitments to APHAs and those affected • Honour and respect commitments to Stakeholders	
Values:	•	• Social justice/fairness, equitable access/opportunity • Human Rights/economic, social/cultural/civil and political rights recognized and respected • Diversity/cultural and individual difference

		• Participation and empowerment/ all PHAs • Global Responsibility/contribute to others • Mutual Accountability
Goals	• Ensure the best possible efforts, in all areas, are placed to meet the needs of APHAs • Prevent the further spread of the disease among Aboriginal populations through education, awareness and whatever means available and necessary.	• Reduce social inequities, stigma and disc. That threaten people's health and well being • Prevent the spread of HIV • Timely, safe, effective diagnosis, care treatment and support for PHAs • Contribute to global efforts
Strategies	• Coordination and technical support • Community development, capacity building and training • Prevention and education • Sustainability, partnerships and collaboration • Legal, ethical and human rights issues • Engaging Aboriginal groups with special needs • Supporting broad-based harm reduction approaches • Holistic Care, treatment and support and • Research and evaluation	The Blueprint: • Commitment to Social Justice and Human Rights • Leadership and innovation • Meaningful participation of people living with HIV/Communities at risk • Early intervention • Research and evidence • A sustained response • Culture, gender and age-appropriate programs and services • A commitment to monitoring, evaluation and quality improvement • Shared responsibility