



Aboriginal HIV and AIDS Services in B.C.

Final Report
Spring, 2010

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Background

The idea of an inventory of government-funded Aboriginal HIV and AIDS services grew from two processes that have great potential to transform the sector's response to the epidemic.

The past three years have seen some notable developments in the area of HIV and AIDS prevention, treatment and care for Aboriginal people in B.C.:

- ▶ Creation of Renewing our Response (ROR), a collective of Aboriginal HIV and AIDS service organizations that has developed a set of recommendations for addressing the high rate of HIV infection among Aboriginal people;
- ▶ Signing and subsequent progress of the Tripartite First Nations Health Plan by Aboriginal, federal and provincial governments with the intent of "closing the health gaps between First Nations and other British Columbians."

A planning session in May 2008, hosted by the First Nations Health Council (FNHC), brought together stakeholders representing: Aboriginal communities and governments, service organizations (SOs), health authorities, the Ministry of Healthy Living and Sport (MHLS), First Nations and Inuit Health (FNIH), the Public Health Agency of Canada (PHAC), and Aboriginal People living with HIV/AIDS (APHAs) to discover a way that all parties could work together to improve the collective response to HIV and AIDS as it affects Aboriginal people.

A process to create an inventory/overview of government-funded Aboriginal HIV and AIDS services grew out of these activities. The first phase of quantitative data collection helped to describe funding sources and how these resources and services are distributed in different health regions. It was hoped that sufficient data would be readily available to identify sub-population groups served, along with the types of supports and interventions, in order to identify gaps in services for particular groups across geographical areas.

The second phase of this process was a collection of qualitative data in order to identify gaps, redundancies and strengths from the perspectives of Aboriginal communities, agencies serving Aboriginal people, researchers, advocates, funders and policy makers. It is hoped that the information gathered can be used in the planning and provision of HIV and AIDS services to Aboriginal people. Ultimately, the goal is to strengthen the sector and all the organizations within it, so that there will be significant progress in addressing HIV and AIDS as it affects Aboriginal people in B.C. It is hoped that the combined results described in this analysis will lead stakeholders in the sector to identify concrete steps that can be taken to improve the response to Aboriginal HIV and AIDS across the province.

Executive Summary

The analysis of government-funded Aboriginal HIV and AIDS services uses both quantitative and qualitative data collection techniques. In the first quantitative phase, a data-gathering tool was developed to collect information about funding provided in response to Aboriginal HIV and AIDS. The tool attempted to identify gaps in geographical areas and sub-populations served, approaches used, and issues addressed. In the course of the first phase, it was discovered that the data currently held is difficult to access and compare. As a result, it was not possible to make a complete assessment of gaps across the province.

In the qualitative phase, interviews were held to gather the words, stories and challenges the sector faces. These conversations with key informants were intended to discover the current state of the sector; identify gaps, redundancies and strengths; and to generate ideas based on improved relationships and a coordinated response to HIV and AIDS.

This report includes quantitative data from the first phase, and provides a thematic analysis of the interviews conducted as part of the second qualitative phase. In addition to describing the realities of addressing Aboriginal HIV and AIDS in the respondent's region and area of service, the respondents described several themes, including:

- ▶ Their sense of the realities of the work to address HIV and AIDS among Aboriginal people;
- ▶ Relevant service access issues;
- ▶ An assessment of the structure and relationships within their region; and
- ▶ Sub-groups who are particularly vulnerable to HIV and AIDS within the Aboriginal population.

Significant access gaps reported were similar to ones that have been identified previously, such as access transportation, generally low levels of community readiness, and access to testing, treatment and support services. At a systemic level, respondents mentioned, accountability, inadequate access to funding, coordination of important services such as education and prevention, the inconsistency of information flows, continued impact of jurisdictional issues and organizational capacity challenges. Respondents reported no redundancies, but did identify some ways of improving efficiency in the sector. They also identified foundations on which an improved response could be based, including some clinical models and approaches to build community readiness and address access issues. Respondents thought that the sector should focus on building the capacity of communities and broaden the range of stakeholder involvement. A list of goals and ideas was generated from these conversations (Appendix C).

The conclusion explores improvements that would advance the sector's ability to respond to the changing nature of HIV and AIDS among Aboriginal people. In particular this paper assesses the sector as struggling to improve its connectedness and coordination. For example:

- ▶ The integration of regional health authority Aboriginal health programs into existing public health, primary care and tertiary care programs continues to be a challenge;
- ▶ Accountability approaches and processes in the sector are still developing;
- ▶ The infrastructure of the sector is underdeveloped, including information flows and data sharing; and
- ▶ The capacity of individual organizations is being stretched by human resources challenges, which makes fundraising, evaluation and reporting difficult.

This paper, based on respondent suggestions, describes a series of incremental change recommendations that would have a positive transformative impact on the sector. It identifies the reasons why successfully conducting an inventory is extremely challenging given the current state of the sector. Results suggest a need for the collaborative development of measurable targets by federal, provincial, regional and private funders, as well as APHAs, agencies and researchers. Once broadly-supported targets are developed, these can be used as the basis for developing more detailed gaps analyses on a regional basis, and for developing more collaborative responses to HIV and AIDS as it affects Aboriginal people.

Project Methodology

The qualitative phase of the inventory project aimed to identify gaps, redundancies and strengths in the sector of services that provide HIV and AIDS services to Aboriginal people in B.C. A set list of questions was developed for each category of informant, which included:

- ▶ Aboriginal HIV/AIDS Services Organizations (AASOs);
- ▶ AIDS Services Organizations (ASOs);
- ▶ Health authority Aboriginal directors and contract managers;
- ▶ Friendship Centres; and
- ▶ Aboriginal Community Tribal Council or Band health services.

The interviews were placed in the context of the work of Renewing Our Response and the stakeholders group, as well as the development and implementation of the Tripartite First Nations Health Plan. Respondents were asked to focus on issues related to the organizations, systems and relationships.

The intent was to collect information and perspectives based on the realities of addressing HIV and AIDS among Aboriginal people in different health regions. Supplementary questions during the interview enabled respondents to speak to issues of relevance not anticipated at the outset of the project. In some cases, time did not permit completion of all the questions in the interview template, so each interview was adjusted to facilitate the unique perspective of each respondent.

Following the qualitative data collection and analysis, elements of the quantitative data collected during the first phase of the inventory were used to clarify, question and strengthen the findings of the qualitative data.

Baseline Quantitative Data

2006 Census data: All figures are for “single response” identity. Approximately 6,200 multiple responses are not included

Status	Total population	On-reserve	Rural	Small Urban	Large Urban
First Nation	129,580	49,270	14,025	36,780	29,500
Metis	59,445	695	13,000	23,845	21,910
Inuit	795	15	100	275	400

Notes:

48% of all Aboriginal people are aged 24 and under;

Population growth among Aboriginal people is six times that of the non-Aboriginal population.

Risk Factors for Aboriginal Transmission (Ministry of Health, 2006):

Intravenous Drug User (IDU)	47%
Heterosexual contact	22%
Sex Trade Worker (STW)/ IDU	21%
Men who engage in sex with men (MSM)	5%
Other	3%
MSM / IDU	2%

32% of HIV positive tests among Aboriginal people in B.C. were in individuals aged 29 and under.

Snapshot of Aboriginal HIV and AIDS funding by Health Region*

Health Region	Aboriginal population (2006)	Aboriginal population as % of total provincial Aboriginal population (2006)	Share of newly diagnosed Aboriginal HIV cases (2007)	Number of Bands (2009**) Source: First Nations Health Council	First Nations and Inuit Health (Health Canada) Funding** (2008-09)	Aboriginal-specific funding from PHAC Grants & Contributions (2008-09)	Contracted Aboriginal-specific funding from health authority (term varies)	Contracted HIV/AIDS-related funding from health authority (term varies)
Northern	48,050	24.5%	33%	55	\$348,725****	\$489,022	Data not available	Data not available
Interior	44,900	22.9%	3%	49	\$50,949	\$213,056	\$711,971	Data not available
Fraser	38,105	19.4%	11%	34	\$12,682	\$0	\$40,000	\$1,249,304
Vancouver Island	40,550	20.7%	10%	50	\$45,227	\$38,079	Data not available	\$1,543,677
Vancouver Coastal	24,470	12.5%	43%	14	\$30,797	\$354,298	\$861,250	\$7,364,597
Provincial					\$498,000	\$155,000	\$617,581	\$9,808,175
Total BC	196,070	100%	100%	211***	\$986,380	\$1,449,455	Incomplete	Incomplete

* Term is the most recent available at the time of analysis.

** Note that several First Nations Bands access services in more than one health region

*** Does not include FNIH Program funding for general health services in Aboriginal communities

**** Includes funding to Nisga'a Lisims Government, the Northern Aboriginal HIV / AIDS Task force and a special project nurse for two communities in the North

Qualitative Results

Describing the Reality

Respondents were asked to describe the current realities of working to address Aboriginal HIV and AIDS in their region. While there was considerable variation from respondents, the following highlights some common themes:

- Transmission is uneven, but is seen to be worsening across the province. Everyone expressed a need for more concerted action to address and stop the epidemic;
- Significant gaps in culturally safe and accessible services were identified. Testing is not evenly available, leaving current epidemiological data unreflective of the true extent of the epidemic;
- Remoteness is an issue in the spread of HIV, and mortality is high for Aboriginal people, in many cases due to treatable opportunistic infections;
- Stigma is still strong in many communities, leading some to deny the presence of HIV in communities. Homophobia is common in Aboriginal communities and is another barrier to raising awareness. If Aboriginal people still see HIV as a gay, white man's disease, there is less interest in taking action;
- At the same time, some Aboriginal communities have developed a good system of supports at various points on the continuum of vulnerability, such as education and prevention approaches, community supports and activities which address stigma against APHAs;
- High-risk behaviour is generally not declining. The most frequently mentioned groups that are particularly vulnerable are women and youth, although other sub-groups were identified (IDU's, MSM, older Aboriginal people and poor, homeless and socially isolated Aboriginal people);
- Industries that provide high incomes were also anecdotally related to the epidemic, both in terms of the availability of money for drugs and persistence of sex trade, and in relation to "truck stop" sex trade;
- Many respondents expressed that concerted action is needed to adequately address the social, political, economic and cultural history of Aboriginal people and their current-day realities.

Respondents also described challenges in accessing services for Aboriginal people in relation to HIV and AIDS:

- Aboriginal people face significant barriers to accessing necessary services, including geography, discrimination (both racial discrimination and serostatus discrimination), and simple shortage of ancillary services related to the determinants of health, such as housing or sufficient income to pay for adequate nutrition. Culturally safe testing and counselling is not available in all parts of the province;

- There are few supports for families of Aboriginal people living with HIV;
- There is a lack of organizations for some particularly vulnerable populations: HIV organizations serving Aboriginal women and Aboriginal youth do not exist in the province, and services are dependent on the ability of organizations to attract funding and implement specific programming;
- Current disability payments make it impossible for many APHAs to afford stable housing and adequate nutrition, and many ancillary services are unavailable to Aboriginal people;
- The mobility of Aboriginal people is not supported by jurisdictional boundaries in terms of on- and off-reserve funding, although some innovative practices have evolved in parts of the province.

Respondents offered their assessment of the structure and relationships within the sector of HIV and AIDS services for Aboriginal people. Themes included:

- A changing landscape of funding and policy development. This includes the relative newness of regional HAs, and the creation and evolution of the FNHA.
- Agencies are largely dependent on project funding, and this leads to constantly changing services offerings, staff turnover, and a chronic loss of organizational memory;
- There have been some improvements in the relationships between funders (mostly HAs) and service providers, although steps are needed to develop agreement on goals, accountability and reporting;
- There are regional collaborative tables discussing HIV and AIDS, and these are generally seen as having good results; however, respondents felt that some of these tables could be improved to have a more inclusive and egalitarian approach;
- Some collaboration and partnerships between service organizations is happening, but these are isolated;
- An overall shortage of resources to deal effectively with issues related to HIV and AIDS among Aboriginal people, and concerns that the integration of a Blood-Borne Pathogen (BBP) approach has stretched resources even further;
- Challenges to the infrastructure of the sector, including communication across the province, human resources issues, organizational capacity for fundraising and reporting, and a lack of common standards for services such as education and prevention; and
- A concentration of expertise and provincial organizations in the Lower Mainland, and in a few cities across the province, with a shortage of services in many regions and Health Service Delivery Areas (HSDAs).

Sub-Groups

Respondents were asked to identify sub-groups within their region's Aboriginal population who were seen to be particularly vulnerable. The two groups most frequently mentioned were women and youth. Aboriginal youth, in many cases due to a lack of employment opportunities, are turning to drug dealing and other criminal activities that increases their risk of contracting HIV. Sexual and other types of violence against Aboriginal women, teen pregnancies and continued reliance on sex trade work are factors that demonstrate Aboriginal women's ongoing and disproportionate vulnerability to HIV and AIDS.

Other groups identified were:

- ▶ Those who use intravenous drugs;
- ▶ Street-involved, homeless, low income, early school leavers and socially isolated Aboriginal people;
- ▶ Dual diagnosis (addiction and mental health), and co-infected (Hepatitis C (HCV));
- ▶ Older Aboriginal people (especially following receipt of residential schools compensation);
- ▶ MSM;
- ▶ Two spirited, Gay, Lesbian, Bisexual and Transgendered people; and
- ▶ Aboriginal people in correctional facilities.

Gaps, Redundancies and Strengths

The core questions asked of respondents related to perceptions of gaps, redundancies and strengths upon which the sector could build. In particular, respondents were asked to focus on the sector's organizations, funders and their relationships, instead of front-line gaps, redundancies and strengths.

Gaps

Respondents identified many gaps in HIV and AIDS services for Aboriginal people in B.C. Themes included access to services, the capacity of communities to effectively respond to HIV and AIDS as it affects Aboriginal communities, and organizational and system capacity.

Access gaps

Respondents identified that Aboriginal people have difficulty accessing, or are not able to access:

- ▶ Housing (often described as low-barrier, supportive, or insufficient portable housing subsidies);
- ▶ Mental health services;
- ▶ Addiction and alcohol and drug services;
- ▶ Primary health care, both on- and off-reserve;
- ▶ HIV Testing;
- ▶ HIV specialists;
- ▶ Acute care services;
- ▶ Safer sex and drug use supplies (particularly on-reserve but also in socially conservative areas);
- ▶ Organizations and programs specifically for Aboriginal women and youth;
- ▶ Sexual assault services; and
- ▶ Sex education in schools.

Capacity Building in an Aboriginal Community

The Canim Lake Band in the Shuswap has a history of including all the members of the community when making decisions about the future efforts in the face of HIV and AIDS are no different.

The Canim Lake Band has focused on building the capacity of its members, and their efforts have been successful in economic development, education and health. Some of the most important elements of their HIV and AIDS efforts include:

- A Circle of Life HIV/AIDS Support Group, that uses culturally specific ways to educate, as well as providing support to Band members living with HIV/AIDS, and their families;

- A Grandmothers' and Mothers' group that includes children and young people;
- Consistent community health staff who stay for a long time and build long-term relationships.

In addition to keeping the issue of HIV and AIDS (and all the related issues of substance abuse, mental and reproductive health) on the mind of community members, the Canim Lake Band's efforts include providing harm reduction resources on-reserve and helping the HA develop long-term improvements in the way that HIV and AIDS is addressed among Aboriginal people. One of their current projects is tracking the supports that Band members are receiving off-reserve and supporting other Aboriginal communities with HIV and AIDS efforts.

These issues are directly affecting the health of Aboriginal people, and many of the gaps identified through interviews are consistent with what have been identified in several settings over the past ten to fifteen years. Access is inhibited by racism, serostatus discrimination, distance and a general lack of services. Even when services are present, the lack of culturally appropriate approaches inhibits Aboriginal people from accessing prevention, testing, treatment and support services.

Community capacity gaps

Respondents identified gaps in the capacity of Aboriginal, on-reserve communities, including:

- ▶ Many communities that are not ready to provide any supports to those vulnerable to contracting HIV;
- ▶ Stigma against HIV that makes it difficult for people to return to their communities;
- ▶ Funds for prevention and education in remote areas and small communities;
- ▶ Funds for Bands to get programs up and running; and
- ▶ HIV and AIDS awareness among some Aboriginal leaders, and specific education programs for Chiefs and Council.

It was also noted that in off-reserve communities there is not universal adherence to the BC Centre for Disease Control's (BCCDC) best practices for harm reduction efforts, particularly with regard to wide availability of safer drug use supplies such as needles, syringes, sterile water, plastic crack-pipe mouthpieces and push sticks. Some respondents felt that cultural norms in non-Aboriginal communities may be a factor in reducing access to harm reduction supplies, and felt that there could be more innovative ways developed to distribute these items.

Organizational capacity gaps

Respondents felt that while people working in the sector are committed and creative, they are hindered from being more effective due to gaps in the capacity of organizations, including:

- ▶ Human resource challenge such as low pay scales, job insecurity and understaffing in all agencies including HAs;
- ▶ The ability to carry out succession planning, resulting in organizational memory issues;
- ▶ Supports for staff working in the area of Aboriginal HIV and AIDS;
- ▶ Funding or resources to engage in collaborative planning, partnership development, fundraising, evaluation and reporting;
- ▶ A traditionally isolated focus of HIV and AIDS and Aboriginal health that needs to be shared by a wider range of staff who work with vulnerable Aboriginal people;

- ▶ Baseline data that would allow analysis and comparisons of funding-to-outcomes;
- ▶ Accountability and approaches that ensure cultural safety at non-Aboriginal organizations; and
- ▶ Systems to connect on-reserve Aboriginal people with HIV-related supports, while protecting their anonymity.

System gaps

- ▶ Cross-provincial communication about developments in the sector or research related to Aboriginal HIV and AIDS;
- ▶ Epidemiological data sharing and coordination of services within HA's and sector-wide;
- ▶ Collaboratively-developed plans with targets and budgets for each health region;
- ▶ Jurisdictional issues (including non-transferability of disability benefits on- and off-reserve) that make it difficult to access disability supports for Aboriginal people moving on- and off-reserve;
- ▶ Social transfers that make it difficult to maintain stable housing and nutrition;
- ▶ Clarity of roles and reach of provincial organizations and overlapping mandates of organizations in urban settings;
- ▶ Collaboration among stakeholders including AASOs, ASOs, and Aboriginal communities;
- ▶ Referral systems that are centred on the needs of clients and effectively facilitate supports as people move on- and off-reserve;
- ▶ Provincial expertise outside of the Lower Mainland; and
- ▶ Isolation of HIV and AIDS from related service delivery systems, such as housing, mental health, and programs for sex trade workers.

Geographic and demographic gaps

Northern Health (NH) – Prince George focus

With the high Aboriginal youth population within NH and the challenge of placing limited funding in such a large region, there are many service gaps. One urban Aboriginal agency funded by PHAC is attempting to address the urban Aboriginal HIV and HCV crisis in Prince George. Service gaps include: Masset, Skidegate, the northwest, and the northeast. Leadership off-reserve comes from the Northern Task Force, Positive Living North and Central Interior Native Health.

Nuu-chah-nulth and VIHA working together

In 2006 during a Tuberculosis (TB) outbreak, it was crucial for the Nuuchah-nulth Tribal Council (NTC) and the Vancouver Island Health Authority (VIHA) to work together. Out of this crisis, and a recognition that other diseases were travelling both onto and off of reserve, the NTC and VIHA decided to manage services together.

The relationship has been maintained and strengthened through project funding approaches that allow each to refer clients to one another's services, as well as a partnership that provides medical and nursing professionals at a downtown health service for urban poor people in Port Alberni. This urban health service does not have ongoing funding but remains the primary link to a population that was the source of the 2006 (TB) outbreak and continues to be at risk for many other health concerns, including HIV and AIDS. The TB outbreak has been managed well and both partners want to continue to meet the needs and address the health concerns of marginalized populations in the urban scene.

More recently, VIHA funded a DVD produced by Nuuchah-nulth youth at an alternative school on the topic

of sexually transmitted infections. The students worked in collaboration with NTC Nursing, NTC Education, VIHA and School District #70 to produce the DVD. The youth presented the DVD to the NTC board of directors who were impressed by the message and its anticipated impact on youth. It is hoped the product will be distributed to district schools, NTC health centres and within VIHA. NTC Nursing is also planning to include this DVD in their Harm Reduction program.

Communicable disease control management is another area of program integration for NTC, Cowichan tribes, FNHI and VIHA. This working relationship recognizes the mutual support required to provide effective and efficient services to First Nations clients.

Both NTC and VIHA create and support the achievement of mutual goals by training their staff to high clinical standards and having an appreciation of each others' cultures. The signing of the Memorandum of Friendship and Mutual Respect in 2009 was a sign of both the positive relationship that has been built up and the expectations that have developed between First Nations people of Vancouver Island and VIHA.

Interior Health (IH) – funding is focused in Kamloops and Okanagan

IH supports Kamloops- and Kelowna-based agencies, consistent with population demographics. Service gaps include Williams Lake (with the exception of a youth HIV worker at the Williams Lake Boys' and Girls' Club Drop-in Centre known to as NOOPA), Quesnel, Lytton, Lillooet and the east and west Kootenays. Respondents noted gaps in services and supports related to testing and the availability of HIV specialist expertise. Leadership off-reserve is present in Friendship Centres, the Okanagan Aboriginal AIDS Society, and Metis Family Services.

Vancouver Island Health (VIH) - gaps in Victoria and North Island

Services were identified in Duncan, the west coast Nuuchah-nulth communities and Nanaimo. A clear gap appears to be in Victoria, where no Aboriginal-specific HIV/AIDS services exist, as well as the North Island region and in Comox and Campbell River. With no AASOs, Aboriginal leadership is from Friendship Centres and Tribal Councils.

Fraser Health (FH) – increased off- and on-reserve Aboriginal supports needed

The high Aboriginal population in the Surrey, Mission and Chilliwack areas warrants increased supports for HIV prevention and education services, and services targeted for women and youth. FH supports one contract within K'la-How-Eya at \$40,000. FH also prioritizes IDUs and incarcerated / recently released individuals in its plan, but the Aboriginal contract has few resources to provide supports in prison. Pacific Community Resources Society provides harm reduction services in Chilliwack, with little distribution to on-reserve communities. Aside from FNIH there are no other Aboriginal funded programs. There is limited capacity for off-reserve Aboriginal leadership in HIV in the region.

Vancouver Coastal Health (VCH) – gaps in women and youth services

VCH puts a good deal of funding into the Downtown Eastside and into clinical services. Despite the HIV crisis and high Aboriginal population, there are no specific services for Aboriginal women or youth. Both these groups cobble together survival services from mainstream agencies. VCH funds the Vancouver Native Health Society. PHAC supports two urban projects: one for urban APHAs, and another for sex trade workers and inmates. The Urban Native Youth Association provides Aboriginal youth services but is not funded for HIV/AIDS services of any kind. Richmond has no Aboriginal HIV/AIDS programs for an Aboriginal population of over 1,200. Off-reserve leadership is engaged in collaborative tables.

Redundancies

None of the respondents identified redundancies, and there was a general recognition that the needs exceed the capacity of the service providers in all regions.

A few respondents did identify issues with efficiency in the sector, including:

- ▶ Underutilized resources, such as a health clinic that was funded to operate only a few days of the week even though demand for services exceeded that;
- ▶ Case management approaches that result in more than one advocate or case manager supporting an individual. Respondents felt this could be improved with a more collaborative approach to case management and a more direct referral process, such as the Partners In Community Case (PICC) Management initiative in Kelowna and;
- ▶ Questions about the relative benefits of using contracted versus direct services relating to cost efficiencies, reach and leveraging of additional funds.

Strengths

Respondents were asked to identify strengths within their health region upon which the sector could build to improve its response to Aboriginal HIV and AIDS. There were several themes within which responses fell, with respondents identifying strengths occurring in communities, HAs, organizations, programs, and collaborative processes.

Communities

Respondents identified that building capacity and readiness in Aboriginal communities is achievable and has happened in some notable cases. Several communities that are addressing the needs of their members were identified as using a variety of starting points (a TB outbreak as a catalyst in one case and a leadership focus on increasing overall community and band member capacity in another). These communities have built community awareness and stronger responses to HIV and AIDS among their members. Some of these communities are helping other communities do the same.

Other strengths regarding communities identified by respondents were:

- ▶ An interest among Aboriginal people in the health of communities and their members;
- ▶ A resilient response to cultural safety, whereby Aboriginal people are receiving support and counseling from informal, personal networks;
- ▶ Integration of elders in awareness efforts and projects that build the capacity of youth;
- ▶ Good relationships between Bands and AASOs;
- ▶ Workshops and learning events on-reserve that engage chiefs and council, youth and elders; and
- ▶ On-reserve schools that enable effective and appropriate HIV and AIDS education at an early age.

Many respondents have reflected on what activities contribute to increasing the readiness of Aboriginal communities. These are included in the community dialogue theme of this report.

Health authorities

Respondents reported that some of the strengths for building a better response to Aboriginal HIV and AIDS are occurring through HAs. In particular, Aboriginal directors were regarded highly, alongside other advocates for harm reduction and HIV and AIDS services inside HAs. Some HA staff were recognized for leadership and for taking reasonable risks to pilot collaborative approaches to service delivery. Many respondents identified a positive clinical model in their health region, and were particularly supportive of HAs that have shifted resources towards primary care in light of the overall savings to the health care system. Some respondents feel that there are as-yet little used resources such as tele-health, a tool that may reduce costs and travel time currently spent on in-person meetings, leaving more funds available for services to Aboriginal people.

Organizations and programs

Respondents discussed a strong group of dedicated, experienced, creative and motivated service providers serving local needs. Provincial and local Aboriginal HIV and AIDS organizations are seen as important foundations, each with their own strengths. The

individuals who work in the sector were recognized for their commitment, creativity and ability to create resources and opportunities. Some ASOs were seen to be working hard to increase cultural competence and prioritize client needs.

In the area of education and prevention, several strengths were identified, including organizations and programs that:

- ▶ Provide or push for more effective harm reduction initiatives;
- ▶ Find ways to share personal stories and to promote the struggles and successes of APHAs using video or theatre;
- ▶ Listen to youth and support them to reduce their own vulnerability and to build on their own capacities as educators;
- ▶ Bring Aboriginal culture to the street level (e.g., the Fire Pit program in Prince George);
- ▶ Deliver HIV and AIDS teaching within traditional and local cultural approaches and present the disease within a holistic context;
- ▶ Integrate HIV and AIDS education in alcohol and drug treatment for women;
- ▶ Reach out to rural and remote communities and take the time to build relationships; and
- ▶ Provide education to Aboriginal people on rights and how to access mainstream health.

Aboriginal and Non-Aboriginal agencies in the Okanagan

Okanagan Aboriginal AIDS Services (OAAS) and the Living Positive Resource Centre (LPRC) have a unique partnership that benefits Aboriginal people and communities throughout the Okanagan.

LPRC serves a general population affected by HIV and AIDS, while OAAS works from an Aboriginal perspective to inform, serve and advocate for Aboriginal people and communities.

The partnership between OAAS and LPRC started with a shared commitment to stopping the epidemic, to anti-discrimination and fighting colonialism. The two organizations chose to co-locate when OAAS suffered a significant funding shortfall. To define

the relationship, the two organizations developed a clear understanding of and distinction between their roles and committed to financial and program accountability.

Defining the fundamentals of the relationship and identifying collaborative approaches to administration and accountability are important to ensuring the autonomy of OAAS and its Aboriginal-centredness. OAAS operates as a program of LPRC but has its own identity and independence. At one point the two organizations shared space, office equipment, a budget and complimentary goals; however OAAS has since established its own offices. Their partnership enables each organization to work more effectively towards their goals, facilitate cross-referrals and support a broader range of people in the Okanagan.

In the area of treatment, strengths identified include:

- ▶ Provision of HIV clinical expertise and supports in an Aboriginal environment;
- ▶ Providing individualized advocacy (such as through a patient navigator), that integrates housing and harm reduction;
- ▶ Outreach approaches that bring medical care, testing and counseling to rural and remote communities;
- ▶ Approaches to building capacity of physicians to provide HIV expertise outside of the Lower Mainland;
- ▶ Treatment programs that accept problematic substance use and serious addictions;
- ▶ Inclusion of Aboriginal people in program evaluation and improvement; and
- ▶ Learning from the success of Aboriginal people that are getting and staying healthy.

Collaboration

Respondents see promise in different types of collaboration across the province. Locally, respondents identified concrete efforts such as collaboration between the OAAS and the LPRC, as well as other examples of co-location that occur between AASOs and ASOs and between HAs and First Nations. Collaborative case management processes, such as Kelowna's PICC Management process, were also identified as a strength that could be applied in other communities. In a few cases, respondents said that school districts and principals were supportive of HIV awareness, and gave access to HIV and AIDS educators.

Regionally, respondents identified regional collaborative tables as strengths through which the sector could focus efforts on local realities. Provincially, the ROR group is seen as a leader in provincial collaboration. The Provincial Health Services Authority's (PHSA) project to develop a standardized outcome evaluation tool is also identified as a positive collaborative step that may help to make reporting more efficient. Also noted was a new initiative between the First Nations Health Council and VCH that will attempt to improve data sharing issues was also noted.

Summary of Respondents' Description of the Sector

Respondents identified that the sector is complex and driven by a committed group of individuals within SOs, funding agencies and policy makers. However, the sector could be better connected and better resourced. Respondents noted a need for the implementation of successful models throughout the province, rather than in isolation.

There are several issues outside the control of the sector's organizations (such as disability payments and historical jurisdictional issues), and others that are within the sector's powers to control (such as accountability and collaborative relationships). Finally, there are a range of issues that are within the sector's ability to influence, such as the development of primary health care settings and collaborative case management approaches. The following section includes broader analysis of these and other issues, and gives shape to the issues, solutions and ideas shared by respondents.

Themes, Observations and Potential Goals

Interviews with respondents were based on a set series of questions, but respondents also discussed issues that were relevant for their particular organization and clientele at the time of the interviews. This section of the report includes themes that were generally expressed across more than one health region. For each area, the goals and ideas for improving efforts across the sector are also included. A summary of the goals and ideas shared by respondents is included in Appendix C.

Access

One of the most frequently mentioned issues was access to services for Aboriginal people in rural areas, the lack of which creates transportation issues, poor health outcomes and preventable deaths. Access issues were identified in urban areas as well, with key factors being racial discrimination, distance to services, and a general shortage of services.

Respondents felt that all services related to HIV and AIDS should be culturally safe services. The discussion themes related to Integration, Education and Prevention, and Treatment all contain ideas that would improve access and cultural safety.

Accountability

Respondents felt that accountability is an important part of ensuring that the sector and its organizations are effective and credible to both each other and outside funders. Several spoke positively of clear accountability standards shared between contracted services and HAs. It was noted to be important to include Aboriginal people in evaluation and program improvement, and provide adequate resources to meet deliverables.

Respondents identified unresolved issues stemming from the reorganization of health care in B.C. into regions, and the need for Aboriginal health to be embedded in the overall work of HAs. HSDAs within HAs appear to sometimes operate independently of one another.

Many HAs have inherited programs and contracted services from the Province but accountability relationships and definitions have not been completed, leaving gaps in the measurability of services available to Aboriginal people. The role of Aboriginal directors remains unclear to many respondents, although there is support for these positions to be fully integrated into the oversight of all services for Aboriginal people. Integrating Aboriginal health

interests across diverse areas such as mental health, addictions, public health and chronic disease management will help address issues related to HIV and AIDS and other complex health conditions in a more holistic manner.

There could be a focus on accountability for services to Aboriginal people related to HIV and AIDS, including Aboriginal and non-Aboriginal contracted services and services operated by HAs. One starting point would be to identify measurable goals for all health regions based on goals stated by the Health Ministries. Several respondents identified a starting point for these goals, including reduced levels of transmission, particularly among women and other vulnerable populations, as well as increased rates of treatment uptake and maintenance.

Once stakeholders identify common goals across the province, the MHLS could consider which “best” practices (for example, those related to harm reduction) should be required practices, and these could be set out in deliverables for HAs.

At the organizational level, respondents familiar with PHSA’s work to develop a shared accountability template felt that this would be a positive development, especially if all government funders of Aboriginal HIV and AIDS services used the same template.

Awareness

Respondents felt that there is a widespread lack of awareness of cultural issues and of HIV in general. Stigma was identified as one of the main impediments to building the capacity to deliver services and supports for APHAs. Some felt that consistent and ongoing social marketing was essential to reducing stigma, and the effort of Cancer organizations was identified as a model for maintaining a high level of awareness that has reduced stigma in that sector. This is an area where a provincial focus would be reasonable.

Simple messages (how HIV is transmitted, the impacts on individuals who are positive, and the need for family and community to support APHAs) would benefit Aboriginal people on-and off-reserve and service providers who come into contact with APHAs.

Collaboration

Respondents felt that collaboration between a range of stakeholders (such as regional tables) is important for communication, acquiring and directing resources, and setting outcomes and measurables. Respondents felt that initiatives need to be inclusive, based on mutual accountability to improving health outcomes for Aboriginal people, and be used to achieve mutually positive ends. Membership at collaborative tables tends to change, making it more difficult to form working relationships among participants. Those involved in collaborative tables may want to consider improving knowledge transfer by recording discussions in greater detail and building each table’s capacity for having a long term strategic effect that is built up through concrete collaborative activities.

Some respondents suggested that regional collaborative bodies could have a more structured set of responsibilities and powers. Groups that are already meeting and discussing HIV and AIDS (e.g., the Northern Aboriginal HIV/AIDS Task Force) could be given the responsibility for setting goals for Aboriginal HIV and AIDS in line with established targets for the sector provincially, assessing and planning services within their health region, and budgeting to address pivotal issues.

Respondents also identified specific collaborative efforts between AASOs and ASOs that were positive. However, there are still some significant challenges to building collaborative efforts, including shared motivation, vision and values, clarity of roles, cultural awareness and trust. Respondents noted that staff moving from one organization in the sector to another are in a position to facilitate partnerships between ASOs and AASOs. Some opportunities for specific future collaborations are with organizations working closely with particularly vulnerable populations, including youth organizations, drug users' groups and needle distribution programs, and organizations serving women and STWs. Such partnerships could help improve the cultural safety of services for Aboriginal participants using those programs.

Finally, respondents noted that there could be better collaboration between federal, provincial and regional funders to coordinate resources, build the capacity of communities and organizations, simplify funding and accountability processes, and address jurisdictional issues. Dr. Evan Adams, B.C.'s Aboriginal Health Physician Advisor, has recommended one approach to addressing this gap, which is included in Appendix B of this report. His proposal would see the development of a high-level collaborative committee that would assess data, provide direction and facilitate resources to achieve treatment, education and prevention goals while bridging traditional wisdom with technical expertise.

Other ideas related to collaboration are discussed in the Leadership and Organizational Capacity themes.

Communication

Respondents felt that there could be better communication across the province in relation to developments in the sector, including:

- ▶ ROR, the FNHC, provincial stakeholders issues and other related developments;
- ▶ New treatment approaches such as the Premier's announcement of the government's intention to expand HIV care and treatment; and
- ▶ Research that is relevant to addressing the epidemic at different points on the continuum of vulnerability.

Information could be distributed across the province in a more organized, timely and structured manner. One organization – likely a provincial Aboriginal HIV/AIDS organization – could be funded to provide this knowledge translation. One suggestion includes the development of plain-language summaries of information. Recipients of this information would include AASOs, ASOs, physicians with an Aboriginal HIV / AIDS caseload, HA staff

working on Aboriginal health and HIV/AIDS and other service providers working with Aboriginal people. There could be an online searchable database of plain-language information, as well as access to the detailed reports upon which the plain-language summaries are based.

Community

There are two main types of Aboriginal communities in B.C.: on-reserve, where Aboriginal leadership is clear and structured; and off-reserve, where Aboriginal leadership is less clear and less structured.

Although only a few Aboriginal communities in B.C. were recognized for their proactive response to HIV and AIDS, respondents felt that one of the most positive impacts that can occur would be to build the capacity of Aboriginal on-reserve communities to provide HIV and AIDS services and supports to their own members.

Respondents identified goals for improving the capacity of Aboriginal communities to support their members. Suggestions of goals for the next five years include:

- ▶ Increased readiness and service delivery in Aboriginal communities;
- ▶ More thorough follow-up on education and prevention in Aboriginal communities, which in turn builds capacity by training and providing support to local trainers;
- ▶ Improved training and awareness to Aboriginal community members to address stigma, improve the ability of communities to prevent HIV and AIDS, and support APHAs at end of life;
- ▶ Coordinating an improved approach to assessing and recording the level of community readiness of all communities in B.C., especially in those areas where transmission is increasing. This could include the development of a concise community readiness tool that is applied and shared with any organization working with a particular community. The community readiness level would be available for educators and prevention professionals to review annually and to allocate resources to benefit specific areas or populations where transmission is occurring, or where risks are high;
- ▶ Developing a resource guide for communities interested in increasing their own level of readiness. Such a guide would be similar to a Community Development Toolbox, and would have specific targets for each component, such as front-line workers, committees and leaders.

Aboriginal people who return to their home community at the end of life would benefit from the development of an individualized transition plan and approach that builds that capacity of local health services, family and community members to support that individual.

While off-reserve Aboriginal communities were less frequently discussed, community readiness affects access to harm reduction supplies and health and social services. It is important to identify and build Aboriginal leadership from local organizations, Friendship Centres and Metis organizations, and include these leaders in collaborative tables.

Cultural Gaps and Cultural Safety

Respondents identified that HAs are engaging in cultural awareness training with the goal of increasing cultural competence of staff and cultural safety of services. Hopefully this will increase the number of non-Aboriginal organizations that are delivering services in a culturally safe manner.

A cultural gap exists between medical and Aboriginal traditional knowledge and medicines, which deepens the cultural gap because western medicine generally ignores the spiritual nature of healing. Current medical approaches to HIV and AIDS are centred within a western paradigm, which can conflict with traditional and holistic approaches. This creates an unsafe space for Aboriginal people and reduces the likelihood of them accessing treatments that can save their lives. Aboriginal people benefit from learning and recovering this knowledge.

If there is an expansion of Highly Active Anti-Retroactive Therapy (HAART), the BC Centre for Excellence in HIV/AIDS (BCCFE) could recruit or develop a relationship with Aboriginal HIV/AIDS organizations and cultural experts to guide the implementation of HAART among Aboriginal people. This could be a paid advisory group with members from all regions of the province and should be tasked with helping to achieve specific goals for implementation, and could include ROR members, or Board members from AASOs and Tribal Councils active in providing HIV and AIDS services.

Other cultural gaps identified include the gap between medical and non-medical service staff. Several respondents felt that some medically-trained staff are resistant to the work of non-medical professionals, particularly related to pre- and post-test counselling. It was suggested that cross-training and the development of standards for these activities would enable Aboriginal people to get the supports they need from Aboriginal staff. Several respondents felt that Aboriginal people should be trained to take on pre- and post-test counselling and the reportability requirement.

Should cultural safety be set as an accountability criteria for all ASOs and HA-provided services, HAs could contract an Aboriginal organization to assess and build cultural safety within organizations serving Aboriginal people.

Those who discussed cultural safety issues felt that all services should be culturally safe, but there is currently no standard or evaluation methodology for cultural safety used in the sector. However, the National Aboriginal Health Organization has tools that may provide a foundation for this work.

Education and Prevention

Many organizations, including provincial and local AASOs, Friendship Centres, and Band health services are delivering prevention and education programs in various parts of the province. However, there is no mechanism or organization that coordinates or sets standards, trains educators, or evaluates the progress of education in raising levels of community readiness across the province. HIV and AIDS educators working with Aboriginal people could collectively develop an accreditation standard and processes for training and refreshing new and existing educators.

This gap is evident in prevention efforts as well. For example, the MHLS's 2006 *Priorities for Action* Progress Report identified an inability to analyze harm reduction efforts across health regions. Respondents in this project confirmed that needles are not widely available, and are often exchanged rather than distributed. Some felt that HAs could take a stronger stand in the face of social conservatism in off-reserve communities to expand needle distribution. There could also be improvements in collaboration among HAs, AASOs and ASOs to improve the reach of harm reduction services. It was suggested that pharmacies be enlisted to distribute needles (as has happened in some areas of the Interior) and that secondary schools would be good places to distribute condoms.

Interagency harm reduction and cultural competence

In 2006, Healing Our Spirit, Chee Mamuk, and YouthCO formed a steering committee to guide an innovative project called the Aboriginal Youth Harm Reduction Project. This collaboration brought together youth and adults, Aboriginal and non-Aboriginal organizations, government and non profit HIV/AIDS organizations - an obviously diverse mix of which to build a partnership. All partnerships require creativity, clear communication, and commitment; this partnership is no different.

The project is housed out of YouthCO and uses a strengths-based approach. This approach builds on traditional teachings and arts-based curriculum as a place to begin conversations about health and wellness. The project aims to support Aboriginal youth in making healthier, safer choices in their lives, and to reduce the rates of HIV and HCV among Aboriginal youth.

While the Aboriginal Youth Harm Reduction Project has many successful workshops under its belt, it faces basic challenges each fiscal year due to the uncertain nature of annual project funding and the busy schedules of partner organizations who are already working at over capacity. Despite these challenges the project has many strengths, including a steering committee that continues to meet once a month. The steering committee offers an Aboriginal perspective and mentorship to project staff, supports long term planning for the work, and ensures that all partner organizations have coordinated and complimentary mandates. In addition, the project has passionate youth educators who care deeply about the future of their Aboriginal youth peers.

This partnership continues to grow and shift to adapt to the needs of Aboriginal youth.

Other issues related to prevention and HIV/AIDS training for those delivering services to Aboriginal people, such as housing and mental health workers, social service agency staff and other ancillary services that are needed by Aboriginal people.

Respondents generally felt that local Aboriginal organizations should carry out local education and prevention programs as well as cultural training so that local capacity and relationships are built on the basis of local cultural relevance. Several suggested an increase in the use of informal methods such as theatre and storytelling, and many suggested concerted efforts around education and prevention for Aboriginal people and communities.

Outreach to Aboriginal people could be more structured and comprehensive, especially for communities where transmission is high. One suggestion is that an HIV-trained nurse or counsellors could accompany HIV educators to discuss testing and treatment, and to coordinate the testing and counselling requested by particular communities.

Epidemiological data that specifies locations and vectors of transmission could be generated and shared with educators, upon request from regional medical health officers (MHOs), with support from the BCCDC. The data would be subject to clear protocols for and limits to the release of community-specific information, and could be used to develop plans and set goals for specific areas where transmissions have been occurring. Care would need to be given to protecting the confidentiality of HIV positive people in small communities.

One organization could be responsible for developing basic education and prevention materials for use across the province. The materials would be available for download by anyone in the province and would be approved by an accrediting body.

Efficiencies

While none of the respondents identified redundancies or duplications, several identified ways to improve the efficiency of services for Aboriginal people. Several respondents felt that contracted treatment and support services could be better utilized because non-profits could serve more people for the same amount of money.

Another respondent suggested that, in light of the amount of work required to raise funds, it would be helpful to provide further education to funding bodies about the conditions and consequences of working in remote communities. This could help avoid any unnecessary duplication in conveying this information.

Finally, collaborative case management in urban areas reduces duplication of efforts because it reduces the amount of work required by Aboriginal people seeking services and provides a forum for facilitating access to resources such as housing, addictions, nutrition, and other ancillary services. Such models are seen to be effective (in urban areas) when there is an established confidentiality agreement and clients are free to give permission to have their situation discussed.

Employment for Aboriginal People Living with HIV and AIDS

Respondents identified that social isolation and a low levels of social supports are harmful for APHAs. APHAs can face racial and serostatus discrimination, and most employers are not ready to accommodate their needs. It may be beneficial to provide a means of generating revenue to achieve housing and nutritional needs outside of, or in addition to, disability payments. There are several models of employment-related social enterprise that facilitate the needs of people with particular health issues, such as Coast Foundation's enterprises for those living with mental illness.

Funders and practitioners could develop a provincial employment strategy for APHAs. Such discussions should include: providing opportunities for APHAs that may have an impact on prevention, education and cultural safety initiatives; building social enterprises that hire APHAs; and accommodation practices for employment in other sectors. This could be developed in partnership with FNIH to ensure that the program responds to the fluidity of movement of Aboriginal people, and could use current employment incentives in the province's Persons With Disabilities (PWD) policy as a starting point.

Funding and Identity

Some respondents discussed the unresolved issues with access, funding and human rights dilemmas related to a funding model that differentiates on the basis of identity. Federally, the differentiation between on-reserve and off-reserve Aboriginal people creates difficulties for people moving from one jurisdiction to another, and results in significant work in accessing funding for disability supports. Several HAs reported that they do not consider FNIH as a partner, because the HA is moving towards a model where it is assuming responsibility for the health of all Aboriginal people in its region regardless of whether or not they live on reserve. In these cases, the focus of the HA is on working with Bands or Tribal Councils and their health professionals, but the issues become more complex when an HA works with a community where health services have not been transferred from FNIH.

Provincially, another funding dilemma presents for organizations serving a mixed (Aboriginal and non-Aboriginal) clientele. Aboriginal funding is seen as a set of dedicated resources to support the specific needs of Aboriginal people, but there is no means of accurately measuring Aboriginal participation because people cannot be forced to disclose their Aboriginal status off-reserve. Non-Aboriginal organizations may not feel they are obligated to provide culturally safe services even though a significant number of their clients are Aboriginal.

The result is an additional set of considerations and struggles for Aboriginal people, AASOs and ASOs, and unresolved disagreements about relative levels of funding and accountability in light of significantly worse health outcomes and mortality rates for Aboriginal people. While it is unlikely that these issues will be resolved in the short term, funders should recognize and take steps to address the symptoms of these identity-based distinctions and consider collaboratively-developed longer term outcomes that are co-created by Aboriginal

stakeholders. In addition, funders should insist on high levels of accountability for Aboriginal health impacts from both Aboriginal and general health and contracted services.

Funders could start by pooling new resources to achieve shared aims related to addressing the jurisdictional and service gaps that result from these distinctions. For example, FNIH (which is responsible for non-insured health benefits) and the Ministry of Housing and Social Development (MHSD) could develop a process for streamlining access to disability benefits for APHAs moving on- and off-reserve.

Fundraising

There is a shared understanding that the amount of funds currently available to address the epidemic is insufficient and that additional resources need to be leveraged. While accountability requirements were seen to help build credibility of organizations and programs, many felt that organizations also need support to raise funds, due to staff workload. This could be provided by a provincial organization not involved in direct service delivery.

Some suggested that funders create shared templates for application and reporting requirements, which may ease the workload burden.

Funding Partnerships

Federal government funders were asked to identify what they perceived as barriers to funding partnerships across different funding agencies. Respondents identified several partnerships that assist in understanding the level of complexity involved, whether they were formal or informal.

Leading Together: Canada Takes Action on HIV/AIDS (2005-10) encourages federal/provincial/regional funding partnerships. Concerted, collaborative efforts are needed to overcome differences in bureaucratic procedures and priorities to form these strategic partnerships. These partnerships can provide AASOs and ASOs and other community based organizations (CBOs) with the tools to work together at regional and provincial levels to prevent the spread of HIV.

At a government legislation and policy level there are different federal/provincial/regional jurisdictional responsibilities regarding Aboriginal health. For example, PHAC's Grants & Contributions programs do not fund any health care services under the jurisdiction of the provincial government, HAs or the FNIH on-reserve health care mandate.

At a government agency level, there are different strategic approaches including separate funding programs with varying goals, objectives and priorities. For example, the AIDS Community Action Program (ACAP) and the Non-Reserve First Nations, Metis and Inuit Community HIV/AIDS Project Fund are two funding programs under the Federal Initiative to address HIV/AIDS. As well, a community-based funding program under the federal Hepatitis C strategy exists in the same environment as the provincial BBP strategies.

At the administrative level, federal/provincial/regional government and private funders have different funding policies and practices, as well as varying contractual methodologies such as grants, contribution agreements, contracts for services, etc., when funding the same CBO or projects.

At a community level, possible confusion and increased workload can result whenever it is necessary to seek and manage funding for one project from several public and private agencies. This is due to differing funding limitations of various funding programs, and varying expectations in application processes, project reporting and evaluation expectations. These can impact proposal quality, leading to a limited ability to deliver the funded programs effectively.

Lack of awareness by agencies co-funding the same projects can lead to less effective or strategic funding or inadvertent duplication of Aboriginal community programs and services to address HIV/AIDS.

At the community agency level, challenges can occur due to capacity issues around proposal development, administration of finances, project delivery, evaluation and reporting. Proposals could meet the expectations of one co-funder but not the other.

Integration

Integration was a common theme for many respondents. It is widely seen to be an effective practice because HIV and AIDS is an issue that cannot be separated from a complex web of causes (colonialism and separation from the land, the legacy of residential schools and racism) and their effects (poverty, unemployment, poor mental health, abuse and poor overall health). Respondents recognized that the current health and social services system is disconnected, and also that providing comprehensive supports for Aboriginal people's health and well-being requires a different way of thinking about how the continuum of services is accessed.

Some of the major themes and ideas related to integration include:

- ▶ Integration of clinical, counseling, mental health, housing and harm reduction services through co-location of services. Many felt that this is the best approach to stabilizing the lives of APHAs. Where full integration of a range of services is not possible, respondents identified successful models of collaborative case management that could be replicated in other areas;
- ▶ Integration of HIV prevention and care into all services through professional development and education. Respondents felt that all service staff working with APHAs or Aboriginal people should have some basic understanding of HIV, universal precautions, entry points into services and ways to support APHAs; and
- ▶ Integration of HIV and HCV into standard health care and overall approaches to addressing Aboriginal health issues. Several respondents said that it is challenging for Aboriginal people to access primary health care, and that specialist care requires significant additional commitments and sacrifices. The best way to connect Aboriginal people with HIV expertise is at the most frequent and least costly point of contact.

Leadership

Respondents felt that leadership in relation to HIV and AIDS needs to be strengthened, both on- and off-reserve. On-reserve, respondents identified the need for Aboriginal leaders to become more engaged in HIV and AIDS issues, and to show leadership in promoting an effective response. Respondents also recognized that leaders need support, information and connection with peers to fulfil this leadership role.

Respondents identified that Elders and youth are two groups that have shown leadership and could be better supported to mobilize changes in response to HIV and AIDS.

Elders could be supported to take a stronger leadership role both at the local and provincial levels. One suggestion was to develop a provincial Elders council to guide AASOs, ASOs and the Tripartite partners by meeting semi-annually. This Elders council would help stakeholders understand how traditional methods can be included or incorporated into strategies, assist organizations in the resolution of conflict impeding progress, and bring a non-political and spiritual approach to planning, funding and implementing. An Elders council may also help to mobilize Elders within Aboriginal communities to promote HIV and AIDS awareness and action on-reserve.

Respondents suggested that Aboriginal people need to lead their own health care. Aboriginal leaders in off-reserve communities should play a role in analysis, planning, implementation and evaluation.

Organizational Capacity and Infrastructure

Respondents identified several gaps in organizational capacity that, if addressed, would benefit both Aboriginal people and the sector as a whole. These included staff turnover and related issues as well as challenges in fundraising, evaluation, reporting and collaboration. In addition, because there is an interest among Aboriginal organizations in the direction of funding through collaborative processes, it would be useful for AASOs to participate in funding decisions. There were several suggestions for addressing these issues:

Aboriginal organizations could be given incentives (ie: additional targeted funding or technical support) to:

- ▶ Build expertise in funding allocation and decision-making among Aboriginal organizations by participating in funding decision-making, through groups such as United Way and other granting bodies;
- ▶ Engage in partnership-building with projects identified by a regional collaborative table;
- ▶ Develop systems for orientation, training of new staff and retaining organizational memory and wise practices; and
- ▶ Take on program evaluation and planning activities to meet a shared standard.

With regard to human resources issues, there could be a provincial campaign that lasts several years to recruit and train Aboriginal youth and adults for work in health care. The campaign would aim to build long-term capacity among Aboriginal people and communities for assuming ownership of health care services and institutions. This campaign would reduce vacancies currently posted by HAs and help reduce unemployment among Aboriginal people.

Provincial Organizations

Respondents expressed support for the work of provincial organizations and felt that they offered particular areas of expertise that benefited the sector. The shortcomings of the provincial organizations were felt to be their ability to reach and serve the needs of a large province.

For those who had worked with the provincial organizations, Chee Mamuk and Healing Our Spirit were felt to bring a combination of expertise and Aboriginal cultural competence. Chee Mamuk was recognized as an organization that maintains a presence and builds deep relationships with communities. Several respondents said that Chee Mamuk provided excellent resources and good presentations at conferences. Healing Our Spirit's annual conference was identified as a positive event. At the same time, many respondents expressed that local cultural and traditional awareness was better served by local educators, particularly due to the great diversity among Aboriginal people in B.C.

Those who had attended a Quarterly Skills session held by Red Road were supportive. Some felt that the Skills sessions were a form of service delivery and that Red Road would have greater impact if its focus were supporting the organizations rather than APHAs.

Respondents said that the Oak Tree Clinic and the BCCfE's services were excellent and appreciated by their clients, but their location in Vancouver made them difficult to access from outlying regions of the province. Respondents appreciated data provided by the BCCDC. Several respondents suggested that the BCCfE would benefit from having greater Aboriginal representation, perhaps as an advisory group.

Relationships

Respondents discussed the importance of developing strong, supportive relationships at a variety of levels:

- ▶ APHAs with service providers and caregivers;
- ▶ Among service providers, both on- and off-reserve, who often compete for resources while being challenged to work collaboratively;
- ▶ Among HA services, ancillary services and contracted services, especially as it pertains to planning, implementation and accountability among them.

Relationships between caregivers and advocates were identified as being critical to achieving health outcomes. Respondents suggested that every APHA should have a personal contact/advocate who can help them in overcoming barriers to accessing services. Using a

collaborative case management model would reduce staff time needed to facilitate access to housing and other supportive services.

Perceptions of the health of the relationships between and within sectoral organizations and Aboriginal communities varied. Some felt that relationships were improving. Others thought that obstacles remained that inhibited positive relationships from being built and maintained, such as mistrust, an absence of shared vision and values, low awareness of cultural practices, resistance to change and a lack of clarity on roles and deliverables..

In all these cases, respondents explained the need to spend time and energy in order to develop healthy and strong relationships among AASOs, ASOs, HAs and Aboriginal communities. Given that this time and energy is not generally recognized by funding contracts, organizations are at a disadvantage in building the capacity to work together.

The importance of relationships was underlined as a significant challenge from many perspectives. At a sectoral level, respondents identified collaborative tables as positive developments. They also identified that it is difficult to build trusting relationships, especially in the context of competing for human resources and funding.

Research

Respondents identified research topics that could help improve the sectors' ability to address the epidemic, using Ownership, Control, Access and Possession (OCAP) principles. Aboriginal organizations should be supported (paid) to partner in research on the best ways to identify and address the needs of Aboriginal people on an ongoing basis. Research could include issues such as:

- ▶ Assessing the needs of APHAs on a regional basis and making recommendations directly to the Aboriginal Health Physician Advisor;
- ▶ Mapping the experiences of APHAs and educating service providers to improve service coordination;
- ▶ Identifying wise practices to maximize impact of education on behaviour and risk reduction;
- ▶ Implementing Cedar Project-type research in more remote areas to help direct prevention and education efforts; and
- ▶ Analysing the economic and social effects of harm reduction practices on acute and chronic care costs and community stigma.

In addition, there is a significant amount of research done in relation to Aboriginal HIV and AIDS, and there is no structured method for AASOs and other organizations serving Aboriginal people, to access that information. The Communication section of this report proposes an approach to knowledge translation as does the ROR Leaders Group's Provincial Coordination proposal.

Treatment

Respondents identified access to primary and expert care as a significant issue that causes challenges for Aboriginal people in terms of cultural safety and transportation issues and costs. Improving access to treatment for Aboriginal people was a goal that many shared. Many respondents discussed the benefits of positive clinical models in their health region and recommended the creation of more of these models as a necessary intervention. Crucial to the success of these models would be:

- ▶ Low barriers, accessible to a general population and a culturally welcoming environment that ensures respectful, dignified treatment and including key staff who are Aboriginal;
- ▶ Focus on primary health care, but with expertise in HIV and AIDS and other chronic diseases or health conditions that disproportionately affect Aboriginal people;
- ▶ A continuum of care (providing housing, harm reduction and nutrition) or link with collaborative and voluntary case management and referrals that help APHAs to access housing, mental health, community care and other supports as needed;
- ▶ An integrated model that includes counselling (1-1 and circles), elders, and acceptance of addiction;
- ▶ Integration of services to address trauma, mental health, addiction, the legacy of residential school and other issues;
- ▶ Carries on outreach activities to remote areas, that could include testing, treatment and support; and
- ▶ A workplace culture that prioritizes the needs of clients.

Respondents suggested that such clinics should be distributed across the province, in relation to existing gaps or on a per capita basis. The model was described as similar to Kelowna's Urban Outreach Health Services or a scaled-down version of BCCfE.

Several respondents identified that meeting the testing, treatment and support needs of Aboriginal people requires financial sacrifice for physicians in private practice – it takes longer to work in a culturally safe manner and successful treatment depends in large part on helping to stabilize the lives of people who face significant and deep challenges. Where there is insufficient demand in a community to justify the presence of an integrated primary health facility (based on reduced burden to emergency rooms and other acute services), the Ministries or partners could consider providing incentives for a local physician to provide integrated care for patients with chronic disease. This could include General Practice Services Committee (GPSC) funding for training in chronic disease, and funds for staffing with counsellors and Aboriginal patient navigators who would help to create a network of supports for APHAs

Urban Outreach Health Clinic

Kelowna's primary health care clinic, Outreach Urban Health, provides a continuum of health services, focusing on the disenfranchised and street population (including Aboriginal people) of the city. Set up and operated by IH to provide accessible inter-professional care, the clinic includes a number of innovative elements: a physician, social work, mental health & addictions, public & community health nursing, telepharmacy and an Aboriginal patient navigator with a focus on cultural competence.. Outreach Urban Health provides wound care, HIV testing, needle exchange services, counselling, case management and primary care services.

The clinic supported an internship at the BCCfE, and continues to provide expertise in management of HIV and AIDS both to patients and to physicians. It also participates in a collaborative service coordination group called "Partners in Community Collaboration", where a patient's broader determinants of health can be addressed through inter-agency case management of the client's care plan.

The Outreach Urban Health clinic was established in 2005, originally using resources from public health. As it became clear that mental health and community care clients were being served, and that there was a measurable reduction in the burden on the hospital emergency department, funding was pieced together from several budgets within the IHA. Outreach Health was expanded in 2007 with \$550,000 from the Province's Health Innovation Fund.

Conclusion

Respondents were generally happy to participate in this project, and enthusiastic about the possibility of an improved response to the HIV and AIDS epidemic among Aboriginal people. What came through the analysis is a commitment to the health and well being of Aboriginal people, some dissatisfaction with the challenges that have hindered efforts, and an awareness of the connectivity of HIV work with broader issues that have contributed to the severity of the situation.

While each individual shared their awareness of issues in their own region or local area, the cumulative impact of their responses is to call for a series of incremental changes that would have a transformative impact on the way that Aboriginal health and wellness is approached. This is evident in the frequent suggestions that HIV should be integrated in the daily work of a range of service delivery areas, and that services for Aboriginal people need to consider and respond to deeper cultural issues that affect the way that Aboriginal people access health care and supports. The most frequently expressed aspiration was for a series of primary health clinics that provide culturally safe HIV testing and treatment in communities across the province. It is likely that there are resources that currently exist that could be leveraged to reduce the initial and ongoing costs of such a model.

Respondents were also clear that the sector needs to have a greater capacity to effectively respond overall. This begins with clear targets and a more collaborative approach to planning, implementation and accountability. Respondents identified better communication, partnerships and a focus on access as strategies to achieve these ends.

While there are some elements of the sector that are new (ie: Aboriginal director positions and RHAs), the sector does not seem to have well-developed mechanisms to change beyond the responses of direct service providers. A well-delivered knowledge translation approach may help stakeholders reconsider their strategies in the face of change on a regular basis. For example, Aboriginal youth or APHAs may be well served through text-messaging or other communication approaches that are being used elsewhere in Canada and abroad. One respondent identified changes in how sex trade work is being carried out in at least one community, resulting in ineffective approaches to prevention and education in that area. Finally, information generated through the reportability requirements could become the basis for collaborative action if the data is made available in a format that does not violate an individual's right to privacy. The entire sector will have to become more nimble to effectively stop the epidemic, which will require new approaches to assessing the environment, developing and communicating strategies, building partnerships, re-training and supporting staff and freeing up or generating resources to rapidly adjust activities.

Challenges

It was originally intended that this paper would include a comprehensive inventory and analysis of government-funded Aboriginal HIV and AIDS services. In the end, a complete inventory was not possible due to lack of data. The quantitative phase, which sought to track financial resources allocation to Aboriginal HIV/AIDS services and programs, was faced with a number of challenges, including determining specific funding allocations and identifying information for agencies. As well, the subsequent qualitative component of the project could not be fully comprehensive, due to scheduling and pressing priorities for respondents.

There are several reasons for these gaps, all of which should be considered in strengthening the sector of services related to HIV and AIDS for Aboriginal people:

- ▶ Not all the stakeholders in the system were part of the direction and coordination of the project. With participation being voluntary, some respondents identified higher priority action items to address and did not take the time to participate;
- ▶ There is no agreement as to the data that is most important in addressing the epidemic. While the project initially intended to identify expenditures related to Aboriginal HIV and AIDS, other factors such as collaboration, geography and relationships are also important. A secondary qualitative survey aspired to capture this information, but availability of respondents limited the success of this stage;
- ▶ There are few consistencies in the distribution of services to Aboriginal people. Harm reduction efforts are uneven and Aboriginal organizations are not distributed in association with the entire Aboriginal population; and

- ▶ The sector is not a closed system, even within HAs. For example, funding for services can come from direct allocations (contributions originating from a number of different parts of the HA), or from the Medical Services Plan (via medical fees). It is likely that this complexity of funding will increase rather than decrease in the future, as HAs and other stakeholders look to offset the direct costs of providing services, and different disciplines engage in activities to address HIV and AIDS among Aboriginal people.

Because of these issues, it is unlikely that a comprehensive inventory can fairly describe the sector of Aboriginal HIV and AIDS services.

Based on the responses received, one potential starting point to assessing the sector and its strengths would be to collaboratively develop several sets of indicators that could be measured. Another starting point would be to use existing resources, such as the inventory completed by Healing Our Spirit in 2007, and combine those with in-depth interviews or focus groups that include:

- ▶ HA Aboriginal directors;
- ▶ HA contract managers;
- ▶ HA medical health officers;
- ▶ HA managers of direct services in areas related to Aboriginal health, HIV/ AIDS or blood-borne pathogens and primary health clinics and;
- ▶ Contracted services with Aboriginal clientele, including those funded by other ministries and regional bodies.

Such an undertaking would require significant resources because it would likely be best completed at a regional level. To ensure comparability, it would be important to base such work on evidence-informed standards that are shared across all regions.

It is hoped that this paper will help to focus dialogue and efforts to renew and improve the Province's ability to ultimately halt this epidemic.

Postscript: Early responses to the report

Feedback to Aboriginal HIV and AIDS Services in B.C.

Health authority respondents were asked for their early response to the paper.

Several emphasized that the report is an accurate reflection of the state of the sector and others suggested that some aspects of the report can be emphasized or strengthened. The following is a summary of their comments on the analysis and on the next steps.

Comments

1. There is confusion among communities and among APHAs. Communities that border two different HAs are often confused about where they should be receiving their services. Clients that migrate on- and off-reserve are often receiving conflicting messages about where they can access services. Individuals with HIV/AIDS are often confused about the many agencies offering HIV services in the larger urban areas;
2. The report could give more clarification to community-driven approaches in First Nation communities;
3. The HIV/AIDS Reference Group – proposed in the report – is a good idea;
4. Currently, there is a lack of HIV/AIDS education of community health workers. Uptake of chronic disease funding for HIV and AIDS is limited – in one HA, only 2 of 6 communities receiving chronic disease program funds are addressing HIV and AIDS. If the workers in Aboriginal communities are better trained, they will apply for the funds to be used to address HIV and AIDS.

Suggestions for Next Steps

1. Make sure that the Aboriginal directors are included in the next steps;
2. Aboriginal directors can be included, but so should others within HAs, including those working in areas related to HIV and AIDS who are not from the Aboriginal health area;
3. It would be ideal to create 3-5 high level goals for which everyone can be held accountable;
4. There is a need to create baseline data – currently we do not really know our starting point with HIV and AIDS as it affects Aboriginal people;
5. Health Authorities are interested in the opportunity to collaborate with the Tripartite First Nations Health Plan.

Questions Raised by the Analysis that could be Considered in the Next Steps:

1. Are First Nation communities that have seen responsibility for health service provision transferred receiving better services than non-transferred Bands?
2. How are individual rights included in the whole process of treatment and holistic care?
3. What are the training needs for community-centered approaches, especially in Aboriginal communities?

Appendix A: Respondents

ASK Wellness Centre	Paul Lagace, Peer to Peer Educator / Coordinator
AIDS Vancouver	David Swan, Executive Director
AIDS Vancouver Island	Katrina Jensen, Executive Director
ANKORS	Cheryl Dowden, E.D.
ANKORS and Ktunaxa Health	Gary Dalton, Community Care Team and Janice Alpine, Researcher
B.C. Ministry of Healthy Living and Sport	Dr. Evan Adams, Provincial Aboriginal Physician Advisor
B.C. Persons With AIDS Society	Ross Harvey, Executive Director
Canim Lake Band	Mary Thomas, Health Director
Cool Aid Primary Health Clinic	Irene Haig-Gidora, Manager of Community Health Services and Dr. Chris Fraser
Chee Mamuk	Melanie Rivers, Program Manager
Dr. Peter AIDS Centre	Maxine Davis, Executive Director and Rosalind Baltzer Turje, Director of Operations
Fraser Health Authority	Barbara Armstrong, Aboriginal Health Liaison
Fraser Health Authority	Leslie Schroeder, Director Aboriginal Health
Interior Health Authority	Coreen Jenner, Aboriginal Contracts Advisor
Interior Indian Friendship Centre	Barry James, Drop-In Services
Living Positive Resource Centre	Daryle Roberts, Executive Director
Lower Mainland Purpose Society	Lynda Fletcher-Gordon, Executive Director
Metis Community Services Society of B.C.	Brian Mairs, Health Services Mentor
Northern Aboriginal HIV and AIDS Task Force	Emma Palmantier, Chair
Northern Health Authority	Paul Hanki, Executive Director, Aboriginal Health
North Okanagan Youth and Family	Sharon Gillespie, Street Nurse Outreach Services Society (Vernon)
Nuu-chah-nulth Tribal Council	Chris Lemphers, Acting Nursing Manager
Okanagan Aboriginal AIDS Society	Buffy Mills, Program Coordinator
Positive Living North	Carmen Nutter, Co-Executive Director
Pacific Community Resources Society	Tom Hetherington, Manager of Addiction Services
Portland Hotel Society	Kim Markel, Registered Nurse
Positive Women's Network	Marcie Summers, Executive Director
Surrey North Community Health Centre	Sam Mohan, Director of Health Services

Urban Outreach Health Services	Andrew Hughes, Health Services Director
Vancouver Coastal Health Authority	Miranda Compton, Manager, HIV/AIDS and Harm Reduction Programs
Vancouver Coastal Health Authority	Peter Vlahos, Leader, Aboriginal Engagement
Vancouver Native Health Society	Doreen Littlejohn, Coordinator Positive Outlook
Vancouver Island Health Authority	Ian Knipe, Director, Aboriginal and Rural Health
VANDU	Ann Livingston, Executive Director
Western Aboriginal Harm Reduction	Chris Livingstone
Youth CO	Stephanie Grant, Executive Director

Appendix B: Proposed Provincial Aboriginal HIV and AIDS Strategy Group

Members:

- Aboriginal Health Physician Advisor
- Executive directors from Healing our Spirit and Red Road HIV/AIDS Network
- First Nations Health Council
- FNIH Program, Health Canada
- Representative from BCCfE
- Elder Advisor
- APHA
- Front line workers from the North and from women's services (Aboriginal staff at community agencies)
- Front line workers from on-reserve and off-reserve (preferably one from representing HAs and one from Tribal Council)

Inputs:

- HIV-related mortality data;
- HIV incidence surveillance and epidemiological data;
- Consultation with APHAs, HA Aboriginal directors, and HA and community agency staff serving hardest-hit areas and populations;
- BCCFE research data; data match(es) and data improvement

Outputs (Treatment-related):

- Identify barriers to HAART and primary health care for APHAs;
- Identify particular areas and populations where HIV-related mortality is high;
- Identify key service delivery agencies and bodies related to ensuring that Aboriginal people are able to access treatment;
- Identify capacity issues in particular areas of the province, and in particular organizations, and work with existing funders to coordinate additional resources and supports;
- Help Aboriginal communities to support members who are HIV positive and;
- Encourage relationships between APHAs and Elders in communities where they live.

Outputs (Education and Prevention-related):

- Identify and target at-risk groups amongst Aboriginal populations;
- Improve curricula and delivery methods of education and prevention-related materials and activities;
- Identify particular areas and populations where HIV transmission is high;
- Direct available funding and resources to provide HIV awareness, harm reduction and supports for communities by community-based leaders, traditional health practitioners and other health personnel in those areas (note: confidentiality issues);
- Identify capacity issues in particular areas of the province, and in particular organizations, and work with existing funders to coordinate additional resources and supports and;
- Support Elders to assist with traditional practices and cultural support activities.

Outcomes:

- Improved life expectancy and quality of life for APHAs;
- Improved capacity of Aboriginal communities to support their members who are at any stage of vulnerability to HIV, regardless of where they live;
- Align policy and implementation with traditional, local and cultural practices; and
- More direct interventions in communities at low levels of readiness, but where disease transmission is high.

Appendix C: List of Ideas and Goals Suggested by Respondents

Theme	Suggestion
Accountability	Set measurable goals and focus on accountability from ministries through to service delivery
	Differentiate between “best” and “required” practices
	Shared accountability template
Awareness	Ongoing social marketing
Collaboration	Give collaborative tables more responsibility and power
Communication	Knowledge translation and dissemination
Community	Build community capacity through trainers
	Track readiness of all communities and focus efforts based on epidemiological data
	Resource guide for improving readiness
Cultural Safety	Set cultural safety as accountability criteria
	Assess and build cultural safety at organizations serving Aboriginal people
Education and Prevention	Set standards for harm reduction and education
	Set standards for education, train and support educators across the province
	Local organizations should provide education
	Strengthen outreach and reach of prevention
	Use timely epidemiological data to target education and prevention
	Develop resources to be available provincially
Efficiencies	Assess benefits of contracted service provision
	Reduce fundraising requirements for remote communities
Employment	Develop provincial employment strategy for APHAs
Funding and Identity	Streamline access to disability coverage on- and off-reserve
Fundraising	Develop a shared template for application and reporting
Integration	Build collaborative case management

Theme	Suggestion
	Cross-train in HIV at organizations serving Aboriginal people
	Build HIV and HCV expertise in primary health
Leadership	Build capacity of Elders to guide the sector and Aboriginal communities
Organizational Capacity	Provide targeted funding for capacity building
	Campaign to recruit and train Aboriginal people
Provincial Organizations	Develop roles that do not require them to provide service delivery in every part of the province, or which focuses their efforts on populations or areas of greater need
Provincial Organizations	Build Aboriginal cultural competence at BCCfE
Relationships	Build advocacy relationships
Research	Topics that will improve service delivery using OCAP principles
Treatment	Culturally safe primary care with ancillary services
Treatment	Incentives for physicians in private practice

Appendix D: Interview Template, Community Agency

1. How would you describe the current realities of work to address Aboriginal HIV and AIDS in your region?
2. How would you describe the relationship between the various regional service delivery partners addressing Aboriginal HIV and AIDS? (Aboriginal, HIV/AIDS or BBP's, Public Health)
3. What are the best practices being used to address the needs of Aboriginal people at different stages of vulnerability to and progression of, HIV and AIDS?
4. Do you have sub-groups within the Aboriginal population? What are the best practices and gaps?
5. Taking into account work done by federal, provincial, regional, aboriginal and community groups, where do you feel that there are gaps?

6. Taking into account work done by federal, provincial, regional, aboriginal and community groups, what are the strengths or foundations upon which we can build?
7. Taking into account work done by federal, provincial, regional, Aboriginal and community groups, where do you feel that there are redundancies or duplication?
8. What do you feel would be ambitious yet achievable goals for Aboriginal HIV and AIDS in your region?
9. What is the relationship between what you deliver for the HA or PHSA and what FNHI provides or funds?
10. How do you feel that provincial/regional and federal funders and service providers could work together more effectively? Identify roles and individuals or organizations, if willing.
11. If you have experience of working with the provincial Aboriginal HIV and AIDS organizations (including Oak Tree Clinic, BCCDC, BC Centre for Excellence, Chee Mamuk, Healing Our Spirit, Red Road HAN), what do you feel are the strengths of each of the organizations? Ask for specifics and rationales or examples.
12. What information do you use to make decisions about allocating resources within the Aboriginal HIV/AIDS area? What are your information needs?
13. Who will play a role in adapting the work of your organization to a Tripartite way of working? What do you think will be the impact of the Tripartite process on how you work with your partners on Aboriginal HIV and AIDS?

Appendix E: List of Acronyms and Definitions

AASO: Aboriginal HIV/AIDS Service Organization. An Aboriginal organization that provides services to people living with, or at risk of becoming infected with HIV and AIDS.

ACAP: AIDS Community Action Program

AIDS: Acquired immune deficiency syndrome

APHA: Aboriginal person/people living with AIDS.

ASO: AIDS Service Organization, which provides services to a general population, usually including Aboriginal people.

BCCDC: B.C. Centre for Disease Control.

BCCfE: B.C. Centre for Excellence in HIV and AIDS

BBP: Provincial government's Blood Borne Pathogen Strategy.

CBO: Community-based organization.

Cultural Safety: Approaches that work to ingrain within all health-care workers a critical understanding of how power imbalances in society affect health, particularly aboriginal health.

FNIH: First Nations and Inuit Health Program of Health Canada.

FNHC: First Nations Health Council

GPSC: General Practice Services Committee. A committee of the Ministry of Health Services, the B.C. Medical Association and the Society of General Practitioners of BC, focused on improving patient health outcomes by supporting General Practitioners.

HA: Health Authority.

FH: Fraser Health Authority

IH: Interior Health Authority

NH: Northern Health Authority

PHSA: Provincial Health Services Authority

VIHA: Vancouver Island Health Authority

VCH: Vancouver Coastal Health Authority

HSDA: Health Service Delivery Area – a sub-region within a health region

HAART: Highly Active Anti-Retroviral Therapy

HCV: Hepatitis C virus

HIV: Human immunodeficiency virus

HSDA: Health Service Delivery Area

Holistic: Taking into account all aspects of a person, community, issue, disease or syndrome.

IDU: Intravenous drug user.

LPRC: Living Positive Research Centre

HIV: Human immunodeficiency virus

HSDA: Health Service Delivery Area

MSM: Men who engage in sex with men

NTC: Nuu-chah-nulth Tribal Council

OAAS: Okanagan Aboriginal AIDS Services

OCAP: Ownership, Control, Access and Possession,

PHAC: Public Health Agency of Canada.

PHSA: Provincial Health Services Authority

PICC: Kelowna's Partners In Community Case Management process

PWD: Persons With Disabilities – a designation used by the Ministry for Housing and Social Development. The designation allows PWD’s to earn up to \$300 per month without penalty.

ROR: Renewing Our Response.

SO: Service organization.

STW: Sex Trade trade worker.

TB: Tuberculosis

Aboriginal communities: Includes Metis, Inuit, urban, and Aboriginal communities, on-and-off reserve, and includes specific populations such as intravenous drug users, sex trade workers and prisoners.

Tripartite First Nations Health Plan: A ten-year plan, led by First Nations and the Federal and Provincial governments, to improve the health and well-being of First Nations, close the gaps in health between First Nations people and other British Columbians, and fully involve First Nations in decision-making regarding the health of their peoples.

Upstream interventions: Activities that occur before a person contracts HIV or which build resilience to prevent becoming infected with HIV.

Vulnerability continuum: the range of points in a person’s life where factors arise that increase the likelihood of contracting HIV and AIDS, or of having HIV progress.

Appendix F: Resources

B.C. Tripartite First Nations Health Plan. First Nations Health Council Presentation to Vancouver Island First Nations Health Governance Conference, `

A Case Study of HIV/AIDS Prevention Strategies with Native American Communities. Rebecca Minish, March, 2007

Cultural safety’ tackles racism in aboriginal health care. Wendy Glauser

Article on website of Indigenous Physicians of Canada website. February, 2009

Chee Mamuk’s “Mobilizing on HIV and STIs in Aboriginal Communities” course is in Terrace, BC this week – Press Release, BCCDC

Community Readiness: A Handbook for Successful Change. Tri-Ethnic Centre for Prevention Research, 2006

The Ethics of Funding Population Health. Brian Evoy, Ph.D. Powerpoint Presentation to Vancouver Coastal Health Population Health, April 15, 2009

Evaluation of the Impact of Making HIV a Reportable Infection in British Columbia. P.R.W (Perry) Kendall, Provincial Health Officer, 2006

FINAL REPORT OF FRONT-LINE CONSULTATIONS: Knowledge Exchange Brokering for HIV/AIDS Information. Canadian AIDS Treatment Information Exchange (CATIE), 2008

HIV/AIDS Environmental Scan with First Nation Communities in British Columbia.

Lori Sellars and Healing Our Spirit, 2007.

HIV/AIDS ANNUAL REPORT. 2007, British Columbia Centre for Disease Control

HIV in British Columbia: Recent Trends. Presentation for the Pacific AIDS Network, Stephen Smith, February 2009

Integrated Approach to Immunization On-Reserve. Draft Agreement between First Nations Health Authorities/Services, Vancouver Island Health Authority, First Nations Inuit Health B.C., 2009.

The Intersecting Risks of Violence and HIV for Rural Aboriginal Women in a Neo-Colonial Canadian Context. Colleen Varcoe, RN, PhD, Associate Professor, School of Nursing, University of British Columbia, and Sheila Dick, BEd, Counsellor/Family Support Worker, Canim Lake Band, Tsq'escenemc Nation, Journal of Aboriginal Health, 2008.

Inventory of HIV Programs and Services available to Aboriginal People in B.C. Leslie Varley, 2008

Making Care Visible: Antiretroviral Therapy and the Health Work of People Living with HIV/AIDS. Making Care Visible Working Group, Toronto, ON, 2002

Next Steps for HIV Prevention Programming: Emerging Issues from the CATIE Knowledge Exchange Consultations. Breakout Group Discussions & Results

Practice Support Program Supporting Data Analysis. General Practice Services Committee. April, 2007

Priorities for Action in Managing the Epidemics: HIV/AIDS in B.C. Ministry of Health (2006 and 2007 Annual Progress Reports)

Privacy and Confidentiality Agreement, and PICC Outline. Partners in Community Collaboration. Kelowna 2008

Regional Profiles of First Nations Communities According to Current Provincial Health Authority Regions. First Nations Health Council, 2009.

Situational Analysis: A Background Paper on HIV/AIDS & Aboriginal People. Special Working Group on Aboriginal Issues, Ministerial Council on HIV/AIDS, 2001.

Students on the move: Ways to address the impact of mobility among Aboriginal students. Canadian Council on Learning May, 2008

Unifying and Strengthening the Response to HIV and AIDS in Aboriginal Communities in B.C. Report on meeting of Aboriginal HIV and AIDS stakeholders, March, 2009.

Vancouver Drug Use Epidemiology. CCENDU Report, Jane Buxton, 2005

Where Does the Money Go? Proactive Disclosure of Grants and Contributions for Aboriginal People. Congress of Aboriginal Peoples, 2007



Ministry of
Healthy Living
and Sport